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Coping Strategies Adopted by Survivors and Women Living with Obstetric Fistula in West Pokot County, Kenya

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Abstract:

This paper uses data collected within the framework of the Ph.D. thesis, Effects of Obstetric-Fistula on Womanhood: The Case of West-Pokot County, Kenya, of Musyoki, K.G., published in 2016 at Kenyatta University. This phenomenological paper used qualitative methods of data collection and was informed by the performative theory by Butler (1988) which posits that an individual becomes a woman or a man through social performance. The study also used Lazarus and Folkman's Transactional model of stress and coping, which emphasizes appraisal to evaluate harm, threat and challenges. The paper explored coping strategies adopted by survivors and women living with obstetric fistula (OF) in West Pokot County, Kenya. To conform to ideals of womanhood, findings indicate that affected women had to adopt and adapt to a number of coping mechanisms. To adjust to their new identities, stigma, social isolation, and marital challenges, the women used self-isolation and withdrawal, immobility, marital separation, sexual abstinence, use of home-made padding, limiting water and liquid-food intake and frequent bathing. Desperate attempts made by the affected women to maintain hygiene and minimize OF effects are remarkable though inadequate and should be augmented by timely treatment (surgery). Thus, communities need to improve their knowledge about the nature and risk of, so that their social interactions are not influenced by stereotypes, prejudices, and unfounded speculations.

Keywords: Coping strategies, women, womanhood, obstetric fistula, West Pokot

1. Introduction

Women who have sustained an of experience constant leakage of urine, faeces or both, a sign that all is not well. With an awful smell from the leakage of urine and/or faeces, women are unable to keep themselves clean and attractive. Losing control of bodily functions is embarrassing as an adult and these women compare themselves with children. In addition, these women suffer discrimination and isolation that is attached to stigma. This stigma is often as a result of misconceptions about the real causes of obstetric fistula which were linked to common themes such as contravening of sexual and cultural taboos and superstitious beliefs.

As such, the women's departure from body norms had a negative domino effect on their identity, gender-roles, social capital and economic opportunities. Despite the social stigma, discrimination and financial constraints, many women with OF showed remarkable resilience and strength. They found ways to be survivors, rather than to be victims; they supported themselves and their children; and some managed to set money aside over many years so that they could seek fistula repair. The success rate of obstetric fistula repair in general is in the 80 to 90 percentiles (Wall, Karshima, Kirschner, & Arrowsmith, 2004; Kelly, 1995).

Despite this demonstration of resilience, effective strategies must be developed to assist the vast majority of women who cannot afford or access surgery and who will continue to live with the condition. In order to do this, a comprehensive and accurate understanding of how obstetric fistula affects their lives is essential. For instance, to improve their socio-economic situation and to cater for food, soap and sanitary towels, women from resource poor households suffering from OF engaged in handicrafts and textile production. Most were financially dependent on their husbands/partners who abandoned them when it is clear that the OF problem would not go away soon. Divorce rates for women who suffered from obstetric fistula ranged from 50% (Hilton, 1998; Kelly and Kwast, 1993; Tahzib, 1983; Ampofo, Out, Uchebo, 1990.) to as high as 89% (Roush, 2009). Obstetric fistula can impact a woman's fertility. The husbands/partners indicated that they could not tolerate being with a woman who leaked urine and manifested an offensive odor, suggesting she had lost all sexual appeal and value as wife (Engenderhealth, 2012).

Emotionally, incontinence has a profound effect on anyone suffering from an obstetric fistula. To cope with the condition, many women become house bound. They felt ashamed and dirty and were constantly worried that people could smell them. Although the odor was overpowering and impossible to control, many women resorted to applying scented powders or perfume to cover it. Ironically, isolation and especially self-isolation was employed as another coping strategy to avoid humiliation whether with family or non-kin. This self-isolation served to limit social interactions, due to concerns that they would be unable to manage the flow of urine. The constant apprehension over exposing their condition and being shamed prohibited women from enjoying basic pleasures, such as gossiping with their peers (Engender health, 2012).

In rural areas where pads or absorbent cotton are not available in the market or are unaffordable, incontinent women wore a protective piece of cloth or layers of cloth to absorb the leaking urine in an attempt to preserve basic hygiene (Gruenbaum 2001). The cloth had to be changed several times a day to avoid wetting their clothes and emitting a bad odor and to prevent irritation on the upper thighs and vaginal area (Engender health, 2012). Coping with incontinence and the associated smell and soiled clothing was very difficult in regions where water scarcity is a reality (Women's Dignity Project and Engender health, 2012). Thus, managing the cloth was an ongoing preoccupation that involved washing the cloths with soap and water and ensuring that they were properly dried, all of which required a tremendous amount of time. Many women covered the cloth with a plastic bag to ensure that the urine did not leak through their clothing.

Another strategy was to place sawdust in the bag to absorb the urine. Despite these efforts, women often were unable to manage the flow of urine and persistently soiled their clothes. Those who could still engage in limited farm work away from people chose to discard their underwear and wore flowing skirts, which allowed the urine to drip freely (Engender health, 2012).

A more positive survival strategy adopted by women with OF was to associate more with others who shared similar stigma. These women with OF derived great satisfaction from being with others who shared their disability. UNFPA (2005) refers to this as 'a sisterhood of suffering'. This peculiar association is necessary for women with OF because they can have solitude when they are within the circle of those with the same condition. This circle gives them a sense of belonging to deal with their life experiences.

Women who have lived with unrepaired OF for many years or those whose condition is medically deemed as incurable are, by definition, survivors. They have endured a difficult and traumatic childbirth; their priorities and ways of dealing with problems may differ from those of the clinician. Women with OF are not just passive victims. Their experiences and viewpoints must be central to the communication between health provider and patient. For instance, counseling services, if they exist at all, are often inadequate in programs trying to meet the needs of women with OF, including reintegration.

Improving communication about self-management and care, beginning with informing women about nonsurgical therapies, is a critical need. If a woman is to be able to care for herself, programs must be able to answer her questions and discuss relevant products (such as pads) and practices (such as hygiene). There is need for tools and methods to assess an individual woman's needs in relation to the options available. Thus, studies will need to come up with a model or framework that a patient could use to understand her options and make a decision about treatment.

1.1. Statement of the Problem

Obstetric fistula is a condition that most frequently affects women of reproductive age due to pregnancy related complications during childbirth. The condition results in chronic incontinence of urine and/or faeces. Most of the women who sustain an obstetric fistula live in resource poor countries where, for a variety of reasons, access to emergency obstetric care (EmOC) is difficult. In Africa, the condition is a brutal punch to the core of womanhood and the empowerment this 'womanhood' bestows on women, with respect to gender roles, identity and social status in the community. Becoming a wife and a mother are two important and crowning markers of womanhood in the African cultural context. Unfortunately, obstetric fistula temporarily or permanently robs women off this opportunity. This is because obstetric fistula occurs on socially defined and culturally constructed women. The impact is on the negative functioning of individuals as well as on social relations in the society.

Despite increased global consciousness on maternal health in recent decades, most studies on obstetric fistulae are largely descriptive and focus on fistula closure and success rates. The studies are limited in their ability to understand from a gender perspective the many dimensions of obstetric fistula and its related social vulnerability. Therefore, the problem of this study is hinged on the effects of obstetric fistula on the afflicted women. The study specifically focused on how the lives of the affected women in West Pokot County-Kenya, have been influenced by the condition.

1.2. Objective of the Study

To assess the coping strategies adopted by survivors and women living with obstetric fistula among the Pokot.

1.3. Research Question

What coping strategies are adopted by survivors and women living with obstetric fistula in West Pokot County?

1.4. Justification and Significance of the Study

It is hoped that the findings, conclusions and recommendations from this study will be useful in assisting women construct a viable self-identity that does not only revolve around wifehood and motherhood in the social construction of womanhood in African societies. It is essential to suggest other rallying points that could emphasize development of new

identities that can empower young girls and women in West-Pokot County, Kenya, to aspire more in life. The study may also serve as an additional literature to scholars while forming a strong base for researches in related fields.

1.5. Scope and Limitations of the Study

The study was conducted in West Pokot County in Kenya. It is targeted women of reproductive age, healed of or living with obstetric fistula. The study investigated the effects of obstetric fistula on the women healed of or living with the condition. This means that the study did not consider the medical conditions related to or psychological impact of obstetric fistula. Another notable limitation relates to non-probability sampling designs, which are prone to biases and the selection process is pre-determined and constrained. In addition, since the study was done in West Pokot County, most of the findings, conclusions and recommendations may be very specific to the study locale. However, the findings may be applied to women healed or living with OF in other areas in similar socio-cultural characteristics.

2. Research Methodology

Qualitative research and the interpretive method through in-depth interview guides with the various study respondents, was used to collect data from women aged 15–49 years who were living with unrepaired obstetric fistula or had been successfully treated/repared. The qualitative approach was appropriate because it allows the researcher to gain insights into the social processes and settings, and more expressively underscores the importance of personal interviews and narratives on the lived experiences of the respondents (Strauss and Corbin, 1994). Qualitative research is a popular and widely used means of collecting qualitative data because the researcher is able to capture firsthand information directly from the respondents. By giving precedence to the voices of the participants through their lived experiences, the researcher was better placed to develop a better understanding of individual and group experiences of the research participants. I found the qualitative research method suitable for the design of the study because of its inductive property of flexibility and amenability, which falls in tandem with the dynamics of the natural settings for the study.

2.1. Study Area

The Pokot people (commonly spelled Pökoot) (Bolling, 1996; Schladt, 1997) live in West Pokot County in the Upper Rift Valley province of North-Western Kenya. Kenya's 2009 census puts the total number of Pokot speakers at about 620,000 in Kenya. The Pokot occupy an isolated and remote area with a vast difficult terrain within very harsh climatic conditions. The Pokot are mainly pastoralists. About 90% of the district is arid and semi-arid (ASAL) to the extent that high levels of poverty push parents to marry off young daughters forcefully to improve family livelihood (UNFPA, 2003). Culture in the Pokot community dictates that women must be submissive. The 'Kokwo' or elders, comprising old men, dictate the running of their homes and the community. With limited knowledge and influence from outside, the Pokot perpetuate traditions and practices adapted to their context. Although the girl-child among the Pokot endures many other less painful rituals while growing up, FGM practiced at a rate of about 97%, is the most defining rite that tests pain-endurance and instantaneously ushers a girl into womanhood. Womanhood and pain are synonymous among the Pokot since it is expected that girls will experience pain when they lose their virginity and when they give birth (Chebet, 2009).

2.2. Targeted Population

The targeted population for this study was made up of all women of reproductive age between 15-49 years who were living with or had been treated of obstetric fistula in West Pokot County, Kenya. The population of those living with the condition was unknown and 64 of those repaired/healed of obstetric fistula from a past fistula campaign conducted in the area between the 8th-14th November, 2014. The said past fistula campaign was spearheaded by the Ministry of Health, in conjunction with African Medical and Research Foundation (AMREF-Health Africa), Bayer HealthCare and a host of private funding donors or organizations.

2.3. Sample and Sampling Technique

The study identified and recruited a total of 57 women affected by obstetric fistula. Thirty-six (36) with repaired obstetric fistula were purposively selected while the study used snowballing sampling method to recruit twenty-one (21) with untreated OF. They were recruited from five study sites across the county: Kapenguria, Kacheliba, Alale, Sigor and Lelan. Conveniently, the study also sampled 49 spouses/caretakers to the affected women. Key informants were purposively selected and they included 6 members of the council of elders (3 men and 3 women), and 4 medical personnel especially those in the obstetrics and gynaecology (often abbreviated to Obs & Gynae) and maternity wards attached to medical facilities in the local area.

3. Research Findings and Interpretation

Asked what they used to conceal the constant flow of urine with, all the women recalled devising various coping mechanisms as presented in table 1.

Coping Strategy	Women Respondents	
	N Count	% of cases
Use of home-made padding	57	100
Limiting water and liquid-food intake	5	9
Frequent bathing	46	81
Sexual abstinence	36	63
Marital separation	2	4
Self-isolation and social withdrawal	48	84
Immobility/isolation	10	18
Total response count	204	358
*Multiple responses allowed		

Table 1: Multiple Response Frequency Table: Women Respondents' Strategies for Coping with Obstetric Fistula

3.1. Use of Home-Made Padding

As illustrated in table 1, all the women reported to have used some form of home-made pads. These were made from strips of old clothes, pieces of mattress and blankets. The strips were rolled into a bundle and placed in between the legs and held in place by their knickers. This type of innovative method of coping has also been reported by Okoye, Echiegu and Tanyi, (2014) among women awaiting OF repairs in Ebonyi State, Nigeria and by Li, Cai, Glance, & Mukamel, (2007) in a study among Chinese women with urinary incontinence. Although they changed the home-made pads regularly, the women were unable to fully manage the flow of urine, persistently wetting their outer clothes. Respondents reported that they always wore and carried extra clothing to cover any visible sign of urine.

3.2. Limiting Water and Liquid-Food Intake

In addition to the frequent change of padding and clothes, some women resorted to limit their water and liquid-food intake to ensure minimal urine flow. The women posited that little water and liquid-food intake could lessen the amount of urine they produced and hence the frequency of padding and clothes change. Low urine production was one way of the women remaining clean and dry for longer. While detrimental to their health and due to lack of knowledge, this coping strategy worked to their disadvantage because many suffered from dehydration which could gradually lead to kidney diseases in the long run. Thus, there is a need to educate the affected women and the general public against this practice which might exacerbate their health.

3.3. Frequent Cleaning the Affected Body Parts

The women also cited maintenance of general neatness by frequently cleaning the affected body parts using scented soap. The use of scented soap helped to mask the smell of urine as the women engaged in petty businesses which would at times necessitate close contact with others. The scent from the soap also temporarily afforded the women brief social contact with the outside world that helps maintain social networks. Children were a major resource for the women with unrepaired OF. The affected women relied on their children to ensure a constant supply of water to maintain body hygiene. This is because local taboos did not permit the women living with OF to fetch water before other healthy women for fear of contaminating the source with urine. This meant that the women living with OF could not meet and socialize with other women at the water-hole as is custom of women in rural settings. Thus, to keep their distance and cushion themselves from stigma, they relied on their children or other family members to fetch water for them.

3.4. Sexual Abstinence

Although sexual abstinence in marital unions was experienced as a major loss of intimacy, the affected women and their husbands and/or partners had to contend with it. Asked if they were sexually active after receiving repairs to their OF, only 44% responded in the affirmative while a significant 56% did not as indicated in figure 4.8 below.

Figure 1: Resumption of Conjugal Duties by Women Repaired of Obstetric Fistula

On the one hand, women with repairs to their OF who did not affirm to resuming their conjugal obligations expressed their fears as follows:

- *'I was strongly advice to abstain'.* (Interview with former fistula patient from Kacheliba on 03/03/2015).
- *'The doctor said any heavy work to be avoided. I fear that it might reoccur'.* (Interview with former fistula patient from Sigor on 05/03/2015).
- *'I am ploughing my farm and observing doctors' orders on abstinence'.* (Interviews with former fistula patient from Kapenguria on 05/02/2015).

However, on the other hand, women with repairs to their OF who affirmed to resuming their conjugal obligations opined that:

- *'Yes, I feel am cured'.* (Interview with former fistula patient from Lelan on 09/02/2015).
- *'I can do all physical work like other women, like before I got sick'.* (Interview with former fistula patient from Alale on 16/02/2015).

The above comments were based on the doctor's advice to abstain from sex for about six months to allow the delicate tissues to heal. This is with the exception of the one respondent who experienced a recurrence of OF as a result of coital trauma inflicted by her husband. She lamented that: *'The tear reoccurred'.* (Interview with a fistula patient from Kasei on 29/01/2015). All the women welcomed the 6-month abstinence with the hope of regaining the lost wife-role for those married/separated and for the single, establishing future long-term relationships with men.

3.5. Marital Separation

The lived experience of OF among some women was not without resentment. This was effectively communicated by one woman who reported that:

'I packed and left my husband because of the constant verbal and physical maltreatment toward me'. (Interview with fistula patient from Lelan on 03/02/2015).

The women directed their feelings of anger and distrust to their spouses due the maltreatment they received during their many years of living with OF. Some of these women could no longer cope with verbal insults from their husbands and in-laws and thus opted to separate from their husbands as soon as they were fully recovered despite the prevailing customs and stigma. This is because people often find it harder to relate to those with a chronic illness. As a result, people often on the one hand, resort to pity and over-protection, and on the other end of the spectrum, some people express a sense of intolerance, impatience and frustration with the chronically ill. The inability to effectively understand and relate to those with chronic illness often leads to both relationship and communication challenges (Drummond and Maison, 1990). This is because any chronic illness impacts nearly every aspect of an individual's life and leaves a devastating imprint on the lives of everyone involved (Thompson, 2009).

From the proceeding expositions, the study established that women were rejected, 'returned', neglected, separated and eventually divorced as a direct consequence of sustaining OF. The women pointed to the atrophy of empathy and sympathy from their husbands who set them aside and were in the process of acquiring 'new, clean and healthy wives'. Study statistics indicate that most of the women respondents were also financially dependent on their husbands/partners who abandoned them when it was clear the OF problem would not go away soon. The husbands/partners on the other hand, were intolerant of being with women who leaked urine and manifested an offensive odor, suggesting that these women had lost all sexual appeal and value as wives (EngenderHealth, 2012).

To cope, these women decided to avoid situations that seemed to worsen their predicament by opting to leave their marital unions and homes regardless of the stigma and socio-cultural norms. By removing themselves from situations of violence, these women asserted themselves through disassociating with the tag of 'oppressed victim'. This is because women with fistula are presented as utterly passive, voiceless, oppressed victims, and not as individual actors (Walley, 1997). This representation subsequently strips them of all individual agency, which discursively disempowers and disenfranchises them and suggests that they need an outside voice to speak 'for' them (De Waal, 1995).

3.6. Self-Isolation and Social Withdrawal

Self-isolation and social withdrawal were practiced by some women as a way to cope with their situation. They distanced themselves from family, friends and community especially in situations that required close interpersonal

contacts. During the interviews, some women reported to be '*living alone in the hut though it's now getting old and may fall any time during the rainy season*'. Some other women living with OF reported that relatives also forced them to self-isolation by providing a separate room/hut for them. A husband to a woman living with OF opined that '*I buy clothes for her to change and sleep in isolated place*'. While alone in a dilapidated hut or in isolated places, the women experienced a loss of social contact with family members especially during meals and socialization in the evenings. They spent the nights alone irrespective of their precarious health with no one to assist them should the need arise.

Another respondent living with OF quipped that '*my young children will not see me wet in the morning*'. With this statement, the woman seeks to cushion her young ones from her obstetric fistula reality while at the same time preserving the little dignity, they may have for her as their mother. The self-isolation, according to the women, is seen as a considerate way of minding the wellbeing of other family members occasioned by the strong smell of urine. The OF patients were more conscious of urine incontinence because it affects personal hygiene and provokes social embarrassment. The problem of social isolation of OF patients has also been discussed in a number of studies (Yeakey, Chipeta, Taalo and Tsui, 2009; Pope, Bangser & Requejo, 2011; Khisa & Nyamongo, 2012).

3.7. Immobility

Immobility was another coping strategy reported by the women respondents. Those cured and those with unrepaired OF reported that at the beginning they felt 'very low' and confused that they preferred to stay behind at home and mind all the children in the homestead. '*I do not move much. Walking is painful because I have wounds 'down there'*' was reported by several women in varying degrees. They reported to be in pain as they moved about because of the thigh-friction and sores around the genital area. With the home-made padding almost permanently in place to absorb urine, walking over long distances would cause the wet cloth to rub against the delicate skin and create new sores or further irritate the already existing ones. They therefore chose to remain immobile at home and care for the children because this did not require much movement. Women reported that they only traveled when it was necessary, such as the times when they were in search of treatment. The immobility also served to confine and restrict social contact with others outside the home. The lack of social contact with the outside world thus cushioned them from further social ridicule and stigma but also diminished their social networking.

4. Conclusion

Women living with or recovering from OF experienced neglect and social stigma. To cope with their new realities with the condition, they used both problem- and emotion-focused coping as they lived with obstetric fistula. The affected women reported to have used some form of home-made pads, frequent bathing and change of clothes. The study also established that some women resorted to limit their water and liquid-food intake to lessen the amount of urine, which was detrimental to their health in the long-run. Women with repaired OF were encouraged to practice a mandatory 6-month medical sexual abstinence to allow healing of the wound. However, the lived experience of OF among some women was not without resentment. This is because chronic illnesses impact nearly every aspect of an individual's life as well as for those around them. The women directed their feelings of anger and distrust to their spouses due the maltreatment they received during their many years of living with OF. Some of these women could no longer cope with verbal insults from their husbands and in-laws and thus opted to separate from their husbands as soon as they were fully recovered despite the prevailing customs and stigma.

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