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Exploring the needs and challenges of women reintegrating after obstetric fistula repair in northern Ghana

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ABSTRACT

Objective: to explore the cultural, social and economic needs and challenges of women in northern Ghana as they resume their day-to-day lives post obstetric fistula repair.
Design: a critical ethnographic approach.
Setting: a state run fistula treatment center in Tamale, northern Ghana, and 24 rural communities in northern Ghana.
Participants: ninety-nine (*N*=99) participants were recruited using purposive, convenience and snowball sampling. The sample consisted of women (*N*=41) who had experienced an obstetric fistula repair and their family members (*N*=24). Health care providers (*N*=17) and stakeholders (*N*=17) who had specialised knowledge about reintegration programs at a community or national level were also included.
Findings: the needs and challenges of northern Ghanaian women post obstetric fistula repair were historically and culturally rooted. A woman's psychosocial acceptance back into her community post obstetric fistula was significant to her well-being but many women felt they had to 'prove' themselves worthy of acceptance and hid any signs of urinary incontinence post obstetric fistula repair. The cost of treatment compounded by a woman's inability to work while having the obstetric fistula exaggerated her economic needs. Skills training programs offered assistance but were often not suited to a woman's physical capability or geographic location. Many women who have experienced obstetric fistula along with women leaders have initiated obstetric fistula awareness campaigns in their communities with the aim of overcoming the challenges and improving the reintegration experiences of others who have had an obstetric fistula repair.
Conclusion: developing understanding about the needs and challenges of women post obstetric fistula is an important step forward in creating social and political change in obstetric fistula care and reintegration.
Implications for practice: Strategies to support women reintegrating to their communities post obstetric fistula repair include exploring alternative forms of skills training and income generation activities, creating innovative pre and post obstetric fistula health education and community awareness to reduce the perception of the condition as 'incurable', and promoting peer advocacy.

Introduction

Obstetric fistula (OF) is one of the most serious and tragic childbirth injuries associated with prolonged, obstructed labour without timely intervention. OF is an opening or openings between the vagina and the bladder and/or rectum that frequently leaves women incontinent of urine and/or faeces (Lewis and de Bernis, 2006). In Ghana, it is estimated that 500 to 1000 new cases of OF are diagnosed annually (Danso et al., 2007) affecting women's physical, psychological and sexual health, and their social and economic status (Pacagnella et al., 2010). A recent study conducted by Ghana Health Service (2015) suggests northern Ghana has the highest number of OF cases in the country.

The approach to care for women with OF is threefold and includes awareness (OF is preventable and treatable), treatment (surgery), and family and community reintegration. Although there is much documented about awareness and treatment, little literature was found regarding how women reintegrate after their OF repair. The majority of studies retrieved were qualitative, limited to health facilities, and occurred in East Africa (Pope et al., 2011; Khisa and Nyamongo, 2012; Mselle et al., 2012; Gebresilase, 2014; Donnelly et al., 2015). No studies conducted in Ghana were found. With respect to OF, reintegration is defined as:

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> ...a process of helping women to return to the life they lived before they developed fistula. This includes how women adjust and reconnect to employment, families, communities, and social life in order to restore their dignity and respect and to increase their self-esteem (Mselle et al., 2012, p.928).

In this article, we draw attention to the needs and challenges affecting women reintegrating post OF in northern Ghana as they resume their day to day lives, culturally, socially and economically. Findings are part of a larger critical ethnographic study which explores a culture of reintegration post OF repair. Insight into the experiences of women within their cultural context, and the generated emancipatory knowledge concerning reintegration following an OF repair will be organised around Habermas' critical theory (Edgar, 2006; Habermas, 1991a, 1991b; Mill et al., 2001; Singh, 1999). Emancipatory knowledge recognises the social and political 'injustices or inequity, to realise that things could be different, and to piece together complex elements of experience and context to change a situation as it is to a situation that improves people's lives' (Chinn and Kramer, 2011, p.64). Through dialectic communication with those affected by or working with women who experienced an OF repair and reflecting upon their needs and challenges, emancipatory knowledge will be generated to inform public policy about the health and well-being of women reintegrating after an OF repair.

Methods

Research design

A critical ethnographic design was employed using a social justice lens to critically explore underlying historical, economic, psychosocial and political issues related to reintegration after OF repair in northern Ghana. The design allowed engagement with participants that challenged dominant societal views and exposed the hidden structures that were oppressive or potentially oppressive. The aim of the design was to create emancipatory knowledge by consciously strengthening participants so that they were more able to reflect on actions that could be taken to change oppressive forces (Thomas, 2011).

The design provided a view beyond the metaphors typically used in Ghanaian society to aid in understanding the hidden meaning behind the importance of socioeconomic reintegration after OF repair. Language is powerful in Ghanaian culture where persons avoid expressing unpleasant information for fear of 'defil[ing] [their] face' (Galyan 1999, Speaking the unspeakable, para.4) and threatening social harmony.

Theoretical Framework

Habermas' ideas about the critical social theory and theory of communicative action helped to inform the methodology and provided the foundation for emancipatory knowledge. Habermas realised that in critical theory; 'dialectics serves as a scientific and holistic method' (Patrascu and Wani, 2015). A dialogical approach was used in this study to discover what was blurred or distorted in the everyday experiences of women post OF. It was assumed that through the process of praxis women who experienced an OF repair, their family members and stakeholders would understand the complex reality of OF in northern Ghana. It was additionally assumed this would lead to critical analysis and consciousness-raising which in turn would bring about emancipatory knowledge to positively change the social, economical and political issues regarding OF care and reintegration.

Setting

This study was conducted in northern Ghana consisting of three geographical regions, Upper East, Upper West and Northern, known to be exceedingly rural as well as economically and socially disadvantaged (Tsikata and Seini, 2004).

Participants and recruitment

Ninety-nine (N=99) participants were recruited using purposive, convenience and snowball sampling techniques. The primary recruitment site was a state run fistula treatment center located in the northern region. Twenty-four northern communities were also visited for the purpose of data collection. Access to participants was negotiated with the support of a Ghanaian nurse-midwife who had a strong connection to the community and community stakeholders.

Participants consisted of women who had experienced an OF repair three months prior to being interviewed, family members who identified themselves as caregivers post OF repair, health-care providers (HCPs), and community/government stakeholders. A list of potential participants (women) was retrieved from the fistula center. Women who met the inclusion criteria and their family members were contacted by a staff nurse or midwife from the fistula center to invite them to participate in a conversation about their needs and challenges returning home after OF repair. HCPs and stakeholders were selected on the grounds of potential knowledge they had about OF care. They were initially recruited from the fistula treatment center, health service agencies, Government Ministries, and later by word of mouth. Participation was voluntary in nature and all participants were assured there were no consequences to declining.

Fieldwork and data collection methods

Fieldwork occurred over two time intervals: March to June 2014 and April to May 2015. Although observation and the review of government, non-government, fistula center documents, health records and cultural artifacts were used in data collection, semistructured interviews and extensive field notes were the main methods utilised. Interviews were conducted by the first author and took a dialogical approach which allowed for stimulating questions to conceptualise the hidden meanings, historically, economically, socially, culturally, and politically, behind the needs and challenges of reintegration post OF repair. Interviews were audio-recorded, ranging from 30 to 90 minutes in length. Participants responded in seven different languages. Interviews were translated with the support of local translator(s). Fourteen follow-up interviews were conducted.

Ethics approval was received from the ethics review board at the University of Alberta, Canada and the Navrongo Health Research Center, Ghana. Data collected were stored in the Health Research Data Repository (HRDR), a secure and confidential virtual research environment, at the University of Alberta, Canada.

Data analysis

Interviews were transcribed verbatim and analyzed according to Hammersley and Atkinson's (2007) approach to ethnographic analysis. A subset of the data was randomly selected and coded to generate concepts that were then organised into larger categories. Ten categories were used to construct a coding framework which was tested on other randomly selected interviews. Adjustments to the framework were made before being applied to the main data set for critical analysis. Nvivo 10.0 software was used for data management.

Trustworthiness was maintained through meticulous record keeping to allow for transparency in the research process; triangulation, utilizing multiple data strategies and sources; employing forward and backward translation; using a stepwise replication procedure, where the first and second author analyzed a subset of the data separately and compared the results to ensure accuracy with how the data were understood; and reflexivity whereby the first author kept a personal journal to allow her to explore her 'conceptual baggage' as well as how