

Partnership in Improving Quality of Obstetric Fistula Care: A Family Systems Perspective

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ABSTRACT

Literature review reveals that women in treatment for obstetric fistula commonly present with various psychological symptoms including depression, shame, diminished self-esteem, post-traumatic stress, somatic complaints, avoidant and resignation coping and, resentment. This is as a result of the familial as well as social dynamics inherent in the course of recovery. These dynamics include, among others, abandonment, discrimination, social ostracism and marginalization. Family Systems approaches postulate that change in one part of the system, leads to change in the whole system. Obstetric fistula thus leads to unhealthy functioning in the family system in different forms including disrupted marital relationship and limited social support. The knowledge gap that the study sought to investigate related to specific family focused systemic interventions either applied during intervention or proposed as part of the continuum of care in the treatment of Obstetric fistula. The study employed a systematic review of studies conducted on treatment and care of Obstetric Fistula patients. This review revealed a gap in systemic family focused interventions, by public health practitioners and other relevant stakeholders, geared towards restoring healthy family functioning, despite evidence that resuming social roles as wives and mothers was found to be a predominantly positive rehabilitation experience. This paper proposes a partnership between psychologists and public health practitioners in implementing family systems focused interventions aimed at restoring healthy family functioning and thus improving the quality of continuum of care among Obstetric Fistula patients.

Background to the Study

Obstetric Fistula is one of the most serious childbirth injuries. It is a severe maternal morbidity and a stark example of inequity. Although it has been virtually eliminated in many countries, it continues to afflict many poor women and girls worldwide who do not have access to health services (Secretary General, 2016)

The effects of obstetric fistula impact women across different domains. These include: physical, economic, psychological and social. Among the physical complications associated with obstetric fistula are urinary, fecal or combined incontinence and physical morbidity. In addition, women may also experience neurological disorder, orthopedic injury, bladder infections, painful sores, kidney failure or infertility (United Nations, 2016).

Review of literature shows that in majority of cases, the urinary and fecal incontinence associated with the condition, result in a range of psychological and social effects that have debilitating consequences on the functioning of women. These include low self-esteem, feelings of rejection, stress, anxiety, mental health dysfunctions such as depression, suicidal thoughts, and loss of dignity. Stigma and isolation are commonly reported by women in treatment for obstetric fistula (Mwini-Nyaledzigbor, Agana, & Pilkington, 2013) as are depression, sadness and giving up hope (Yeakey, Chipeta, Taulo, & Tsui, 2009) and (Zelege, Ayele, Woldetsadik, Bistegn, & Adane, 2013).

A major reason for the psychological consequences outlined, thus far, relates to the fact that the condition is perceived as an assault on the woman's ability to fulfil social expectations (Yeakey, Chipeta, Taulo, & Tsui, 2009). In addition, women's mental health status is particularly influenced by their ability to re-engage in community and family life (Donnelly, Oliveras, Tilahun, Belachew, & Asnake, 2015). Further, impairment of social relationships is a major cause

of suffering (Muleta, Rasmussen, & Kiserud, 2010). These findings indicate that the family system, is impacted significantly when women suffer obstetric fistula because the woman's ability to fulfil her roles as a partner, wife, mother and productive member of her community are severely compromised.

According to the (World Health Organization , 2006) millions of young girls and women in resource poor countries, and have obstetric fistula, are living in shame and isolation, often abandoned by their husbands and excluded by their families and communities. Many of these women usually live in abject poverty, shunned and blamed by society, and unable to earn money, fall deeper into poverty and further despair. It is no wonder that they often manifest the psychological symptoms explained above.

The need to address the psychological and social consequences of obstetric fistula are widely acknowledged. Researchers, as well as policymaking institutions have proposed and in many cases implemented interventions to remedy these challenges. The (World Health Organization , 2006)published the Guiding Principles for Clinical Management & Programme Development for Obstetric Fistula. Among the principles are; social reintegration and rehabilitation of women who have had an obstetric fistula repair.

With specific reference to psychological interventions, the guiding principles suggest that women with fistula should be advised (by a social worker or trained nurse) about how to enter into a dialogue with family members about what they have experienced and how a successful fistula repair enables a woman to return to a full family and community life. In terms of family reintegration, the principles acknowledge that providing assistance for reconciliation and reintegration is important to ensure that women are able to return to their communities successfully. They further suggest that if possible, a nurse or social worker may escort the

woman home and help explain to the family and community the causes of fistula (stressing that it is not the woman's fault or due to a curse) and how to prevent fistula in the future.

While researchers and other stakeholders have consistently noted the devastating psychological effects suffered by obstetric fistula patients, as well as the impact on their marriages and other relationships, there is little scientific evidence as to the extent to which psychotherapeutic interventions are applied towards repairing unhealthy relational dynamics in the family systems of women that have had surgical repair. Therefore, establishing what knowledge exists about the use of systemic psychotherapeutic interventions in fistula care is necessary if the continuum of care is to be improved.

Methodology

Systematic literature review was done to determine what the evidence is on psychotherapeutic interventions applied to the family system. Literature search was done on the following databases: EBSCO, SAGE, Taylor & Francis, AJOL, Wiley Interscience and BioMed Central. The review consisted of a search for articles, published in English, on the psychosocial implications of obstetric fistula. Date limitations of 10 years (2007-2017) were used. Policy documents and reports of agencies such as World Health Organization and United Nations Population Fund were reviewed for content related to systemic psychotherapeutic interventions in fistula care.

The inclusion criteria for articles constituted the following: primary research studies conducted in sub-Saharan Africa that reported data on one or more of the following psychosocial factors: relational challenges, psychological symptoms, and counseling interventions. Exclusion criteria included studies that reported on the factors only as part of the demographic statistics as well as meta-studies. The exclusion criteria yielded 10 studies conducted in the years 2009-2016.

Of the ten studies, six used a qualitative design, three used a mixed method approach while one employed a quantitative approach.

Analysis

Table 1 presents the design, sample sizes and methodology of the studies that were analyzed.

Results

Table1: Details of studies

Study	Design	Sample Size and Type
Donnelly et al. 2015	Mixed Method	51 women, purposively sampled
Drew et al. 2016	Qualitative; case studies	20 women, purposively sampled
Johnson et al. 2010	Mixed Method	47 women, purposively sampled
Maulet et al. 2013	Mixed Method	120 women
Maulet et al. 2015	Descriptive, survey	54 fistula patients & 92 gynecology patients
Mwini-Nyaledzigbor, 2013	Qualitative: cross-sectional	10 women, purposively sampled
Wilson et al. 2015	Descriptive: quantitative	54 fistula patients & 92 gynecology outpatients
Yeakey et al. 2009	Qualitative: exploratory	45 women, purposively sampled & 30 family members
Zelege et al. 2013	Mixed Method	306 women

The studies were analyzed for findings related to relationship challenges, psychological symptoms and counselling interventions. The results are as follows: (Donnelly, Oliveras, Tilahun, Belachew, & Asnake, 2015) sought to identify priority post-repair interventions that could maximize their quality of life. They found that women's mental health was influenced by their ability to re-engage in their community and family life. They also found that before obtaining surgical repair, 13 women had become divorced or separated due to their husband's dislike of their fistula. Some women, however, continued to receive support from their husbands.

The study authors made the following recommendations: more robust counseling about fistula and its preventions should be integrated into the post-operative care regime, a follow-up system to identify women needing further treatment and to address ongoing primary care, sexual and reproductive health and mental health needs and, increased engagement of women affected by fistula and their family members and communities.

(Drew, et al., 2016), assessed long-term outcomes among women who underwent obstetric fistula repair. Their findings showed that the greatest concerns of the women prior to surgery were: death during surgery, having an irreparable fistula and, marital discord. They also found that most women became a second wife after their fistula developed. In addition, most women reported that despite undergoing repair, their relationship challenges persisted. The women also continued to struggle in unsupportive relationships after repair. In addition, many women reported to having become avoidant while 55% of the sample stated that their family relationships had improved after the fistula surgery. Among the recommendations made by the study authors was the need to focus more on addressing relationship counseling.

(Johnson, et al., 2010), evaluated the first formal counseling program for obstetric fistula patients in Eritrea. They found a statistically significant increase in women's self-esteem scores

and a decrease in beliefs of unworthiness. In addition, the study participants expressed concern that they would be returning to their home areas with new information about their conditions that their family members were not exposed to. The study authors recommended a component of the counseling that also targets the family members of patients.

(Maulet, Keita, & Macq, 2013), sought to understand care pathways and induced mobility patterns of obstetric fistula patients in French-Speaking West African fistula repair centers. They found that divorce took place immediately after incontinence diagnosis and also when the care process took longer than expected.

(Maulet, Berthe, Traore, & Macq, 2015), studied how fistula patients' perceptions impacted care uptake and coping. The study findings revealed that social relationships were a major cause of suffering for patients. The patients reported that lack of social support and stigma were perceived as aggravating factors and that moral torment deeply and enduringly affected them. The study authors reported that among other factors, provision of psychological support was notably absent from the care stories of patients. They recommended that psychological counseling throughout the care process should be considered as an essential component of obstetric fistula management.

(Mwini-Nyaledzigbor, Agana, & Pilkington, 2013), explored and described the experiences of women living with obstetric fistula in Ghana. They found that participants were victims of derogatory remarks and that their children were sometimes insulted. The participants also reported to being abused, ostracized and abandoned by husbands, rivals, siblings, relatives and friends. In addition, majority of the participants ceased enjoying sex while most indicated that the relationship with their spouse had ended. Most of the participants also reported to no longer being involved, by others, in family matters. The study authors recommended that public

awareness must be created about the causes, prevention and treatment of obstetric fistula in order to reduce the associated stigma.

(Wilson, Sikkema, Watt, & Masenga, 2015), conducted a study in Tanzania to quantify the psychological symptoms and social support in obstetric fistula patients, compared with a population of women without obstetric fistula. They found that outpatients with obstetric fistula had significantly higher depression and PTSD symptoms compared to gynecology patients. Fistula patients also reported higher somatic symptoms, more resignation coping and lower social support.

The study authors recommended that: obstetric fistula clinicians should address psychosocial problems through targeted mental health interventions and that training of nurses or lay workers in psychological interventions could successfully integrate mental health care into the treatment of obstetric fistula patients.

(Yeakey, Chipeta, Taulo, & Tsui, 2009), studied the lived experience of obstetric fistula in Malawi. They found that the condition causes worry and fear and that constant sadness and giving up hope were recurrent themes in the lives of patients. Findings also showed that divorce and/or abandonment by women's husbands was common, with the divorce decision usually made on the part of the husband. A proportion of the sample, however, had positive relational experiences with 27% reporting social, emotional and financial support from their husbands.

(Zelege, Ayele, Woldetsadik, Bistegn, & Adane, 2013), examined the experiences of 51 Ethiopian women after fistula repair surgery to identify priority post-repair interventions that could maximize their quality of life. They found that women's mental health was influenced by their ability to re-engage in community and family life. They also found that before repair, 13

women had become divorced or separated due to their husband's dislike of their fistula. As with the findings from Malawi, some women continued to receive support from their husbands.

The authors made the following recommendations: integrating more robust counseling about fistula and its preventions during the post-operative care regime, a follow-up system to identify women needing further treatment and to address ongoing primary care, sexual and reproductive health and mental health needs and, increased engagement of women affected by fistula and their family members and communities.

Summary of Findings

Evidence from literature review shows that sustaining an obstetric fistula has a severe impact on the relational dynamics in the family systems of recovering women. Marital discord was found to be a defining characteristic in the lives of many women that had undergone surgical repair. A majority of respondents in the studies experienced less social support, both from family and the community, after their obstetric fistula with some experiencing reduced to no involvement in family life.

The mental health effects of disrupted relational dynamics include feelings of shame, hopelessness, depression, post-traumatic stress, decreased self-esteem, suicidal ideation and psycho-somatic symptoms. In terms of interventions, the following were recommended: counseling for fistula patients, targeted mental health interventions for patients and, public awareness on causes, prevention and treatment of obstetric fistula. Other recommendations included relationship counseling, counseling for patient's family members and increased engagement of patient's family members.

Despite the realization of the impact of fistula on the social functioning of the women and the recommendations for different forms of counseling, the studies did not make specific

systemic recommendations to address the unhealthy family dynamics that were found to exist in the families of fistula patients. This was perhaps due to the fact that the studies did not seek to specifically gather data on relational dynamics, and patterns in the families of fistula patients.

Implications for Collaborative Practice

It is evident from literature that the effects of obstetric fistula are experienced not just by the primary victim, but also by other members of the family system. Unfortunately spouses, parents, children and other family members must deal with the physical, emotional and behavioural changes that the patient experiences, as a result of the injury. Family members must also deal with their own emotional and behavioural changes as a result of the victim's reaction to the injury.

The manner in which the effects of obstetric fistula are experienced is systemic. This is as a result of the interactional pattern between the victim of obstetric fistula and those that she interacts with on a daily basis. This interactional nature is explained by Family Systems Theory which was developed by Murray Bowen (1975).

According to this theory, Family is an emotional unit and the nature of a family is that its members are connected emotionally. The connectedness and reactivity of individuals in a family make its functioning interdependent. Because of this a change in one person's functioning is predictably followed by reciprocal changes in the functioning of others (Kerr, 2003).

It is therefore not surprising that the effects of obstetric fistula are experienced not just by the woman who has sustained injury, but also by members of the family system. It is also due to this fact that this paper makes recommendations on how psychologists, specifically systemic therapists can work collaboratively with public health practitioners to improve the quality of care for fistula survivors. The recommendations are presented below.

Firstly, it is important to expand the focus of obstetric fistula treatment from individual to systemic. In other words, public health practitioners should consider partnering with systemic therapists in prioritizing the family as the unit of care, as opposed to focusing on the primary patient. This expanded focus is informed by a systems perspective as well as findings from literature on families living with chronic illness.

(Arestedt, Benzein, & Persson, 2005), found that in families where there is a core belief that illness is a threat to life, there is uncertainty on how to meet and handle illness expressions. In addition, families strive to live as normal as possible and avoid thinking and talking about the illness. As a result of this when illness expressions appear, they are experienced as frightening and feelings of fear and frustration arise. When families do not talk about illness, it seems to be difficult for them to meet and understand situations related to illness and when family members' needs to talk about the illness differ, there could be imbalance that decreases well-being.

This imbalance is seen in the unhealthy reactions and behaviour patterns that include stigmatization of patients, separation and divorce, withdrawal and isolation by both patients and family members, depression and suicidal ideation, hopelessness and shame, among others.

Secondly, and stemming from the expanded systemic focus, this paper recommends broadening pre and post repair assessment to include family functioning. This means shifting from overwhelmingly focusing on physical and emotional symptoms, to considering how fistula injury has influenced interactional sequences mentioned above.

In addition, members of the treatment team should gather data on how roles in the family have been influenced since the occurrence of injury. Pre and post repair assessment should also take into consideration strengths of the patient's family system. These considerations are

important in informing the prioritization of systemic interventions that would be applied among the families of fistula patients.

The unhealthy family dynamics that are commonly experienced by patients and their families relate directly to unhealthy interactional patterns, shifting of roles in the family and in many cases a lack of realization of family strengths that can be used to help families cope with the condition in the healthiest way possible.

Thirdly, the treatment milieu should include psychotherapy for both the patient and their families (where possible). Among the focus areas of counseling should include; awareness of emotions related to expectations of healing and, attitudes, perceptions and beliefs concerning functioning of both the individual and the family system. These focus areas would be important in helping both patients and their family members to internalize and understanding what prompts their emotional, psychological and behavioural reactions as a result of fistula injury. This awareness would create conditions that allow patients and family members to adopt healthy coping styles in dealing with the after effects of the injury.

Fourthly, treatment should include follow up and ongoing psychosocial care after discharge. The quality of care may be greatly improved by connecting the patient and family to other resources that could become essential elements of the support system. These resources may include support groups and religious communities.

Finally, obstetric fistula commonly occurs in areas where there is a deficit of health care professionals including midwives, nurses and physicians. In recognition of the fact that there is typically a dearth of psychologists and counsellors in the regions where obstetric fistula is most prevalent, the authors recommend the use of task-shifting model to provide systemic psychological intervention and thus improve the quality of post repair care. Task-shifting

involves shifting specific tasks, traditionally the domain of physicians, to nurses who deliver care with autonomous or delegated responsibility (Martinez-Gonzalez, Rosemann, Huber-Geismann, & Tandjung, 2015).

Task-shifting, as envisaged in this case, would mean shifting psychotherapeutic tasks from psychologists to nurses, midwives and community workers who would conduct pre and post repair systemic assessment and conduct psychotherapy with patients and their families.

Conclusion

Obstetric fistula is serious childbirth injury that has a profound impact on the functioning of both the patient and her family system. The manner in which families respond to the condition has serious implications on the functioning of the patient. The effects of fistula on the family system have been empirically established and recommendations made for intervention. This literature review further expands the understanding of the effects of obstetric fistula on the family system by adopting a systemic focus and making recommendations for partnership among psychologists and public health practitioners to improve the quality of care for fistula patients.

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