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Research Article

Psychosocial Experience of Women with Obstetric Fistula: Case of Patients Consulting the Obstetric Gynecology Department of the Korhogo Regional Hospital (Côte d'Ivoire)

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Abstract

The objective of this study was to explore the psychosocial experience of women with obstetric fistula followed at the Korhogo Regional Hospital in order to improve their care. Thirty-nine (39) women with obstetric fistula were studied. The study revealed that all the women surveyed were not enrolled in school, 92.3% lived in rural areas and 79.5% were between 14 and 31 years of age at the time of their obstetric fistula. According to the professional situation, it was noted that 97.4% were active before the fistula and only 15.4% since the fistula. In terms of marital status, it was noted that all respondents (100%) were living with a spouse before fistula. However, after the disease, only 28.2% of the respondents were able to maintain this marital status. The feelings of our respondents after obstetric fistula were marked by suicidal thoughts in 56.4% of them and social isolation in 43.6%. In general, the quality of the respondents' relationships with their family and friends had become poor and 84.6% of them stated that they no longer had sexual relations with their partners since the occurrence of obstetric fistula. The feelings of these women, combined with the lack of social support, led to psychosocial distress among the women concerned. Therefore, it would be wise to associate psychosocial support with their medical and surgical care, thus allowing them to have a better readjustment to their living environment.

Keywords: *Obstetric Fistula; Psychosocial Experience; Korhogo; Ivory Coast*

Introduction

Obstetric fistula is a complication of childbirth that is still as relevant as ever despite the progress made in its prevention and management. Indeed, through the project "prevention and management of obstetric fistula", initiated by Côte d'Ivoire and its partners, several women have been provided with preventive and curative care in this area. However, in the north of the country, particularly in Korhogo, there are still many cases for various reasons. The political crisis that the country has been going through since September 2002 has led to malfunctions in the health structures, including a lack of personnel and the closure of health facilities in areas controlled by the new army. This situation, combined with some socio-anthropological factors (the high number of children per woman, closely spaced births, and above all, deliveries without medical assistance) has led to an increase in the number of women suffering from obstetric fistula. According to Desrumaux, obstetric fistula is defined as "the occurrence of an abnormal communication between the vagina and the bladder or between the vagina and the rectum, or in some cases, both" [1]. This is usually one of the complications of dystocic deliveries. Neilson will affirm that "for every woman who dies in childbirth, 20 to 30 survive, but with acute or chronic complications, one of the most serious being obstetric fistula" [2]. As for Soumano, he believes that the difficulties encountered by women suffering from this pathology are of two types:

1. The first difficulty is related to the very serious somatic consequences for women who are carriers. These include vaginal atresia, ulcerated and superinfected vegetations, salpingitis, etc.

2. The second difficulty is related to the psychosocial experience. Obstetric fistula relegates the women who suffer from it to the background and annihilates their reason for being. These women lose their place in the social fabric, like this Bangladeshi woman who uttered this heartfelt cry: "Everyone rejects me. Treat me or kill me!" [3].

Fistula patients are stigmatized, rejected by the community, and abandoned because of the odor of urine and/or feces that constantly leaks from the vagina. These patients generally have a low self-esteem. The distress that drives them can be seen on their faces and in their attitudes. They no longer feel "alive", as they are consumed by the corrosive effect and smell of urine and/or feces. They end up losing all self-esteem [2].

Obstetric fistula is a source of physical, psychological and social suffering. It is therefore a serious public health problem. Although women with fistula are treated surgically with a cure rate often reaching 95%, their psychosocial care remains poor. In other words, more attention is paid to obstetric fistula than to the woman suffering from it [4]. For this reason, Wall recommends treating "the whole person with fistula, not just her bladder or damaged rectum" [5]. This means that the management of women with obstetric fistula (OF) should not only be surgical but holistic, as this disease has a psychosocial impact that also deserves to be known and managed.

In light of the above, we proposed to explore the psychosocial experience of women with obstetric fistula followed in the gynecology-obstetrics department of the Korhogo Regional Hospital, so that it is not only known but also and above all integrated into the management of these patients.

Methodology

Our study was a cross-sectional exploratory study with a descriptive aim. It focused on women with obstetric fistula followed in the gynecology/obstetrics department of the Korhogo Regional Hospital. The sampling was accidental and consisted of interviewing women with obstetric fistula as they came to the consultation for their care.

For the purposes of the study, we used a questionnaire developed for this purpose by the sponsors of the survey. It was sent to women with obstetric fistula. This instrument had a header and 16 questions divided into three (03) sections:

1. Socio-demographic characteristics of women with obstetric fistula (06 questions). This section will allow for the successive description of the level of education, religion, profession and marital status, and will then highlight the impact of obstetric fistula on these different parameters.

2. The level of knowledge and perception of women with obstetric fistula regarding this condition (02 questions). The aim here is to obtain the definition and possible causes of obstetric fistula according to women with obstetric fistula.

3. Daily feelings of women with obstetric fistula (08 questions). This section will determine the psychological and social dysfunction caused by obstetric fistula.

This questionnaire was pretested to make it more comprehensive and objective before administration.

Due to the specificity and the sensitive aspect of our study subject, the survey was done after obtaining the agreement of the competent authorities (N°504/MSHP/DGS/DEPS/S-DPS/Kae-kl of April 06, 2017). In addition, the questionnaire administered in a confidential manner respected anonymity.

Results

Sociodemographic characteristics of respondents

The majority of respondents, 79.5%, were between 14 and 31 years old at the time of obstetric fistula. None of the respondents had attended school and 92.3% of them came from rural areas. In our study, 97.4% of the respondents were engaged in an income-generating activity before the fistula. The advent of fistula forced 82% of them to abandon their activities. The same is true for marital status, which has changed. While all respondents were living with a partner before fistula, only 28.2% were able to maintain this marital status after the onset of fistula.

Knowledge, duration of illness and perception of disability data

All of the respondents had a very good definition of the disease. Indeed, they all maintained that obstetric fistula was a disease characterized by the continuous loss of urine and/or stool through the vagina. However, it should be noted that 74.3% of them attributed its occurrence to a mystical-religious fact, more precisely to a spell. In terms of duration of the disease, 84.6% of the respondents had been living with the disease for more than 6 years.

Socio-demographic characteristics		Number	Frequency (%)
Age ranges	≤ 15	2	5,1
	16 - 20	9	23,1
	21 - 25	12	30,76
	26 - 30	8	20,51
	31 - 35	5	12,82
	> 35	3	7,69
Marital status	Married	5	12,8
	Common-law union	34	87,2
	Single	0	0
Religion	Aninist	16	41,1
	Christian	7	17,9
	Muslim	13	33,3
	Other	3	7,7
Education level	No schooling	39	100
	Primary	0	0
	Secondary	0	0
	Higher	0	0
Professional category	Without activity	1	2,6
	Worker	38	97,4
	Supervisor	0	0
	Manager	0	0
Child number	1	2	5,2
	2	5	12,8
	3	23	58,9
	4	3	7,7
	≥5	6	15,4

Table 1: *Socio-demographic characteristics of respondents at the time of fistula occurrence.*

Expressed feelings and quality of sleep	Respondents	
	N	%
Feeling at diagnostic announcement		
Shame	21	53,84
Discouragement	7	17,64
Anger	5	12,83
Revolt	5	12,83
Guilt	1	2,56
Feeling after obstetrical fistula		
Suicidal ideation	22	56,41
Isolation	17	43,59
Sleep quality		
Insomnia of sleep	16	41,02
Multiple awakenings	14	35,89
Early awakening	6	15,38
Total insomnia	3	7,71
Total	39	100

Table 2: *Distribution of respondents according to the emotion felt at the announcement and after the disease and impact on sleep.*

Respondents' relationships with their family and friends N		Respondents %	
Quality of relationships	Partners		
	Good	11	28,20
	Bad	28	71,80
	Nice family		
	Good	7	17,94
	bad	32	82,06
	Family		
	Good	15	38,46
	Bad	24	61,54
	Friends		
	Good	5	12,82
	bad	34	87,18
Sharing information with family and friends			
Yes		14	35,90
No		25	64,10
Sexual life Maintenance			
Yes		6	15,39
No		33	84,61
Total		39	100

Table 3: *Distribution of respondents according to their relationship with their family and friends after obstetrical fistula.*

Discussion

Sociodemographic characteristics

The socio-demographic data collected from our respondents showed that 79.5% of them were between 15 - 30 years old. The average age of fistula patients has always been unanimously, a young and active population in most of the studies conducted in Africa [4,6,7]. Indeed, if they were all of childbearing age, their young age could well contribute to the fetomaternal disproportion incriminated in dystocic deliveries. They belonged to the professional class of workers in 95% of the cases and were in 64.2% of cases not educated. This result corroborated those of some studies conducted on this pathology in Africa [8,9]. The lack of education and financial resources could justify the delay or absence of recourse to care. Moreover, 84.62% of the women surveyed had been living with this disease for more than 6 years without ever having used conventional care. In her study, Lagou showed that women's level of knowledge about obstetric fistula was correlated with their level of education. Thus, the most educated women were those who had a high level of knowledge [10]. Also, the lack of financial means could be at the origin of poor prenatal follow-up, which is a source of dystocic deliveries that lead to obstetric fistula. All of the women lived in rural areas and had difficulty accessing health centers, most of which are located in urban areas. This finding should lead the health authorities to review the distribution of health care facilities throughout the country, as well as the specialists who run them. As for the professional situation, the occurrence of fistula led to significant changes in the lives of the respondents in terms of giving up their professional activity. As a result, obstetric fistula had a real socioeconomic impact on the lives of these women. This could also have a negative impact on access to care, since we know that in our country, fistula treatment is not free. In addition, the cultural representation and interpretation of this disease can be considered as factors hindering the use of modern medicine. Indeed, 74.3% of these victims attributed it to a mystico-religious cause, more precisely to a spell. This fact has been highlighted in several socio-anthropological studies on the issue [11,12]. Before the occurrence of fistula, all respondents were living in a marital relationship. However, 71.8% of them were abandoned and expelled from their homes after the onset of fistula. This finding was also highlighted in several studies that stated that the occurrence of fistula was an event that led to the separation of the couple [12-14].

Psychological experience of the disease

The first feelings expressed by the respondents following the announcement of the diagnosis were all unfavourable, marked by shame, discouragement, anger and revolt. Also, some of them expressed suicidal ideas and gradually became socially isolated. These results show that obstetric fistula has a negative psychological impact on the lives of these women. In her study, Kaboré reported that feelings of humiliation and sadness were noted in obstetric fistula patients who had undergone a psychological evaluation [8]. In addition, 56.4% had suicidal thoughts. In addition, sleep disturbances were identified, including insomnia of all types, reflecting anxiety-depressive states. The combined analysis of the above results easily translated the psychological suffering caused by this disease; sometimes resulting in suicides.

Social experience of the pathology

In 64.1% of cases, the victims did not inform their family and friends of their illness. However, the relatives eventually got the information, probably because of the manifestations of this disease. Indeed, urine odors and/or fecal matter that constantly leak through the vagina necessarily attract attention. This situation has led to distortions in the relational dynamics in terms of stigmatization, rejection and abandonment. The lack of social support for women with fistula has been highlighted in several studies [9,12, 15]. In addition, 84.6% of women with fistula reported that they had not had sexual relations with their partner since then. In a similar vein, Tebeu in Cameroon argued that fistula patients were rejected by their husbands, families and even the community at large, who falsely accused them of witchcraft [13].

The feelings of these women, combined with the negative attitudes of the social network, have made the psychosocial experience of women living with fistula painful.

So, the management of fistulas should not only be surgical, but should also take into account the psychological and social dimension. This need for social integration has been noted by some authors [16].

Conclusion

Despite efforts to reduce the incidence of obstetric fistula in Côte d'Ivoire, we still record many cases, especially in the northern region of the country. This study has shown the influence of certain socio-anthropological factors in the occurrence and use of care. It emerges from this work that obstetric fistula remains a medico-socio-economic problem with major social and psychological consequences. It is therefore necessary to include in its management, preventive measures such as information and awareness campaigns, monitoring of pregnancies through prenatal consultations, to associate psychological care and also the reintegration of patients into the social fabric.

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