THE EFFECTS OF OBSTETRIC FISTULA ON WOMANHOOD: 
THE CASE OF WEST POKOT COUNTY, KENYA

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C82/26090/2011

A THESIS SUBMITTED TO THE SCHOOL OF HUMANITIES AND 
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REQUIREMENTS FOR THE AWARD OF THE DEGREE OF DOCTOR 
OF PHILOSOPHY IN GENDER AND DEVELOPMENT STUDIES OF 
KENYATTA UNIVERSITY

NOVEMBER 2016
DECLARATION

I confirm that this thesis is my original work and has not been presented for a degree in any other University or any other award.

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Signature: _______________ Date: _______________

Dr. Casper O. Masiga
Department of Gender & Development Studies
Kenyatta University
DEDICATION

To the survivors of obstetric fistula in particular the brave women who participated in this study.
ACKNOWLEDGEMENT

First and foremost I thank God for the life and opportunity He has given me.

I also want to express my gratitude to my employer, Kenyatta University (K.U.) for granting me this chance to pursue a doctoral degree and to the Department of Gender and Development Studies, for their inspiration and commitment to promoting the gender discourse and knowledge. I appreciate the research grant awarded to me by the School of Humanities and Social Sciences that enabled me to carry out fieldwork in West Pokot County.

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A particular thank you to my mother and father who have taught me that nothing is impossible. And to brother Musyo, for the care he gave me when I was sick.
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ABSTRACT

This study sought to explore the effects of obstetric fistula on womanhood and demonstrate how these effects shape the identities of afflicted women in West Pokot County, Kenya. The specific objectives of this study were: to explore the social construction of womanhood among the Pokot; identify perceived factors contributing to the development of obstetric fistula among women; determine the effects of obstetric fistula on womanhood in the County and assess the coping strategies adopted by afflicted women to cope or live with obstetric fistula. The study was guided by Judith Butler’s Performative Acts and Gender Constitution Theory. The theory was complemented by Lazarus and Folkman’s Transactional model of stress and coping, which emphasizes appraisal to evaluate harm, threat and challenges. The study used the phenomenological design to both quantitative and qualitative research. Purposive sampling was used to identify the study-site, key-informants and women with repaired obstetric fistula. Snowball sampling identified women with unrepaired obstetric fistula while convenience sampling was used to sample their spouses/care-givers. Guided questionnaires, interview schedules and observation check-list were used to generate data. Quantitative data were analyzed using descriptive statistics and presented in tables and graphics as percentages and frequencies. Qualitative data were collected through narratives during interviews and analyzed and presented thematically. Findings from this study revealed that 88% of the affected women had never heard of the condition before diagnosis at a health facility. Misconceptions about the real causes of obstetric fistula were linked to cultural taboos and superstitious beliefs. Only 18% of the respondents could associate the condition with the immediate events of childbirth, while 53% thought it was incurable. The affected women at 77% had a high preference for non-skilled birth attendants during delivery away from health facilities, a factor that predisposed them to obstetric fistula. The women, their spouses/care-givers, elders and medical health providers represented at 95% affirmed that obstetric fistula affected women in various ways. The affected women experienced a deep sense of loss that has a negative impact on their identity and quality of life. These losses were signified as failures of motherhood, reproduction, sexuality, identity and marriage. To cope with obstetric fistula, the women used among others, home-made padding, frequent bathing, self-isolation, and limited food and water intake. The study recommends an intensive awareness on factors that predispose women to the occurrence and management of obstetric fistula and the potentially positive reproductive prospects after treatment. Prevention strategies must be community inclusive and participatory so as to build locally appropriate and acceptable solutions. Any efforts to reduce maternal mortality and morbidity, must focus on having a sound knowledge of the risk factors that predispose girls and women in Kenya to developing obstetric fistula; mass awareness and mobilization of the community on the condition; improvements in emergency obstetric care as well as the socio-economic status of women, their education and empowerment.
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<th>Abbreviation</th>
<th>Acronym</th>
<th>Full Form</th>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>AMREF- Health</td>
<td>The African Medical and Research Foundation- Health</td>
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<td>Africa</td>
<td>Africa</td>
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<td>ASAL</td>
<td>Arid and Semi-Arid Lands</td>
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<td>BMI</td>
<td>Body Mass Index</td>
<td></td>
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<td>EmOC</td>
<td>Emergency Obstetric Care</td>
<td></td>
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<td>FCI</td>
<td>Family Care International</td>
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<td>FGC</td>
<td>Female Genital Cutting</td>
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<td>FGM</td>
<td>Female Genital Mutilation</td>
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<td>GBV</td>
<td>Gender Based Violence</td>
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<tr>
<td>HIV</td>
<td>Human Immune Deficiency Virus</td>
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<tr>
<td>IGAD</td>
<td>Intergovernmental Authority on Development</td>
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<tr>
<td>ISS</td>
<td>Institute for Security Studies Africa</td>
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<tr>
<td>KDHS</td>
<td>Kenya Demographic and Health Survey</td>
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<tr>
<td>KEMRI</td>
<td>Kenya Medical Research Institute</td>
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<tr>
<td>KMTC</td>
<td>Kenya Medical Training College</td>
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<tr>
<td>KNH</td>
<td>Kenyatta National Hospital</td>
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<td>Kenyatta University Ethics Review Committee</td>
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<td>MCH/FP</td>
<td>Maternal &amp;Child Health/Family Planning services</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>NTDs</td>
<td>Neglected Tropical Diseases</td>
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<tr>
<td>non-SBAs</td>
<td>non-Skilled Birth Attendants</td>
<td></td>
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<tr>
<td>Obs/Gyn</td>
<td>Obstetrician/Gynaecologist</td>
<td></td>
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<td>OF</td>
<td>Obstetric Fistula</td>
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<tr>
<td>RVF</td>
<td>Recto-Vaginal Fistula</td>
<td></td>
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<tr>
<td>SES</td>
<td>Socio-economic Status</td>
<td></td>
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<tr>
<td>SPSS</td>
<td>Statistical Package for Social Sciences</td>
<td></td>
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<tr>
<td>STI/D</td>
<td>Sexually Transmitted Infection/Disease</td>
<td></td>
</tr>
<tr>
<td>SBAs</td>
<td>Skilled Birth Attendants</td>
<td></td>
</tr>
<tr>
<td>TBAs</td>
<td>Traditional Birth Attendants</td>
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<tr>
<td>UNPFA</td>
<td>United Nations Population Fund</td>
<td></td>
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<tr>
<td>VVF</td>
<td>Vesico-Vaginal Fistula</td>
<td></td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
<td></td>
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<tr>
<td>WRA</td>
<td>Women of Reproductive Age</td>
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**OPERATIONAL DEFINITION OF TERMS**

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<th>Term</th>
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<tr>
<td>Female Genital Mutilation</td>
<td>The term is alternatively referred to as “female circumcision” and comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, medical or other non-therapeutic reasons.</td>
</tr>
<tr>
<td>Fistula</td>
<td>The term refers to a false connection/hole/passageway between two bodily organs or vessels that normally do not connect. Examples of naturally occurring fistulas are those that form between the anus and an opening in the skin (anal fistula) or between the intestine and the vagina (enterovaginal fistula).</td>
</tr>
<tr>
<td>Motherhood</td>
<td>This refers to the traditional way of defining a ‘real’ woman’s status, through a relationship to progeny. In the African culture, it is viewed as an essential part of womanhood.</td>
</tr>
<tr>
<td>Obstetric Fistula</td>
<td>Obstetric fistula refers to an “accident of childbirth”. It is a severe medical condition in which a fistula (hole) develops between either the birth cavity and the bladder or rectum or both after prolonged obstructed labour, with little or no adequate medical attention.</td>
</tr>
<tr>
<td>Socialization Process</td>
<td>In this study, the socialization process entails all those processes of learning behaviours that are appropriate for members of a particular group distinguished from others on the basis of certain ascribed and/or acquired status.</td>
</tr>
<tr>
<td>Wellbeing</td>
<td>The term is used to refer to a good or satisfactory condition of existence; a state characterized by health, happiness, and prosperity.</td>
</tr>
<tr>
<td>Womanhood</td>
<td>The term refers to an idealized concept constituted by a range of socially sanctioned “feminine” characteristics such as the beliefs, notions and ideas people have about females in terms of what they represent in their relationship to men as well as expectations about appropriate female roles.</td>
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CHAPTER ONE
INTRODUCTION

1.1 Background Information

Globally, the burden of death and illness due to pregnancy and childbirth related complications is massive. In developing countries, and especially in South Asia and Sub-Saharan Africa, obstetric fistula (OF) is still very visible and continues to cause untold pain and suffering in millions of women (Donnay & Weil, 2004; Wall, Karshima, Kirschner and Arrowsmith, 2004; Roush, 2009).

Obstetric fistula (OF) is one of the most devastating maternal morbidities resulting from prolonged and obstructed labour (Hilton, 2003; MINEPAT, 2009). Often, labour is prolonged and obstructed when the mother’s pelvis is too small or the baby is too large for a vaginal delivery. If labour remains obstructed, the unrelenting pressure of the baby’s head against the mother’s bony pelvis can greatly reduce the flow of blood to the soft tissues surrounding the bladder, vagina and rectum. If the mother survives, this kind of labour often ends when the foetus dies and gradually decomposes enough to slide out of the birth canal. The injured pelvic tissue also rots away, leaving a hole, or a fistula, between adjacent organs (WHO, 2006). The women thus present with uncontrolled urine leakage due to a false communication between the bladder and the vaginal vault resulting in vesico-vaginal fistula (VVF) or between the vaginal vault and the rectum resulting in recto-vaginal fistula (RVF). While OF affects women at all ages, first time mothers, mostly adolescent girls, are particularly at risk of obstructed labour, because their pelvises may not be fully
developed (France & Laura, 2004; UNFPA, et al., 2005). In this situation, both the mother and the baby are at risk for several complications and obstetric fistula is one of them (Mutambara, Maunganidze, and Muchichwa, 2013).

The United Nations (2010) estimates that more than 350,000 women die from pregnancy and childbirth-related morbidities each year with 99% of them from developing countries. It is also estimated that for every maternal death, 30% or more women suffer disabling and humiliating injuries including obstetric fistulae. The most common morbidities include prolonged labour, obstructed labour, anemia, and excessive bleeding during childbirth.

Despite progress and advancement in maternal health, pregnancy remains a major health risk and women suffer from a wide range of birth complications. A small percentage of women mostly first time mothers may experience a labour that lasts too long which in most cases may lead to the development of obstetric fistula (WHO, 2006). Apart from obstetric causes, obstetric fistula may also occur due to surgical trauma, accidents and sexual violence in war or conflict and post-conflict settings (Wall et al., 2004). Harmful traditional practices that affect body integrity such as genital cuttings which are extremely invasive such as infilulations and gishiri cut also contribute to the formation of fistulas (Ridder, 2009). From various regions within Sub-Saharan Africa, the underlying factors for OF are considered biological, social and cultural, behavioural and environmental. Some of the examples encircling these factors are young maternal age at delivery, poverty, childhood malnutrition, illnesses, genetics and health seeking behaviour (Wall, et al., 2004; Tsui, Creanga & Ahmed, 2007). Several studies from Africa show increases in obstetric complications
among women who have undergone genital cutting operations (Hakim, 2001; Larsen & Okonofua, 2002). However, the vast majority of gynaecological fistulas globally are due to obstetric causes.

The advent of modern obstetric care has led to the eradication of obstetric fistula in nearly every industrialized country. This is due to the availability of skilled and professional assistance and well developed health facilities to provide emergency obstetric care (Veronique, Rasmane, Rebecca, Tom, Katerini, Issiaka, Fatoumata, Ronas, Melanie, Nicolas, 2007). It is generally accepted that a minimum of 2 million girls and women live with untreated obstetric fistula, and at least 75,000 new cases occur each year (Abouzahr, 2003; WHO, 2006; Wall, Arrowsmith, Briggs, Browning, & Lassey, 2005 and Wall, 2006). Obstetric fistulas (OF) are most common in South Asia and Sub-Saharan Africa where access to or use of obstetric care is limited (Kalembo & Zgambo, 2012).

Although there is enough medical literature on OF, available data on the magnitude of this condition are diverse and considered severely understated (Hassan & Ekele, 2009; Keri, Kaye & Sibylle, 2010). This can be attributed to the poorly developed or nonexistent tracking systems in rural communities, and to the associated social stigma (Bangser, 2006; Browning 2004; Velez, Ramsey & Tell, 2007); hence the paucity of telling data (Hassan et al., 2009; Semere & Nour, 2008; Keri et al., 2010). It is generally accepted and estimated that about 2 million women are living with OF worldwide, with a greater proportion being reported from Sub-Saharan Africa and South Asian countries (Murk, 2009; Wall et al., 2006). Prevalence and incidence rates of OF in Sub-Saharan Africa
vary among countries. Data from African countries estimate the incidence of OF to be between 1–3 per 1000 deliveries for West Africa and 1.6 per 1000 women in Malawi. Ethiopia reported a lifetime prevalence of 2.2 per 1000 women of reproductive age (Muleta, Fantahun, Tafesse, Hamlin, Kennedy, 2007).

Kenya has made great progress in addressing maternal health and with the inauguration of Safe Motherhood Initiative in Nairobi in 1987, specific programmes to reduce maternal mortality and improve maternal health were established (UNFPA, 2004). In a survey of four districts in Kenya (Kwale, Mwingi, West Pokot and Homa Bay), the United Nations Population Fund (UNFPA) (2004) estimated that 3,000 new cases of obstetric fistula (OF) developed each year, with approximately one to two obstetric fistulas per 1,000 deliveries. Health providers have proposed that the incidence may be as high as 2 to 5 cases per 1000 deliveries in areas that lack access to emergency obstetric care (UNFPA & Engender Health, 2003).

Only 7.5 per cent of women with OF are able to access treatment annually. In the four districts surveyed, there were 113 reported obstetric fistula cases, of which 94 were repaired with West Pokot receiving and repairing 79 of the cases (UNFPA, 2004). The backlog of cases is estimated at 30,000 (UNFPA 2003, UNFPA, 2004, KDHS, 2008). However, data on obstetric fistula are not readily available at the district level and where available, information is very limited (Mwangi & Warren, 2008).

Although the risk factors leading to obstetric fistula are myriad and far reaching, it is also undeniable that sustaining an obstetric fistula changes a woman’s self-image (Donnay & Weil, 2004). The worst suffering for these
women may not be the physical manifestations of obstetric fistula or grief over the loss of their baby, but rather the social repercussions that follow. The majority of women who suffer an obstetric fistula already live in precarious socio-economic circumstances complicated by the low social status of women in Sub-Saharan Africa (Wall et al., 2004). Many are really only girls, as young as 14 or 15 years of age, married shortly after puberty with a first pregnancy following soon after (Wall et al., 2004; Harrison, 1985). Their value in society is derived from their roles as wife and mother, both of which are severely threatened when obstetric fistula occurs.

The importance of successful childbearing in Sub-Saharan African culture cannot be overstated (Illiffe, 2007). A woman’s value in society and her own sense of self-worth is directly related to her ability to bear healthy children within a heterosexual marriage bond and to fulfill her role as a wife, including satisfying her husband sexually (Wall et al., 2005). The short-term failure to produce a healthy baby and the long-term inability to fulfill her role as wife and mother have potentially disastrous implications for a woman in Sub-Saharan Africa (Roush, 2009). This is because the socialization and enculturation of girls in the various coming-of-age ceremonies in Africa, focus on the natural unfolding of the female life cycle.

African female socialization processes into womanhood tend to focus heavily on the preparation of pubescent girls for marriage, to be good wives and excellent mothers. Among the Pokot in Kenya, the focus community of this study, pubescent girls aged between 9 and 14 years are mutilated annually to attain automatic status of “womanhood” (UNFPA & UNICEF, 2010). They do
this by enduring female “circumcision” as opposed to biological dictates like age or menstruation. These young girls are recognized as newly constituted adult women after enduring the prescribed community’s socialization rituals into womanhood. An initiated woman in the African context, the Pokot notwithstanding, was thought to be socially mature, disciplined, inhibited, industrious, conforming, altruistic (Brink, 1990; Roberts, 1984) and most importantly, marriageable. These qualities ensured her readiness to bear the responsibilities of marriage.

In addition to marriage, motherhood was expected of a married woman and therefore, the young initiates were encouraged to marry and bear children. Thus, spinsterhood and childlessness are equally scorned at in African cultures (Mbiti, 1989). As a consequence of “social maturity”, young girls in this community are plunged into the world of wifehood and motherhood instead of being encouraged to pursue education and better themselves in the future as their agemates elsewhere. As such, they are exposed to early marriage, early coitus and subsequent early pregnancy when their bodies are not yet ready to cope with the demands of pregnancy and childbirth (WHO, 2006; Ahmed & Holtz, 2007).

Thus, becoming a wife and later being a mother are two important and crowning markers of womanhood in the African context (Mungwini, 2008). It is important to note that motherhood is a significant marker of womanhood because it confers so much power on a woman (Mungwini, 2008). It provides a respectable social identity, an important set of child-rearing tasks, access to kin networks, and a space where authority, a sense of control and self-expression
can be cultivated. As a result, many African women find a great deal of satisfaction in their familial roles, especially those of partner, wife and mother (Chaney, 2011). Therefore, a woman’s ability to bear and rear children defines her position in the kinship group and in the community in general. Obstetric fistula temporarily or permanently robs women off this opportunity.

A woman who acquires an obstetric fistula endures severe nerve damage to the leg(s), constant leaking of urine and/or faeces and a host of other ensuing vulnerabilities (Creanga & Genadry, 2007; UNFPA et al., 2004). Moreover, obstructed labour leads almost invariably to the death of the foetus during birth in up to 90% of the cases, and is one of the leading causes of maternal mortality (Hilton, 2001; Ijaiya & Aboyefi, 2004; Creanga & Genadry, 2007).

A major concern is that many women living with OF are still unaware of the availability of its treatment and/or management. It is estimated that 80% of these women do not seek treatment and live with the condition for several years (Miller, Lester, Webster & Cowan, 2005). WHO (2006) also notes that birth injuries can be devastating and present a chain reaction of untold physical, social and psychological pain and suffering in millions of women. This creates a need for a study to focus on the impact of obstetric fistula on womanhood of the afflicted women in West Pokot County.
1.2 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.
1.3 OBJECTIVES OF THE STUDY

The main objective of the study was to explore the effects of obstetric fistula on womanhood. The specific objectives were to:

(i). Describe the social construction of womanhood among the Pokot.
(ii). Identify perceived contributing factors to the development of obstetric fistula among women.
(iii). Determine the effects of obstetric fistula on womanhood in West Pokot County.
(iv). Assess the coping strategies adopted by survivors and women living with obstetric fistula among the Pokot.

1.4 RESEARCH QUESTIONS

From a gender perspective, the study sought to address the following questions:

(i). How is womanhood socially constructed among the Pokot?
(ii). What are the perceived contributing factors to the development of obstetric fistula among women?
(iii). What are the effects of obstetric fistula on womanhood among the Pokot?
(iv). What coping strategies are adopted by survivors and women living with obstetric fistula in West Pokot County?

1.5 JUSTIFICATION AND SIGNIFICANCE OF THE STUDY

It is hoped that the findings, conclusions and recommendations from this study will be useful in developing locally appropriate strategies that would encourage
women with obstetric fistula and their families to seek medical intervention promptly. The study findings may also be used to educate women and the community about obstetric fistula so as to deal adequately with the associated stigma. Further, the study findings will be useful to the medical fraternity in that they may shed light on the need to offer services that match the needs of affected women. The findings may also inform policy makers, so as to formulate, improve and strengthen the packaging and delivery of women-centred programmes and activities on obstetric fistula that are more participatory and locally acceptable. The study may also serve as an additional literature to scholars while forming a strong base for researches in related fields.

1.6 SCOPE AND LIMITATIONS OF THE STUDY

The study was conducted in West Pokot County in Kenya. It 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.
CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction
The chapter reviews literature related to the study of social construction of womanhood and the subsequent development of Obstetric Fistula and how the two interrelate. The chapter also explores the various societal perceptions on factors contributing to the development of obstetric fistula as well as its effects on Pokot women’s wellbeing. This section also discusses the theoretical and conceptual frameworks of the study.

2.2 The Social Construction of Womanhood in the African Societies
The perceptions of women among the communities in the world and specifically in traditional African societies are important as they shape the way people think about women and inevitably the way women think about themselves. In respect to these perceptions, the question as to what constitutes a woman and how to define an ideal woman in the African society comes to mind.

The “making” of a woman in the African context entailed a series of events. Among 28 countries in Africa (Wilson, 2012/2013), “circumcision” was incorporated in a series of other events that together codified the expectations for successful social maturation. “Circumcision” represents an act of socialization into cultural values and a connection to family, community and the spirit world (Rahman & Toubia, 2000). It is an outward, permanent physical mark on the body visible to the society as a first step in attaining “womanhood”.

During a girl’s confinement and healing in the seclusion camp, she is thought to undergo a gradual process of change produced by intensive care from women who attend to her. A well initiated girl should emerge fat, pale, soft and well-schooled in both sexual and household matters. The girls acquired the knowledge they would need to perform as mature women, as mothers, and as citizens in their community both in public and in private. This “learning-to-become” was comprehensive in the sense that the young girl learnt and internalized both the derogatory and positive concepts, judgments and attitudes towards womanhood and how to deal with them throughout her life.

Emphasis was placed on reproductive roles within marriage. The young initiate was socialized on how to behave in marriage and how to run a home by performing most of the domestic duties while in her mother’s home not as a daughter but as a future wife and mother. This “learning-to-become” took place through example, direct teaching and in patterns of behaviour, in songs, proverbs, wise sayings and folktales. What was learnt directed towards corresponding patterns of behaviour. These produced women who were disciplined, industrious, inhibited, conforming and altruistic (Brink, 1990; Roberts, 1984). At the end of the socialization and seclusion period, the novice was presented in a public square and recognized as a newly constituted adult woman charged, eager and ready for marriage and its other accompanying responsibilities. In traditional settings, this type of schooling during seclusion provided a thorough and well balanced preparation for life (Maambo, 2007).
Marriage is intertwined with the successful completion of this phase of ordeals and tests. With emphasis being placed on reproductive roles within marriage, the newly constituted socially mature women were encouraged to marry and bear children. Thus, becoming a wife and later being a mother are two important and crowning markers of womanhood in the African context (Mungwini, 2008). In Africa, a woman’s social recognition and sense of womanhood suffer greatly when they are not married or when they are married but cannot have children. To be one without the other renders one inadequate or incomplete unless one has been widowed, in which case, one may not be held to blame as this is taken as being beyond one’s control. In other words, without children, they cannot attain “motherhood” as they will not have “produced” (Mungwini, 2008).

It is thus important to note that motherhood is a significant marker of womanhood. Motherhood confers so much power on a woman. It provides a respectable social identity, an important set of child-rearing tasks, access to kin networks, and a space where authority, a sense of control, and self-expression can be cultivated. A woman without a child cannot see herself as a member of her husband’s family. She is viewed as a waste to herself, to her husband and to her society (Akujobi, 2011).

In patriarchal social arrangements such as those found in most African communities, the so called cultural essentials are used as tools in the domination of women by emphasizing that true and authentic African women are those who
resist the “contamination” of westernization by sticking to their culture. The effect is that it narrows the window through which women look at the world and as a result, they become incapacitated to bring about radical changes that could overhaul the social arrangement and ultimately their status in the community. Women must be alert and be in a position to question the so-called cultural essentials. Women must not be blind to the fact that in these patriarchal societies, those who have the power, that is the males, often abandon or modify cultural traditions when it suits them and women must not hesitate to do the same.

Women in Britain and America in the Victorian Age of the 19th century endured the *Cult of True Womanhood or Cult of Domesticity*. This was a strict ideology of womanhood which upheld a collection of attitudes that regulated women’s behaviour. It associated “true” womanhood with the home and family. The “cult” identified four characteristics that were supposedly central to women's identity: piety, purity, domesticity, and submissiveness (Welter, 1978). Women who personified these virtues passed the test of True Womanhood. The “Cult”, argued that women's nature suited them especially for tasks associated with the home and children. It sanctioned the cliché that a woman’s place was in the home (Smith, 2002).

Although the Cult of True Womanhood was dominant during the 19th century, remnants linger in our present-day culture and influence current views of femininity. Butler (1988) posits that womanhood is formed or constructed
through repetitions and emulation of ideas put forward about what a “woman” is. This is true with regard to the construction of the ideal African woman presented as a wife and mother who is disciplined, industrious, inhibited, conforming and altruistic. These traits are in many ways similar to the attitudes that embodied true womanhood in the Victorian Age of the 19th century in Britain and America. Thus, womanhood is regulated and shaped according to social and cultural norms, values and expectations (Elinami, 2006).

While most literature on the subject of initiation, socialization and enculturation into womanhood in Africa centres more on the injurious side of the rituals, few of them go on to show the positive significance of the initiation itself, its worth on the individual and the society in general. With reference to the social construction of womanhood in African societies, this study would like to impress that is imperative for society to assist women construct a viable self-identity, one that does not only revolve around “belonging”, “mothering” or “producing”. This calls for a revolution since the “normal” and the “usual” can no longer respond to emerging challenges. There is need to question the continued valorization of the image of the traditional African woman and possibly modify the prevailing social attitudes that continue to cast African women as child bearers, labour maids and wives in servitude to their husbands as household heads.

Therefore, for African women to shift the focus of their selfhood and identity from wifehood and motherhood, it is important to suggest other rallying points
that they could emphasize such that they develop or mould new identities that can empower them to aspire more in life. For example, women can learn from their male counterparts by first getting to understand the response to the question: what makes a man in many African communities? (Mungwini, 2008). In response, Mungwini, (2008), argues that being a man means attaining a level of financial independence, having employment, an income or some level of self-sufficiency and then starting a family. It is also interesting to note that men’s social recognition and their own sense of manhood suffer greatly when they lack some work and financial self-sustenance, that is, when they are just like women. Women can also move to construct this kind of selfhood for themselves by simply constructing their selfhood around similar rallying points like a profession. Such things as a career where girls and women begin to see themselves as this or that professional can shift the foundation of their identity from the one of just being a wife and a mother. Once girls and women begin to see themselves outside the confines of marriage and motherhood by enhancing their self-worth through the pursuit of an education, a skill or a profession they will be better able to assert their rights including delaying marriage, negotiating for safer sex in their unions and deciding whether they can have a child or not. This study seeks to provide new trends in thinking about womanhood among the Pokot and Kenyan women.

2.3 Causes of Obstetric Fistula

Obstetric fistula has not been eradicated from the world. It still occurs in developed countries but is less common. However, there are differentials in the
causes of OF between the developed countries and in resource poor countries in Africa and Asia. But a fistula is a fistula, no matter where it occurs globally. The risk factors and stressors leading to OF are myriad and far-reaching with variations depending on the social and educational status of the people. Differences exist between the causes of OF in both industrialized and developing countries. In developed countries, the reported causes of OF include surgery, malignancy, radiotherapy and coital injury and neglected foreign bodies. Other rare causes are from the complication of unsafe abortion, surgical trauma, sexual abuse and rape. However, in resource poor countries found mainly in Africa and Asia, prolonged, obstructed labour without prompt and skilled medical care is the direct cause of about 90% of obstetric fistulas (Hilton, 2001; UNFPA, 2004; Keri, Kaye, Sibylle, 2010; Kelly, 1992). Undoubtedly, women from low and poor social and educational status are more often ravaged (Fasakin, 2007).

From various regions within Sub-Saharan Africa, the underlying factors for OF are considered to be biological, socio-cultural, behavioural and environmental (Miller, Lester, Webster, Cowan, 2005). Some of the examples encircling these indirect risk factors are young maternal age at delivery, poverty, practice of severe forms of female genital mutilation, childhood malnutrition and associated anemia, limited decision-making power of women, illiteracy and low status of women, illnesses, genetics and health seeking behaviour (Wall et al., 2004; Tsui et al., 2007). This interplay determines the status of women, their
health, nutrition, fertility, behaviour and susceptibility to obstetric fistula (Mabeya, 2004).

However, despite the acknowledgement of these indirect risk factors by many of the observational studies and researches on areas that expose women to the risk of developing an OF, few focus on preventive measures. Therefore, problems of obstetric fistula in areas of high prevalence and more so in sub-Saharan Africa can best be solved by identifying and addressing the predisposing factors. There is also a need to approach the fistula prevention and management in a different way, with respect to considering that other compounding risk factors and stressors could be present in the locales, leading to OF, other than just prolonged obstructed labour.

This review has indicated that the occurrence of obstetric fistula is a reflection of a variety of inadequacies, as the women had been in labour at home for more than 3 days before reaching health institutions, lacking information, transportation, support, economic resources and appropriate healthcare services. However, observational studies comparing the situation of other women without obstetric fistula from a similar community are hardly available. Hence, there is a need for observational studies addressing this issue.
2.4 The Effects of Obstetric Fistula on “Womanhood” in West Pokot County

Using the example of the HIV and AIDS epidemic in Sub-Saharan Africa and chronic illnesses in developed countries, we consider how illness can be socially constructed and how it disrupts one’s concept of self-identity. This involves the patient’s illness experience in light of societal reactions to the ill-person’s symptoms. Chavunduka, (1986), argues that to be ill is not just to be ill; the symptoms carry with them a “discourse”. Included in this discussion is the social stigma attached to certain illnesses, which adds to the suffering inherent in the illness experience. This stigma goes beyond the individual living with the illness as it affects members of his/her family. This applies to women living with OF in communities where understanding of the illness and its causes are not clear to the residents.

One of the first steps towards the prevention and treatment of any illness and especially OF is to understand the full range of the causes and effects of the disease. The risk factors and stressors leading to OF are myriad and far reaching. The impact of obstetric fistula on women, their families, healthcare, public health and clinical research is enormous and requires urgent attention. For this to be realized, a sound knowledge of the risk factors that predispose women in West Pokot to developing obstetric fistula needs an indebt understanding. It should be noted that not all OF cases can be cured. A gap in literature indicate that sometimes the services offered do not match what women want, and non-surgical options are not discussed. As such, standardized
information and counseling should be provided to fistula patients to address this inadequacy in care (Turan, Johnson, & Polan, 2007). Like other chronic diseases, OF and especially incurable fistula has a profound impact on quality of life, family life, social life, and ability to work. Similarly, it requires self-care and management and could benefit from approaches used successfully for other chronic diseases such as the management for diabetes.

In the African context, *diseases and illnesses* are classified as either natural or supernatural. The process by which definition of an illness is arrived at, the people making the definition and the situation in which the definition is made may all be important in understanding illness behaviour (Chavunduka, 1986). Many people believe that illness may have either a normal or an abnormal cause. Illnesses such as coughs, common colds, stomachache and headaches are generally regarded as normal since they occur from time to time in the life of an individual and are of a fleeting nature and may disappear completely. These can be treated with modern or traditional medicines. Many people agree that normal illnesses are caused by among others, germs, bad food, accidents, toxins.

When an illness persists over a long time, it ceases to be “normal” because it is considered unusual to fail to respond to treatment. The illness is then regarded as “abnormal”, sent by witches or attributed to the anger of ancestors, spirits and gods, especially when taboos are perceived to have been broken. Once an illness has been defined as abnormal, those afflicted consult traditional healers because they believe modern doctors are unable to attack the ultimate cause of
abnormal illness. The current body of literature on obstetric fistula is predominantly concerned with the epidemiology of the injury and surgical treatment techniques.

However, only one qualitative study has been conducted on the experiences of women seeking treatment. The authors found that women seeking treatment in Eritrea received very little information from medical staff both pre- and post-surgery about the cause of their obstetric fistula or what to expect from the surgery (Turan et al., 2007). They contend that standardized information and counseling should be provided to obstetric fistula patients to address this inadequacy in care (Turan et al., 2007).

The worst suffering for women with an obstetric fistula may not be the physical manifestations of the condition or grief over the loss of their baby, but rather the social repercussions that follow. The majority of women who suffer an OF already live in precarious socio-economic circumstances complicated by the low social status of women in Sub-Saharan Africa. The social vulnerabilities that accrue in the life of women living with an OF are numerous (Mohammad, 2007). For this reason, the WHO (2006) emphasized that management of women with obstetric fistula require a holistic approach that does not only see this disease as a medical problem but also addresses the psycho-social impact it has on their lives and families. In most fistula care programmes, few platforms if any exist for women to exchange information, make their needs known, and inform programme design. This gap affects clients, providers, facilities, and
communities. Sometimes the services offered do not match what women want, and nonsurgical options are not discussed.

To address the problem of stigma in the treatment and management of OF, future studies and literature need to borrow a leaf from chronic diseases such as those that touch on social mores such as sexually transmitted diseases including HIV and AIDS. Thus, stigma could be addressed through challenging the stigmatization on the part of perpetrators, and challenging the internalized stigma of the stigmatized. In addition, cultural and spiritual aspects of pregnancy and childbirth have a strong influence on behaviour in most African societies. It is important that modern healthcare providers are aware of these aspects so that they can organize services that are appropriate and acceptable to the people. Unfortunately, there are usually limited opportunities for modern health personnel to explore the socio-cultural context of childbirth (Royston & Armstrong, 1989).

Conclusion

Most literature on the subject is based almost exclusively on convenience samples of women presenting to healthcare facilities for repair and this creates a gap to be explored in future research. However, there are certain cultural characteristics that appear to be consistent in areas where fistula is prevalent. Most notably are the pertinent social norms regarding the low status of women and their designated roles of wife and mother which apparently have been ignored in the reviewed studies. Thus, this study attempts to narrow these gaps
by specifically focusing on and documenting the lived experiences of women afflicted with obstetric fistula.

Also, quantitative studies in this area are loaded with medical jargon which makes it difficult for lay people to understand the message communicated. In addition, these studies seek to enrich the medical knowledge base by identifying the best surgical techniques for fistula closure and success rates. They are limited in the ability to understand from a gender perspective the many dimensions of obstetric fistula and its related social vulnerability. Most of the studies and research on the subject only concentrate on the medical causes of the disease without addressing the interplay of socio-cultural factors as key determinants (Donnay & Ramsey, 2006). The health and social problems encountered by repaired and unrepaired obstetric fistula patients in various parts of Africa and Asia, depict unfortunate results that women with the condition encounter in terms of on-going health, psychological, and social consequences that are not completely alleviated by repairing the fistula alone (Muleta, 2008).

2.6 Theoretical Framework

This study was guided by the Stigma Theory of Identity Management by Goffman (1963), the Transactional Model of Stress and Coping by Lazarus and Folkman (1980) as well as Judith Butler’s “Performatative Theory” (1988).
2.6.1 The Stigma Theory of Identity Management

The study was guided by the stigma theory, as described by Goffman (1963), and the transactional model of stress and coping by Lazarus and Folkman (1980), to discuss the experiences of women affected by obstetric fistula. Stigma was used with regard to the way women perceived their lived experiences. Through this theory, the study sought to expound the interpretation of what is at stake for a stigmatised woman living with a fistula in West Pokot County. The transactional model of stress and coping was used to explore the way women coped in their daily lives with this stigmatising condition. Goffman defines stigma as “an attribute that is significantly discrediting” (Goffman, 1963).

Within the social process, a stigmatised person possesses an “undesirable difference” or “deviance” (Goffman, 1963). Stigma is a constantly changing social process that occurs when five interrelated components converge: namely “labelling”, “stereotyping”, “separation”, “status loss and discrimination” and the playing out of “social and political power” (Link and Phelan, 2001). Discrimination can be individual, structural or self-imposed (Link and Phelan, 2001; Mahajan, Sayles, Patel, Remien, Sawires, Ortiz, Szekeres, Coates, 2008). Anthropologically, the concept of stigma remains empty and decontextualised if not filled with meaning from people’s lived experiences (Kleinman, Wang, Li, et al., 1995).
Stigmatisation is a pragmatic response to “perceived threats, real dangers, and fear of the unknown” (Yang, Kleinman, Link, et al., 2007) and can either be enacted or felt. Enacted stigma refers to the unfair treatment of others towards the stigmatised person, in this case, the women living with OF, including discriminatory attitudes and acts of discrimination; whereas felt stigma refers to the stigmatised person’s internal feelings of shame (self-stigma) and fear of discrimination (perceived stigma) (Herek, 2002).

2.6.2 Transactional Model of Stress and Coping

This is a framework for evaluating the processes of coping with stressful events. When faced with a stressor, first, people evaluate the potential as stressful, controllable, challenging, positive or downright irrelevant. Second, they assess their capabilities to change or manage their reactions to the threat (Lazarus & Cohen, 1977; Antonovsky & Kats, 1967; Cohen, 1984). The model uses problem-focused and emotion-focused forms of coping.

Problem-focused coping strategies encompass efforts to define the problem, generate alternative solutions, weigh the costs and benefits of various actions, take actions to change what is changeable, and, if necessary, learn new skills. Problem-focused efforts can be directed outward to alter some aspect of the environment or inward to alter some aspect of self. Many of the efforts directed at self, fall into the category of reappraisals, for example, changing the meaning of the situation or event, reducing ego involvement, or recognizing the existence of personal resources or strengths.
Emotion-focused coping strategies are more suitable when the stressor is unchangeable and are directed toward decreasing emotional distress. These tactics include such efforts as distancing, avoiding, blaming, wishful thinking, venting emotions, seeking social support and denial. The Transactional Model of Stress and Coping is useful for health education, health promotion and disease prevention. Stress does not affect all people equally, but stress can lead to illness and negative experiences. Coping with stress is, therefore, an important factor, it affects whether and how people search for medical care and social support and how they believe in the advice of the professionals (Lyon, 2000).

![Figure 2.1: Lazarus and Folkman’s (1984) basic model for stress and coping processes (Adapted from (Goh, Sawang & Oei, 2010)](image)

The relevance of this Transactional Model of Stress and Coping in this study is that the framework emphasizes appraisal to evaluate harm, threat and challenges, which result in the process of coping with stressful events (Lazaurus, 1966; Lazarus & Folkman, 1984) as is seen with women affected by OF. According to Lazarus & Folkman (1984), stress may result from internal processes or perceptions, due to major life events and daily hassles. In relation to this study, OF, a debilitating disease, is a major life event for the affected women. The level of stress experienced by the women was in the form of
thoughts, feelings, emotions and behaviours (Lazarus & Folkman, 1984). These were due to external stressors and the appraisals of the situation which involved a judgment about their contribution to and accompanying social meanings of the condition.

### 2.6.3 The Performatative Theory

In addition to the above, the study also looked at the performatative theory advanced by Judith Butler in 1988, the theory argues that “gender is located in the acts that constitute it”. The theory posits that gender is made up of the acts that mark a person as “man” or “woman” (dress, mannerisms, etc). Butler, asserts that gender involves the stylized repetition of acts and it is through the repetition of those gendered acts (gestures, movements and enactments) that the illusion of a stable gender identity is created. She argues that the performance of gender itself creates gender. Therefore, an individual becomes a woman or a man through social performance.

Additionally, Butler compares the performativity of gender to the performance of the theatre. While actors know that they are acting, we, performing gender, often do not know that we ever formed a belief in our gender. We take our gender as natural, and forget that it is naturalized through performative acts. However, Butler brings into light a critical difference between gender performance in reality and theater performances. It is evident from the theory that gender performances in non-theatrical context face punitive social measures, which are absent from theatrical performances.
Gender as a performance, is influenced by social norms, taboos, rewards, and punishments. Thus, as performers of gender, we are always under duress to give the gendered performance expected from us. Performative acts which construct gender may seemingly appear as a personal choice, but they always work within the existing framework of cultural sanctions and proscriptions, of a “shared social structure”. Recognizing these gender acts is significant in ending inequality. Butler explains that because of this performance, it is not true that women and men have to behave in certain ways because of their sex. Therefore, a realization of these acts has repercussions for changing oppressive systems.

In this study, the gender performatative theory has been linked to the socialization process of Pokot females into womanhood. Among the Pokot, ‘womanhood’ takes place through learning-to-become and internalization of and adherence to a series of prevailing historical forms of femininity in the community. The social ideals of being “woman” for the Pokot females follow a natural and sequential pattern of life events. To attain “womanhood”, the Pokot females must enlist to the socialization rites into adulthood, marry, bear children and carry out motherly and wifely duties while in their matrimonial homes. These life events are acted out in accordance with social scripts prescribing ideals which are unrealizable, but which provide the framework for their routine social interactions (Butler, 1990, 1993, 2004). In the theory, Butler (1990, 1993, 2004), explains, “the body becomes its gender through a series of acts which are renewed, revised, and consolidated through time”.
The adherence and performance of these life-events are the means by which the Pokot females and their bodies become gendered. However, this gendering of the Pokot females and their bodies can vary in different contexts, and can change over time. This is true for the study women afflicted by obstetric fistula. Many of these women living with the condition find it difficult to achieve ‘womanhood’ because obstetric fistula disrupts and alters the socially proscribed flow of life events and social interactions. Leaking of urine and/or feaces produced a polluted and spoilt identity and hence, feelings of ‘disorder’ for the affected women. In addition, obstetric fistula heralded a negative domino effect on the loss of their ascribed gendered roles which ushered in a cohort of other losses. These losses were signified as wife, mother and community member. These losses led to long-term interruptions between their realities with the condition versus socio-cultural expectations.

Women affected by OF, may be deemed to have failed to meet the normal expectations of their family and society. Therefore, they were isolated into their own “abnormal” world. According to the theory, the women were isolated into their own “abnormal” world because performative acts which construct gender may seemingly appear as a personal choice, but they always work within the existing framework of cultural sanctions and proscriptions, of a “shared social structure”. Those who do not conform to the established social standards face punitive social measures such as the stigma experienced by the women affected by OF. This is because performing one’s gender wrong initiates a set of
punishments both obvious and indirect, and performing it well provides the reassurance that there is an essentialism of gender identity after all.

Just as a script may be enacted in various ways by performing theatrical actors on stage, and just as the play requires both text and interpretation, so the gendered body acts its part in a culturally restricted corporeal space and enacts interpretations within the confines of already existing directives (Butler, 1990, 1993, 2004). The significance, therefore, of certain bodily statuses, informs our sense of our own body and those of others. The sense of our own body reflects, the way it is perceived by others (Lennon, 2014). Although stigmatized women living with OF do not live successful and happy life, they develop different survival strategies in order to have a relative good life. Incontinence, among other effects can dramatically diminish self-esteem and alter the women’s relationships to their own bodies, denying them the pleasure of feeling attractive as sexual beings.

Gender performatative theory was used to explain the development of social norms and the lengths to which people go to conform to such constructions, as well as to provide a positive model for how categories can embrace their own instability. These acts are significant because they are key in understanding the dichotomizing nature of gender and the subordination of women (Butler, 1990, 1993, 2004) in this study.

From the study, it is apparent that sustaining an OF changes a woman’s self-image (Donnay & Weil, 2004). This is because of the apparent departure from
cultural ideals of womanhood which contrasted with the socio-cultural expectations that they had been socialized to live up to. Also, there is an undeniable link between fistula and social stigmatization, with stigma being a powerful social process of devaluing people or groups based on a real or perceived difference. Thus, the personal significance of the event is critical and depends on the affected person’s history, life stage and circumstances and that each event, whether major or minor, leads to an individual experience with individual meaning in the way it is interpreted on a day-to-day basis (Lazarus & Folkman, 1984).

2.7 Conceptual Framework

Women who acquire an obstetric fistula gradually experience irreversible discontinuities between their realities with the condition versus the socio-cultural expectations they have been socialized to live up to. This is because of the apparent departure from cultural ideals of womanhood and their realities with OF. 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. 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. The conceptual framework that guides this study as shown in figure 2.2, examines how women who have been affected by obstetric fistula reconstruct their identities, negotiate its meanings and seek orientation in life across various contexts.
The framework is not, however, very precise; the boxes can be thought of as general concepts that can encompass a much larger set of variables. Any efforts to reduce maternal mortality and morbidity, must focus on having a sound knowledge of the risk factors that predispose girls and women in Kenya to developing obstetric fistula; mass awareness and mobilization of the community on the condition; improvements in emergency obstetric care and improvements in the socio-economic status of women, their education and empowerment.
Figure 2.2: From Lost to Regained Womanhood

**INDIRECT VARIABLES**
- Socio-Cultural Factors - (Preparation of females for ideal “womanhood”)
- Society’s social structure
- Norms and practices
- Women status in family and community
- Limited knowledge
- Misconceptions
- Poverty
- Poor medical attention

**DIRECT VARIABLES**
**Complications of Pregnancy and Birth**
- **Obstructed Labour** (due to birth complications e.g. malpresentation of foetus, immature pelvis -due to early age at delivery, etc)

**Pregnancy outcome**
- Live birth
- Stillbirth

**OBSTETRIC FISTULA**
& its manifestations
- Urine and/or fecal incontinence

**MODERATING FACTORS**
- Prompt medical intervention
- Awareness raising and sensitization
- Education
- Gender empowerment

**Reconstructed womanhood**

**Effects of Obstetric fistula**
- Incontinence (poor health)
- Loss of womanhood
- Low social status
- Loss of baby
- Stigma, …etc

**Coping strategies**
- Padding, Isolation, Bathing, Cloth-change, …etc
CHAPTER THREE

METHODOLOGY OF THE STUDY

3.0 Introduction

This chapter presents the methodology that the study utilized in order to generate the required data specific to this study’s design, site and the population. The chapter also discusses the sample size and sampling techniques, the methods of data collection, data analysis and the ethical considerations.

3.1 Study Design

The study used the phenomenological design to generate both quantitative and qualitative data. The essence of this methodological design is its holistic characteristics in evaluating research, as well as its ability to resist standardized categories that have been prearranged. This methodology is 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. This allowed for the generation of insights into the experiences and perceptions of affected women on obstetric fistula (OF) and the cumulative effects this malady has had on the affected women.

Phenomenology is the study of things as they appear (phenomena). It is descriptive rather than explanatory. A central task of phenomenology is to provide a clear, undistorted description of the ways things appear, which was critical for this study. The advantage was that, phenomenological research is concerned with the lived experiences of a group of people with a phenomenon of interest (Hancock, 2002). The approach was also ideal in that it allowed for the use of personal interviews and narratives on the lived experiences of the
respondents without biasness (Strauss & Corbin, 1994). In addition, it also allowed for the development of a rich and in-depth understanding of the women living with obstetric fistula through their documented narrative and experiences.

3.2 The Study Site

West Pokot County lies in the Rift Valley region of Kenya as shown in Appendix 2. It borders the Republic of Uganda to the West and the following Kenyan counties: Trans-Nzoia to the South, Elgeyo Marakwet and Baringo to the South East, and Turkana to the North and North East. It lies between latitudes 24° 40’ North, and 10° 7’ North and longitudes 34° 37’ East and 35° 49’ East. The county covers a surface area of 9,169.4 square kilometres and has a population of 512,690 with a population density of 59.33 per square kilometre (KNBS, 2009). The County is divided into 4 sub counties namely West Pokot, Pokot North, Pokot Central and Pokot South. It has 13 divisions, 61 locations and 222 sub-locations. Kapenguria town is the county headquarters. West Pokot has 4 constituencies namely, Kapenguria, Kacheliba, Sigor and South Pokot (Makanga, Munene, Baringo County, 2013).

A study conducted by Mabeya in 2004, established that 62.7% of the single largest group of patients who developed obstetric fistula constituted first-time mothers. In the same year, the Ministry of Health, Kenya, supported by UNFPA in 2004, undertook a study based in four districts (Kwale, Mwingi, West Pokot and Homa Bay) where fistula was suspected to be most prevalent. In the four districts surveyed, there were a total of 113 reported obstetric fistula cases, of which 94 were repaired with West Pokot receiving and repairing 79 of the cases
In addition, the UNFPA Kenya Country Office suggested the need to approach the fistula prevention and management in a different way, with respect to considering that other compounding risk factors and stressors present in the locale, led to OF, other than just prolonged obstructed labour. Thus, on the strength of these reasons, West Pokot County was purposively selected as the study site.

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 as shown in Appendix 2. They speak Pökoot, a language of the Southern Nilotic language family which is close to the Marakwet, Nandi, Tuken and other members of the Kalenjin grouping found in 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 (MoH & UNFPA, 2003).

Culture among 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. They have many strong beliefs and traditional practices which they nurture. With limited knowledge and influence from outside, the Pokot perpetuate traditions and practices adapted to their context. Of particular
interest to this study is the practice of “female-circumcision” commonly referred to as female genital mutilation/modification (FGM). “Female-circumcision” was incorporated in a series of other events that together codified the expectations for successful female social maturation.

Although the girl-child among the Pokot endures many other less painful rituals while growing up, FGM 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). FGM can thus explain the role of invasive genital mutilation/modification in obstetric fistula formation in the community. In the Pokot region, the FGM rate is about 97%, a figure that is markedly higher than the average national prevalence of 32.2% (Ogolla, 2015).

The most prevalent form of FGM among the Pokot is “infibulations”, which involves the removal of all or part of the external genitalia and stitching up the vaginal opening, leaving a very small passage. Local officials in the Pokot region indicate that over 80% of girls either do not join school at all or drop out prematurely after undergoing FGM because they are often married off immediately following the procedure.

### 3.3 Target Population

The study targeted women affected by obstetric fistula in West Pokot County. These women comprised two categories: those living with the condition whose
population 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. The study identified and recruited 36 of the 64 women with repaired obstetric fistula. These gave an insight into their lives after obstetric fistula. Others included in the study were spouses of the targeted women. Key informants included members of the council of elders, and 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.

### 3.4 Sampling Techniques and Sample Size

#### 3.4.1 Recruitment of Women with Repaired Obstetric Fistula

*Table 3.1: Sampling procedure and sample size determination for women repaired of obstetric fistula*

<table>
<thead>
<tr>
<th>West-Pokot County: Study sites</th>
<th>Cases found</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women cured of OF</td>
</tr>
<tr>
<td>1. Kapenguria</td>
<td>12/13</td>
</tr>
<tr>
<td>2. Kacheliba</td>
<td>3/11</td>
</tr>
<tr>
<td>3. Alale</td>
<td>3/8</td>
</tr>
<tr>
<td>4. Sigor</td>
<td>10/17</td>
</tr>
<tr>
<td>5. Lelan</td>
<td>8/15</td>
</tr>
<tr>
<td>Total frequency count</td>
<td>36/64</td>
</tr>
</tbody>
</table>

The study recruited community health workers as research enumerators. These were involved in the recruitment of the women repaired of obstetric fistula in
the last fistula camp held in the region. This is because the community health workers had created a rapport with these women during the identification and recruitment exercise in the field and in the screening and repair period at the Kapenguria County Referral Hospital. According to the community health workers’ analysis and experiences during field recruitment of the women prior to their treatment, it emerged that most of the women with repaired OF were dispersed in Kapenguria, Kacheliba, Alale, Sigor and Lelan districts of the study area. These five districts informed and guided the study’s sampling blocks and locations as indicated in table 3.1.

The study used the women with repaired obstetric fistula as an entry point to the study locale and sampling process. The community health workers relied on the contacts they had established during check-ups and follow-ups to trace and recruit a total of 36 out of the 64 women repaired of OF in the last fistula camp held between the 8th – 14th November, 2014 at Kapenguria County Referral Hospital. This gave a response rate of 56.3%. Thus, through purposive sampling technique, the study recruited 36 women repaired of obstetric fistula. For purposes of medical ethics and doctor-patient confidentiality, the study did not have access to the medical list because it was classified.
3.4.2 Recruitment of Women Living with Obstetric Fistula

Table 3.2: Sampling procedure and sample size determination for women living with obstetric fistula

<table>
<thead>
<tr>
<th>West-Pokot County: Study sites</th>
<th>Cases found Women living with OF</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Kapenguria</td>
<td>4</td>
</tr>
<tr>
<td>2. Kacheliba</td>
<td>5</td>
</tr>
<tr>
<td>3. Alale</td>
<td>3</td>
</tr>
<tr>
<td>4. Sigor</td>
<td>5</td>
</tr>
<tr>
<td>5. Lelan</td>
<td>4</td>
</tr>
<tr>
<td>Total frequency count</td>
<td>21</td>
</tr>
</tbody>
</table>

Though the number of women living with obstetric fistula in the study locale was unknown due to the nature of the study, the research team, through snowball sampling technique, were able to identify 21 women living with obstetric fistula across the selected districts. This was through the references made by some of the women repaired of OF and help from village elders. This is illustrated in table 3.2. Snowball sampling consists of identifying respondents who are then used to refer researchers on to other respondents. The technique offers real benefits for studies which seek to access the vulnerable, hidden, and at times, difficult to reach and more impenetrable social groupings, objects or events not easily accessible through other sampling strategies. These are often obscured from the view of social researchers and policy makers who are keen to obtain evidence of the experiences of some of the more marginal excluded groups. This was noted to be the case with the target group of this study. Snowball sampling technique seeks referrals from the initial participant to identify additional participants, until data saturation is reached and estimations for the number of participants to be included in the study made. Community health
workers acting as research enumerators ascertained saturation of data when they referred to women living with OF whom they had already sampled.

3.4.3 Recruitment of Key Informants

Also, 4 medical personnel from Kapenguria County Referral Hospital, which is the main referral public health facility in the study area, were purposively recruited as key informants. These were based in the main theatre, obstetrics and gynaecology and maternity wards. In addition to these, 6 “Kokwo” or members of the council of elders, comprising 3 men and 3 women, were purposively selected. These were thought to provide in-depth information about the condition and traditions of the community in relation to the affected women.

3.4.4 Recruitment of Spouses/Caregivers of Women Affected by Obstetric Fistula

Table 3.3: Sampling procedure and sample size determination for spouses/caregivers of women affected by obstetric fistula

<table>
<thead>
<tr>
<th>West-Pokot County: Study sites</th>
<th>Cases found</th>
<th>Spouses/caregivers of women cured of OF</th>
<th>Spouses/caregivers of women living with OF</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Kapenguria</td>
<td>10</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2. Kacheliba</td>
<td>3</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>3. Alale</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>4. Sigor</td>
<td>9</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>5. Lelan</td>
<td>7</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Total frequency count = 49</td>
<td>32</td>
<td>17</td>
<td></td>
</tr>
</tbody>
</table>

In order to capture the family level experiences with a chronic condition, the study also managed to recruit and sample spouses of the women affected by OF. This was done through convenient sampling. The study managed to sample 57
women, among these, 36 had had their obstetric fistula repaired and 21 were living with the condition. Among the 57 women recruited into the study, 10 were unmarried with two of these being cared for by their mothers. As shown in table 3.3, the study was able to sample 49 spouses/caregivers of the affected women through convenience sampling. This was 86% of the expected sample. Convenience sampling is a type of non-probability sampling that involves the sample being drawn from that part of the population that is close to hand. That is, a sample population selected because it is readily available and convenient, as researchers are drawing on relationships or networks to which they have easy access. Convenience sampling is justified if the researcher wants to study the characteristics of people at a certain context or point in time. Convenience samples provide vital contributions to individual case records, qualitative summaries, and documentation.

3.5 Study Tools

This study utilized both primary and secondary data. The study used interview-schedules administered to women affected by obstetric fistula and their spouses/caregivers and guided questionnaires administered to key-informants as well as observation of the respondents to capture non-verbal data. To augment the field data, the study also used archival methods. These were derived from secondary sources which comprised review of related literature on the subject in the university and online based-libraries, e-books, journals, reports, United Nations (UN) and its subsidiaries and associated partners in the fight to end obstetric fistula, World Health Organization (WHO), and the media.
3.5.1  *Guided-Questionnaires Administered to Key-Informants*

These were administered to the key informants basically the “Kokwo” or six members of the council of elders in an interview-style by the enumerators and the four medical personnel based in the obstetrics, gynaecology and maternity wards at Kapenguria County Referral Hospital. Before self-administration of the questionnaire to the four medical personnel, the research team went over the questions with the key informants to ensure clarity of questions. The key informants were easy to locate and hence, the return rate was 100%, though some questions had no responses.

The study chose to use questionnaires because they are fairly advantageous in field research. Questionnaires are fairly easy to use in field surveys in a time-efficient manner. The similarity of the questions ensures that the acquired data is more identical, correct and standard. The questionnaires also ensure respondents’ anonymity thus enabling them share information more easily.

3.5.2  *Interview Guides Administered to the Women Affected by OF and Their Spouses*

These were administered to the women living with OF, those with repairs and their spouses. Interviews were conducted on a face-to-face basis. Interview guide approach is a popular and widely used means of collecting qualitative data because the researcher is able to capture firsthand information directly from the respondents. Interviews reveal existing knowledge in a way that can be “expressed in the form of answers and so become accessible to interpretation” (Flick, 2006: 160). A key characteristic of interview guides is that the inquirer
is able “to obtain a special kind of information” (Merriam, 1998, p. 71) and investigates for himself/herself what is going on in the respondent’s mind.

Interviewing is key to understanding what and how people perceive and “interpret the world around them” (ibid: 72). This is an important feature in phenomenological research designs, which seek to describe in order to provide a clear, undistorted description of the way things appear as opposed to explaining. The flexibility in this form of interview is that the topics and questions are specified but they can be reworded in any sequence based on the situation.

3.5.3 Observation of the Women Affected by OF

During the interviews, the study employed observation technique to capture the non-verbal data. Observation as a technique involves sustained direct observations by the researcher. The research team made observation notes as the respondents gave oral narratives of their personal experiences of transition to womanhood and lived-experiences of obstetric fistula. Observation focused on the non-verbal cues and body language of individual respondents to understand the meaning of certain behaviours or beliefs. The advantages of in-person-observation are that there is interaction between the respondents and researcher through the observation of the phenomena of interest as it occurs and the researcher can clarify on and understand what is said, done or observed (Bogdewic, 1999).
3.6 Pre-test, Validity and Reliability of Study Tools

The study tools were pre-tested with 5 respondents in Chepareria Division in South Pokot Sub-county. The pre-test sample included two women living with obstetric fistula and another cured of it, an elder, and a TBA. This helped to highlight any errors of inclusion or omissions in the study tools. Necessary alteration and modifications were then effected before the tools were administered in the study’s main data gathering exercise.

3.7 Data Collection Procedure

The procedure of data collection was systematic and sequential. For the purposes of complying with the Operational Guidelines for Biomedical Research, as set by the Ethics Review Committee of Kenyatta University a research ethical permit was sought and granted. After obtaining the necessary approvals and permits, from Kenyatta University, the National Commission for Science, Technology and Innovation (NACOSTI) and line County Ministries, the study embarked on identifying and training data enumerators. The study recruited community health workers as research enumerators and were involved in the pretest of survey instruments prior to the main field survey exercise. The community health workers were assigned to the five selected districts of Kapenguria, Kacheliba, Alale, Sigor and Lelan as shown in tables 3.1, 3.2 and 3.3 above. The research enumerators were able to communicate very well in English, Swahili and Pokot and were knowledgeable on OF issues. This enabled them to translate research questions with ease to the Pokot dialect for
respondents who could not communicate in and/or understand English or Swahili.

With the help of the community health workers, the study was able to “enter” the field by presenting the permits to the local political administrators, administrators of health centres in the five districts and members of council of elders. Before commencement of the face-to-face interviews, the study secured individual informed formal consent from the respondents. The study purposively targeted and interviewed women repaired of obstetric fistula. Through snowballing, the study included those women living with the condition. The study interviewed their spouses/caregivers and administered guided questionnaires to key informants. The data extracted was captured on the interview schedules and guided questionnaires as quantitative and qualitative/verbatim data. The observation check list was operational concurrently.

3.8 Data Analysis and Presentation

The Statistical Package for Social Sciences (SPSS) version 21 was used to analyze the data. Quantitative data were analyzed using descriptive statistics because the process allows the researcher to organize the data to give meaning, facilitate insight and examine a phenomenon from a variety of angles in order to understand more clearly what is being seen (Burns & Grove, 2005). The data were analyzed using descriptive statistics and presented as percentage frequencies, averages, tabulations and histograms and pie-charts. Qualitative
data were analyzed thematically. Essentially, thematic analysis involves the ‘identification of passages of text and applying labels to them as examples of some theme’ (Lewins, Taylor & Gibbs, 2005).

3.9 Data Management and Ethical Issues

3.9.1 Data Management

The completed guided-questionnaires and interview schedules were sorted according the various categories of study respondents. The guided-questionnaires and interview schedules were then stored under key-and-lock for safe keeping before coding. The data were keyed-in to a pre-coded SPSS data-sheet as variables representing the different types of data. The completed data files were backed up and stored electronically with multiple-passwords to restrict unauthorized access. The data were used for academic purposes only as outlined in appendix 1.

3.9.2 Ethical Issues

After obtaining the necessary approvals and permits, from Kenyatta University, the National Commission for Science, Technology and Innovation (NACOSTI) and line County Ministries, the researcher was able to “enter” the field. During the actual survey, and just before commencement of the face-to-face interviews, the study sought to secure individual informed formal consent from the respondents. The respondents were informed of their rights as well as the purpose of the study. To ensure confidentiality of the information divulged, all study tools were assigned a number, rather than the respondent’s name. As a
sign of goodwill, the research team was sensitive to the respondents’ responsibilities and would from time to time excuse them to attend to those obligations before resuming the interview.
CHAPTER FOUR
PRESENTATION OF FINDINGS, INTERPRETATIONS AND DISCUSSION

4.1 Introduction

This chapter presents the findings on the basis of the analyzed data, interpretation and discussions. The chapter is organized in six sections. While the first section presents the demographic characteristics of the men and women who participated in the study, presentation of the other five sections is based on the study objectives which focused on the social construction of womanhood among the Pokot; the perceived contributing factors to the development of obstetric fistula among women; the effects of obstetric fistula on womanhood in the county; as well as the obstetric-fistula-coping-strategies employed by the affected women in West Pokot County.

4.2 Socio Demographic Characteristics of Respondents

The demographic characteristics presented are for the women who participated in the study as either living with OF or having been cured of the condition. The analyses were necessary because they were found to affect on the womanhood of the affected women as well as the coping strategies. The demographic characteristics of the women were analyzed on the basis of age, marital status, number of children born to affected women before and after OF, level of formal education, knowledge of obstetric fistula, occupation, level of income per month and length of time respondents endured obstetric fistula.
4.2.1 Age of Women Respondents at Interview

As shown in figure 4.1, the majority of the respondents, represented at 53% were at the age bracket of 21-35 years. However, very few of the respondents below the age of 20 and those above 50 years were represented at 14% and 4% respectively.

![Figure 4.1: Age of women respondents](image)

From the above scenario, it is clear that obstetric fistula is not only a problem for adolescent girls but for women of all ages.

4.2.2 Age of Women Respondents at First and Last Pregnancy Prior to Sustaining Obstetric Fistula

Table 4.1: Age of Women Respondents at First Pregnancy

<table>
<thead>
<tr>
<th>Age Group of Respondents</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 20</td>
<td>42</td>
<td>73.7</td>
</tr>
<tr>
<td>20-35</td>
<td>15</td>
<td>26.3</td>
</tr>
<tr>
<td>36-50</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>51+</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Total</td>
<td>57</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 4.1: Age of Women Respondents at First Pregnancy

Mean 17.6
Minimum 11
Maximum 27
The mean age of women respondents at first pregnancy at the time of interview was 17.6 years with the youngest participant being 11 and the oldest 27. Further analysis as presented in table 4.1 revealed that majority of the women represented at 73.7% were below the age of 20 at their time of their first pregnancy while 26.3% were between the ages of 21-35 years.

**Table 4.2: Age of Women Respondents at Last Pregnancy Prior to Sustaining Obstetric Fistula**

<table>
<thead>
<tr>
<th>Age at last pregnancy prior to sustaining obstetric fistula</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 20</td>
<td>31</td>
<td>54.4</td>
</tr>
<tr>
<td>20-35</td>
<td>24</td>
<td>42.1</td>
</tr>
<tr>
<td>36-50</td>
<td>2</td>
<td>3.5</td>
</tr>
<tr>
<td>51 +</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Total</td>
<td>57</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The mean age of women respondents at the last pregnancy prior to sustaining OF at the time of interview was 21.8 years with the youngest participant being 11 and the oldest 47. Thirty-one women, represented at 54.4% were below the age of 20, while 24 women at 42.1% were between the ages of 20-35 years as presented in table 4.2 above.

Findings from the data presented in tables 4.1 and 4.2, indicate that adolescent pregnancy is high in the study area given 54.4% had endured a fistula before age 20. Evidently, therefore, adolescent girls in this area are more susceptible to pregnancy and childbirth-related complications, among them, obstetric fistula. This confirms the WHO report (2012) which observes that up to 65% of women
with obstetric fistula develop this as adolescents. The increased obstetrical risk in teenagers can partially be explained by anatomic immaturity. This is because teenage pregnancies account for a higher proportion of all pregnancies (7–30%) in developing countries (Chang, O’Brien, Nathanson, Mancini, Witter, 2003; Tebeu, Tantchou, Obama-Abena, Mevoula, Leke, 2006; UNFPA, 2007; Santhya, 2011; UNICEF, 2012; WHO, 2008). From the data, slightly less than half of the respondents at 42.1% of women aged between 20-35 or older had sustained a fistula, indicating that fistula is not selective; it affects women across all age groups, not just young women.

### 4.2.3 Marital Status of Women Respondents

**Table 4.3: Marital Status of Women Respondents**

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Type of marriage</th>
<th>Frequency count</th>
<th>Percentage count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>-</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td>Married</td>
<td>Monogamous</td>
<td>15</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Polygynous</td>
<td>14</td>
<td>25</td>
</tr>
<tr>
<td>Widowed</td>
<td>Polygynous</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Separated</td>
<td>Polygynous</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Divorced</td>
<td>Monogamous</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Polygynous</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>57</td>
<td>100</td>
</tr>
</tbody>
</table>

As shown in table 4.3 above, the analysis of the marital status of the women respondents revealed that 18% were single never married. Of these, 16% were cured of OF during the last fistula camp held in the study area. A total of 51% were married either in a monogamous or polygynous union. The high percentage of women reporting to be married was attributed to the culture of polygamy in the study area and to children. During the interviews with women
living with OF, it emerged that the presence of co-wives in polygynous settings ensured that a husband’s sexual needs were routinely met. Some of the women respondents cited the presence of their other live children prior to sustaining an OF as the main reason they were still married and/or allowed to stay back in their matrimonial homes.

4.2.4 Number of Children Before and After Sustaining Obstetric Fistula

Table 4.4: Number of Children Born to Women Respondents Before Sustaining Obstetric Fistula

<table>
<thead>
<tr>
<th>No of children before OF</th>
<th>Women repaired of OF</th>
<th>Women living with OF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>%</td>
</tr>
<tr>
<td>0</td>
<td>13</td>
<td>23</td>
</tr>
<tr>
<td>1-2</td>
<td>11</td>
<td>19</td>
</tr>
<tr>
<td>3-4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>5-6</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>7+</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Totals</td>
<td>36</td>
<td>63</td>
</tr>
</tbody>
</table>

The study sought to find out if the women respondents, both the cured and those living with the condition, had had any children prior to sustaining an obstetric fistula. As shown in table 4.4, as the number of children increased from 0-7 the percentage representation of the women cascaded in a descending order.

Table 4.5: Number of Children Born to Women Respondents after Sustaining Obstetric Fistula

<table>
<thead>
<tr>
<th>No of children after OF</th>
<th>Women repaired of OF</th>
<th>Women living with OF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>%</td>
</tr>
<tr>
<td>0</td>
<td>22</td>
<td>39</td>
</tr>
<tr>
<td>1-2</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td>3-4</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Totals</td>
<td>36</td>
<td>63</td>
</tr>
</tbody>
</table>
The study also sought to investigate if the women respondents had had any children after sustaining OF. As shown in table 4.5 above, women repaired of OF did not have any children at 39% while those living with the condition were represented at 26%. The women affected by OF reported that they had stillbirths at the time they sustained the condition and were experiencing difficulties conceiving. Women with repaired OF expressed fears of recurrence of the condition and were apprehensive of falling pregnant, hence the high percentages of women with no children. The results of this study found that childlessness is a blight to womanhood especially in a culture where poor reproductive outcome is scorned at. This study’s results concur with Holme, Breen and MacArthur, (2007), who found that childlessness is so devastating in a culture where a woman’s status is largely determined by her reproductive functioning. Mungwini (2008), notes that motherhood is a significant marker of womanhood because it confers so much power on a woman, power that childless women who also suffered from OF could not access.

However, statistics from this study unveil a departure from the typical story line presented in most studies about women living with obstetric fistula. The typical story line indicates that OF obliterates intimacy and motherhood in the afflicted women. The various studies (Donnay & Weil, 2004; Women’s Dignity Project and EngenderHealth, 2006; Muleta et al., 2008; Wall et al., 2001; Capes, Ascher-Walsh, Abdoulaye, Brodman, 2011; Mselle et al., 2011; Okoye, Echigoe & Tanyi, 2014) argue that only a quarter of women who suffer OF in
their first birth are able to have a living baby, and therefore, have minuscule chances of conceiving a healthy baby later on.

### 4.2.5 Level of Formal Education of the Study Women

**Table 4.6: Education Level of the Women Respondents**

<table>
<thead>
<tr>
<th>Education level of women respondents</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No formal education</td>
<td>31</td>
<td>54</td>
</tr>
<tr>
<td>Primary school</td>
<td>22</td>
<td>39</td>
</tr>
<tr>
<td>Secondary school</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Post-Secondary education</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>57</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

As demonstrated in table 4.6, the study findings indicate that the majority of the women respondents at 54% did not have any formal schooling and only 5% and 2% were reported to have attained secondary and post-secondary education in that order. The findings indicate a low level of access to formal schooling in the study area given that more than 50% of the women respondents had no formal schooling. The study observed that respondents as young as 11 years of age were out of school and married. Findings from the data presented in tables 4.1 and 4.2, indicate that adolescent pregnancy is high in the study area given that 73.7% had had a pregnancy and 54.4% had endured obstetric fistula before age 20. This can be attributed to the socio-cultural and economic engagements that militate against girls schooling in the study area. Also adherence to social norms that dictate female life events based on “social maturity” predispose young adolescent girls to early marriages and early coitus when their immature bodies are not ready to cope with the ravages of pregnancies and childbirth. There is
therefore a need to sensitize the community on the importance of schooling that delays marriage and early pregnancies.

### 4.2.6 Respondents’ Knowledge and Treatment of Obstetric Fistula

The study statistics indicate that 50 (88%) as opposed to 7 (12%) of the respondents had no knowledge of obstetric fistula which could follow after obstructed and prolonged labour and delivery. Also, it was revealed that 30 (53%) of the study women respondents had not known obstetric fistula was curable. They had been made to believe that there was no treatment for their condition due to the belief system in the community.

![Figure 4.2: Women Respondents’ Knowledge of Obstetric Fistula and its Treatment](image)

Twenty-seven (47%) of women who knew that obstetric fistula could be treated comprised those that had had repairs in the previous fistula camp held in the area by the visiting African Medical and Research Foundation – Health Africa (AMREF) doctors in collaboration with Kapenguria County Referral Hospital and Bayer Healthcare. They too confessed of their ignorance of the condition prior to the concerted campaigns by the Ministry of Health and other players.
such as Sentinelles, Bayer Healthcare and AMREF-Health Africa sensitization of the condition, their visit to the hospital and eventual treatment.

When asked if they thought that there was a delay in seeking treatment for their condition, 48 (84%) of the 57 women responded in the affirmative. Some of the reasons they advanced to have contributed to their delay in seeking treatment were captured verbatim from across the study site as follows:

“For 2 years and four months, I have been taking traditional herbs and home remedies. I was told that it takes time to seal itself up but the condition remains the same”. (Interview with fistula patient from Alale on 20/01/2015).

On discovering that they leak of urine, some of the study women sought counsel from older mothers who opined that indeed “something comes out for some time and then it stops”. Another woman respondent expressed her fear of stigma and common misconceptions on the cause of her ailment:

“I have had it for 8 years because of personal stigma, beliefs of curse and witchcraft and not aware of availability of medical assistance. Then I heard on the Kalya FM (vernacular radio broadcast) about a cure at the hospital”. (Interview with fistula patient from Kacheliba on 18/01/2015).

The study also established that some of the women respondents believed that their condition could not be cured. The awareness that a cure for the condition exists came as a shock to them. This indicates that the dissemination of health information in rural communities is minimal. One woman respondent explained:

I have lived with it for 18 years. One day, while at the market, I heard some people (AMREF-Health Africa) talk about my disease, calling on those with it to go for a cure! (Interview with fistula patient from Makutano on 20/01/2015).
Reconstructive surgery can mend this injury with success rates as high as 90%. Unfortunately, many women are either unaware of the availability of treatment for their condition or cannot access or afford it (UNFPA and EngenderHealth, 2003; Addis Ababa Fistula Hospital, 2002). It is estimated that 80% of women with OF never seek treatment (UNFPA and EngenderHealth, 2003) majorly because of lack of knowledge that anything can be done and because the availability of OF repair centres is limited or the patients are not aware of the existence of such facilities as is illustrated above by the women respondents’ quotes. For that reason a lot more needs to be done to create awareness about the disease, its causes, and where and when fistula repair services are available.

4.2.7 Occupation of the Women Respondents

Table 4.7: Occupation of the Study Women

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Women repaired of OF</th>
<th>Women living with OF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>%</td>
</tr>
<tr>
<td>Care-work</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td>Farmer</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Business</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Casual labourer</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Employed</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>63</td>
</tr>
</tbody>
</table>

Majority of the women with repaired OF represented at 21% and those living with the condition represented at 28% were engaged in care-work which includes the array of domestic unpaid work that is often disproportionately performed by women. The study noted that OF greatly affected the ability and choice of economic engagement for women living with the condition. This is
evidently displayed by the negative cascading percentage representation of these women in economic engagement as is illustrated in table 4.7 above.

When asked if and how they supported themselves financially, majority of the women living with OF reported that they engaged in some form of income generating activity for self-sustenance. A common denominator to their sentiments is that they experienced an increase of their dependence on significant others while reducing their sources of independent income. Thus, for them to regain a sense of independence, they felt a strong need to work. Nevertheless, they were quick to note that OF had limited their choice of and ability to work because of the co-morbidities such as foot-drop and skin ulcers along the inner thighs which limited their mobility.

Some of the women affected by OF ventured outside their homes to earn a living from petty businesses. They reported that they did not deal in food stuffs. Asked to expound on the thought, a common theme emerged that, as “spoilt, dirty and contaminated” people, they were “not to touch food meant for others because they were likely to contaminate it too”. Being “spoilt, dirty and contaminated” from OF, limited their choice of economic engagement as most engaged in non-food stuff petty businesses such as charcoal and kerosene selling.

In a bid to remain clean and dry, the women reported that the meagre earnings were all spent on toiletries in their struggle to control the constant urine leakage
and subdue the persistent bad odor. The study also noted that 5% were in some form of formal employment engaged as teachers in nursery school level and imparting ICT knowledge. This group of women respondents had OF repairs and had developed some confidence in themselves though they distanced themselves from the condition.

Women living with OF cited their inability to control the urine leak and pungent smell and thought that it was better for them to engage in farming and household duties. These two environments - the farm and the house; were considered friendlier because they were not crowded for outsiders to notice the urine leaks or sense the foul smell. Efforts by the women respondents to remain unnoticed especially by strangers point to a strong fear of stigma. One woman wondered:

“How do you go out there smelling and leaking of urine like this? Who will want to trade with you?” (Interview with fistula patient from Marich, Sigor Division on 27/01/2015).

Another woman respondent found the constant urine leakage a bother. She found comfort isolated either in her home or farm. She opined that:

“In my compound/house and the farm, am free to let it loose without offending others and attracting attention”. (Interview with fistula patient from Kiwawa, Kacheliba on 27/01/2015).

Mselle et al., (2011) found that OF reduces the ability of women to work, and if in addition they do not have the support of their husbands and relatives, they could be driven deeper into poverty. It is widely known that financial independence brings about not only one’s freedom, but also happiness and confidence. Obstetric fistula limits women’s ability to work or access jobs due
to stigma (UNFPA, 2006). Table 4.7 above summarizes the representation of women in the various economic engagements.

4.2.8 Study Respondents Estimated Income Per Month

Table 4.8: Estimated Monthly Income of Study Respondents

<table>
<thead>
<tr>
<th>Income range (KShs.)</th>
<th>Women affected by OF</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency count</td>
<td>Percentage</td>
<td></td>
</tr>
<tr>
<td>&lt; 3,000</td>
<td>49</td>
<td>86</td>
<td></td>
</tr>
<tr>
<td>3,000-6,000</td>
<td>6</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>6,001-10,000</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>&gt; 10,000</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>57</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Mean Income</td>
<td>3,178.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Min. Income</td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max. Income</td>
<td>10,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Asked to estimate how much income they made per month, the study respondents presented a bleak picture of their financial household situation. From table 4.8 above, the study found that 86% of the women earned less than KShs. 3,000 (Approx. 30USD) per month. Eleven percent of the women respondents earned a monthly income of between KShs. 3,000-6,000 (Approx. 30-60USD). The women respondents reported to be dependent on either their husbands or other members of the extended family. According to the women, the meagre earnings and handouts from husbands and other family members were used for feeding and other little recurring expenses to keep themselves clean and dry.
With the low reported incomes, it is obvious that the women respondents would take a long time to save up for the OF surgery. This is because OF, unlike other types of wounds does not heal on its own without the intervention of surgical repair. According to the Fistula Foundation (2014), the approximate average cost to treat obstetric fistula is US$450 or approximately KShs. 45,700 including surgery, post-operative care, and physical rehabilitation. (This figure is computed courtesy of the Central Bank of Kenya’s exchange rate of the Kenya shilling against the U.S. dollar on 07-03-2016 which stood at 101.4109 on average). This price estimate is based on average costs reported to the Fistula Foundation in 25 countries in Sub-Saharan Africa and South Asia. The longer they take to save up enough monies for the surgery would invariably result in some women losing their gender-roles of mother and wife, or live in isolation because of the bad odour they produce.

4.2.9 Duration of Time Respondents Endured Obstetric Fistula

Table 4.9: Women Respondents Length of Time Living With Obstetric Fistula

<table>
<thead>
<tr>
<th>Duration of time living with OF</th>
<th>Women repaired of OF</th>
<th>Women living with OF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>%</td>
</tr>
<tr>
<td>&lt; 3 months</td>
<td>4</td>
<td>7.0</td>
</tr>
<tr>
<td>3 - 6 months</td>
<td>2</td>
<td>3.5</td>
</tr>
<tr>
<td>6 - 12 months</td>
<td>14</td>
<td>24.6</td>
</tr>
<tr>
<td>1 - 3 years</td>
<td>8</td>
<td>14.0</td>
</tr>
<tr>
<td>3 - 5 years</td>
<td>4</td>
<td>7.0</td>
</tr>
<tr>
<td>5 - 10 years</td>
<td>2</td>
<td>3.5</td>
</tr>
<tr>
<td>&gt; 10 years</td>
<td>2</td>
<td>3.5</td>
</tr>
<tr>
<td>Totals</td>
<td>36</td>
<td>63.2</td>
</tr>
</tbody>
</table>
The study established that some women respondents had lived with the condition for more than 10 years, hence they were reporting on events from several years past. There was a variance in the length of time the women had lived with OF. The shortest time was less than 3-months and the longest span was more than 10 years. For women living with OF, majority at 12.3% had been living with fistula for 3 years, 7% of the women in this category had the condition for 5 years. Slightly more than 5% of the women had endured fistula for more than 10 years. Table 4.9 above summarizes the length of time that women affected by OF had lived with this debilitating condition. At the time of the study, 63.2% of the study women respondents had had successful OF closure.

This study, just like Mabeya, (2004), established that there was a prolonged lag time between onset of obstetric fistula and first hospital visit. This can be attributed to a number of factors among them, the respondent’s low economic power for surgical repairs and their little knowledge about the availability of treatment for obstetric fistula owing to their low levels of education, superstitions, cultural belief system and old wives’ tales.

4.3. Social Construction of Womanhood among the Pokot

This section focuses on the first objective of the study which aimed at establishing the social construction of womanhood among the Pokot people. Analyzed data revealed that the Pokot, like every other culture in the world ritualizes the important milestones throughout life. Among the Pokot, initiation
into adulthood happens in a continuum from childhood through to adulthood. The “making” of a woman in the African context entailed a series of events in a gradual process.

Information on the socialization process among the Pokot was gathered through in depth interviews with the “Kokwo” or members of the council of elder as key-informants and the study respondents. The “Kokwo” explained that there are gender-differentiated experiences of socialization into adulthood for boys and girls among the Pokot. The “Kokwo” noted that gender is a more important differentiator of people and status, more specifically men and women. With reference to womanhood, the study gathered that between the ages of 2-5 years, both young girls and boys were indiscriminately assigned simple home chores and encouraged to identify with same sex family members. This was intended to gauge their competency in understanding instructions and carrying out simple assignments.

The study respondents noted that girls and boys between the ages of 5-7 were assigned different chores along gender specific roles. The “Kokwo” confirmed that the main intention was to equip both genders with skills and knowledge that enabled them to perform the roles that society allocates them in the future. For instance, boys were entrusted with productive property such as cattle while girls were engaged in the kitchen. Also the children were exposed to specialized skills such as mock hunting for boys while girls were encouraged to compete in bead-making as a way of gauging their acumen in completing tasks to the satisfaction of the adults.
Women respondents recalled that just before their circumcision, they had their ears pierced and two central incisors removed from the lower jaw. Asked to clarify on the age group, they pointed to young girls aged 6-12 years. The “Kokwo” noted that:

“Ear piercing and removal of two incisors on the lower jaw is painful and it marks the pre-initiation ceremonies for girls in that age bracket. It is essential for their transition to adulthood”. (Interview with male member of the council of elders or Kokwo on 05/02/2015).

The women respondents recalled enduring a headache, and that the procedure was “very painful”. The women reported that the initiates were never tranquilized. Although it was a painful experience they nonetheless argued one would rather voluntarily endure the pain than be forced into it or even be treated like a pariah in their own land. One woman noted that:

“I had my two lower incisors removed at the age of 12 on the orders of my father”. (Interview with former fistula patient from Kacheliba on 12/02/2015)

Commenting on the painful ritual, the “Kokwo” reiterated that:

“It is obligatory for both boys and girls aged 12 to undergo the painful exercise which is also regarded as a rite of passage. It is used to distinguish children from adults and an indicator of how courageous one is and this earns them positions in the society.” (Interview with male member of the council of elders or Kokwo on 05/02/2015).

The “Kokwo” reiterated that the anterior teeth extraction occurs just after permanent teeth eruption and has been associated with adulthood, beauty, tribal identity, sound production, and soft food consumption. They also affirmed that young girls at that age who were thought to have mastered most of home chores
and beading would gradually be gauged in pain endurance, since it is expected that they would experience pain during circumcision, when they lose their virginity and when they give birth (Chebet, 2009).

In most African cultures, rituals leading to the final passage from childhood to adulthood, infringe on body integrity because they feature blood-letting, scarification and painful genital amputations. Initiates were schooled on their new status and its responsibilities and pain endurance as the main test/ordeal to “growing up” socially. Thus, girls aged 11-14 years had their genitals mutilated in what is famously known as “circumcision”. The decision to have a girl circumcised was made by a father or father-figure after assessing that she was “ready”. Some women respondents recalled receiving body welts/tattoos/scars on their torsos at about 11-14 years of age. The scarification was thought to beautify the body upon healing.

In addition to scarification, all women respondents endured “circumcision” or female genital mutilation/cutting (FGM/C). The women respondents and the “Kokwo” affirmed that girls deemed as socially mature in this age group were circumcised and betrothed for future marriage. Circumcision was incorporated in a series of other events that together codified the expectations for successful social maturation. The “Kokwo” noted that, circumcision was the last ritual that served as an outward, permanent physical mark on the body visible to the society as a first step to attaining “adulthood”. In the case of young girls, “womanhood”.
Completion of this phase of the rite enabled the adolescent who had been “aching to age”, partake and engage in activities reserved for the socially mature. From the women’s narratives, this phase of socialization was not a comfortable or pleasurable experience but was and still is thought of as necessary. Girls and women who deviate from this social norm suffer labeling, constant social peer pressure, stigmatization, belittling, ostracisation from communal activities and lifelong condemnation to the status of a “little girl” (Chebet, 2009). This explains why FGM, in the Pokot region, is practiced at 97%, a figure that is markedly higher than the average national prevalence of 32.2% (Ogolla, 2015).

Initiated women among the Pokot were rewarded with gifts, praises acceptance, dignity, cleanliness, chastity, respect, worth and more importantly marriageability. Marriage was intertwined with the successful transition from childhood to adulthood. With emphasis being placed on reproductive roles within marriage, the newly constituted socially mature women were encouraged to marry and bear children. By the early twenties, women in the Pokot community were expected to have been married and borne children within their husbands’ compounds. Many of the newly constituted socially mature women were only girls, as young as 14 or 15 years of age, married shortly after menarche with a first pregnancy following soon after before the pelvis is fully developed for childbearing. As a consequence of “social maturity”, young girls in this community are plunged into the world of wifehood and motherhood instead of being encouraged to pursue education and better themselves for the
future as their age mates elsewhere. This explains why 73.7% of study women respondents had had a pregnancy before age 20 as illustrated in table 4.1 and 54.4% of the same group had sustained OF before the same age as shown in table 4.2. Thus, becoming a wife and later being a mother are two important and crowning markers of womanhood in the African context (Mungwini, 2008).

The women respondents observed that in their late adulthood which is considered to be well above the age of 45, their status changed to that of counselor to the young initiates and new mothers. They were allowed to participate in officiating ritual ceremonies and attend council of elders’ meetings. The “Kokwo” noted that these particular women were admitted into the council of elders whose membership is purely male because most women at that age were slowly metamorphosing in to “men” through menopause. To clarify on the characteristics of older women admitted into the council of elders, the study sought the views of the female “Kokwo” who unanimously agreed that:

“The women must be dry. She should have stopped menstruating, lactating or expecting. These traits make her impure and vulnerable to preside over sacred rituals. When she is dry, she is like a man”. (Interview with female members of the council of elders or Kokwo on 05/02/2015).

Illife, (2007) in his work titled Africans: The history of a continent, echoes the importance of successful childbearing in Sub-Saharan African culture. The value of African women in society is derived from the roles of wife and mother, both of which are severely threatened when obstetric fistula occurs. Thus, a woman who acquires an obstetric fistula gradually experiences irreversible
discontinuities between their realities with the condition versus socio-cultural expectations. It is therefore important to note that motherhood is a significant marker of womanhood because it confers so much power on a woman (Mungwini, 2008). It provides a respectable social identity, an important set of child-rearing tasks, access to kin networks, and a space where authority, a sense of control and self-expression can be cultivated (Chaney, 2011).

Thus, the study establishes that social maturity as opposed to physical puberty was more important in female initiation ceremonies in this community. The “making” of a woman in the African culture entails a series of gradual processes and rites that involve a “learning-to-become” style of enculturation into their ascribed social roles. Female socialization and initiation ceremonies provide girls with a coherent view of themselves as wives, mothers, and providers. Thus, through culture, young pubescent “socially mature” girls are thrust into the roles of wife and mother when they are physiologically immature. Although not all cultural practices and beliefs are bad, most of the negative practices are due to ignorance and non-availability of better alternatives. This explains why many cultural practices have helped to perpetuate and increase the prevalence of certain diseases and health problems. Therefore, efforts should be made to encourage those practices that promote health and then, through the provision of information and better healthcare services, discourage those that harm human health.

This section focuses on objective two of the study which sought to identify the perceived contributing factors to the development of obstetric fistula among women in West Pokot County. Study respondents were asked to state what they perceived as causes of their condition. The causes identified were diverse as shown in table 4.10.

Table 4.10: Study Respondents’ Perceived Causes of Obstetric Fistula

<table>
<thead>
<tr>
<th>Perceived causes</th>
<th>Women respondents</th>
<th>Spouses of women respondents</th>
<th>Elders</th>
<th>Medical staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N Coun t</td>
<td>% of cases</td>
<td>N Coun t</td>
<td>% of cases</td>
</tr>
<tr>
<td>Effects of OFa</td>
<td>112</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Witchcraft, Curses and Bad-omen</td>
<td>15</td>
<td>26</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>The child tore my bladder</td>
<td>25</td>
<td>44</td>
<td>20</td>
<td>41</td>
</tr>
<tr>
<td>Accidentally cut by health provider during episiotomy</td>
<td>18</td>
<td>32</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>It happened at childbirth</td>
<td>10</td>
<td>18</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Home delivery and mode of delivery</td>
<td>7</td>
<td>12</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Circumcision</td>
<td>5</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disease (STI)</td>
<td>8</td>
<td>14</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Coitus</td>
<td>5</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total response count</td>
<td>93</td>
<td>163</td>
<td>60</td>
<td>122</td>
</tr>
</tbody>
</table>

*aMultiple responses allowed

*Dichotomy group tabulated at value 1.
4.4.1 Witchcraft, Curses and Bad-Omen

The affected women and their families believed that their condition was caused by *Paan* (witchcraft), *Kwotut nyoghaa* (bad-omen), and *Chipoot* (curses), punishment from God or retribution for breaking some taboos. Bad-omen as a cause of OF was experienced in the case of first time mothers. First-time-would-be mothers, who lost their only child and subsequently sustained an OF reported that they were condemned for their poor reproductive outcome especially by in-laws, who encouraged their son to “return” her to her natal family and remarry. The elders or “Kokwo” noted that the loss of a child in a first-birth was and still is interpreted as a bad-omen among the Pokot and hence the women respondents who fell in this category reported that they were regarded as “carriers of bad luck”.

The “Kokwo” reiterated that as tradition would have it; such unfortunate women were “returned” back to their natal families by their husbands’ kinsmen in an attempt to remove the bad omen away from their sons’ homes. The “returning” symbolized total divorce which ushered the women in the world of stigma and social labeling. They were labeled as failures in marriage which negatively reduced their honour, self-esteem and hierarchy in society (EngenderHealth, 2012).

In addition to the bad omen, some respondents thought their condition was as a result of a curse and this belief significantly affected their care seeking behaviour and caused the women to “hide” at home believing that nothing could be done to reverse the curse. Unfortunately this only served to extend the lag
time to treatment. A similar result was also found in a study carried out in Africa (Kavai, et al., 2010). This gives credence to the widely held view that the true number of women living with untreated obstetric fistula and suffering the consequent pain and degradation may have been underestimated at 3000 new cases a year in the country.

Respondents also cited witchcraft as a cause of OF. Witchcraft is an innate power which can be used only to do harm to others with the main aim being to change another person’s situation for worse. In the African setting, witches were and still are thought to be motivated by envy, malice and jealousy in their practice of witchcraft to harm others. Witches were said to have powers to curse and psychically send bad omen to their victims (Mbiti, 1989). As a result, it was not surprising that the study respondents presented witchcraft, bad omen and curses in close association to their obstetric fistula condition.

The respondents strongly believed that for no apparent reason and without provocation, “the witches did not want the baby to be born and hence with diabolical powers closed its path”. From this explanation of a “closed path”, the study deduced that the women had experienced prolonged or obstructed labour which is a major factor to the development of obstetric fistula. The women respondents opined that the intention of the witches in “closing the baby’s path” was to impede a natural vaginal delivery which is a priced demonstration of a woman’s strength among the Pokot. To ensure that the “closed path” was opened, those present at such a birth embarked on pacifying the supernatural and diabolical powers responsible for the delay in delivery, than understanding
and promptly rectifying the faulty obstetrical mechanics involved. Such concerns have significant implications for what happens next. A lack of education about reproductive health, reproductive outcomes and ignorance of signs of danger to look out for, contribute into the development of OF in women. As a consequence, the women experience an apparent departure from cultural ideals of womanhood.

4.4.2 The Child Tore My Bladder

“The child tore my bladder” was casually expressed by more than 40% of the affected women and their spouses as well as by 50% of the “Kokwo” as the cause of OF. The torn bladder was the source of the constant leakage of urine which manifested immediately or a few days after delivery, hence the inference that the baby could have injured the bladder in an effort to find its way out of the womb. This explanation of “the child tore my bladder” effectively communicates a lack of knowledge of the reproductive tract and its mechanisms on the part of the women. The explanation further points to an experience of a delay in recognizing a complication in the birth process and another of taking prompt action to redress it.

Thaddeus and Maine, (1994); Johns Hopkins Bloomberg School of Public Health and International Federation of Red Cross and Red Crescent Societies, (2008), report on women experiencing one or several of the three delays causing maternal mortality. These delays are: delay in recognizing a complication, delay to make an informed decision to seek appropriate medical care/reach a
health/obstetric facility, and delay to actually receive adequate and appropriate obstetric care. In their publication of the Public health Guide in Emergencies: Chapter 4: Reproductive Healthcare, the Johns Hopkins Bloomberg School of Public Health and International Federation of Red Cross and Red Crescent Societies (2008), echo an urgent need to address the three delays. They argue that in doing so; most obstetric emergencies can be avoided if women, family members, and birth attendants (both skilled and unskilled) can recognize obstetrical emergency signs.

4.4.3 Accidentally Cut by Health Provider during Episiotomy

During the interviews, some women respondents recalled making it to hospital after labouring at home for many hours albeit too late. To relieve the obstructed labour, health providers performed an episiotomy on the women, who later on experienced OF symptoms. Thirty two percent of these women, 24% of their spouses and 17% of the “Kokwo” attributed the episiotomy that relieved them from obstructed labour as a cause of their condition. This claim was refuted by the health providers with none of them attributing the OF to the episiotomy performed on any of the women who presented themselves albeit too late at a health facility. Nonetheless, this group of women apparently blamed the health providers in the labour wards for their problem. The common expression from women respondents drawn from across the five locations of the study site was:

“The baby was stuck at the outlet and so they (attending health providers) cut me badly.”
The results agree with what was found in other studies in Africa where no education or low-level education was a significant risk factor for fistula (Raassen, Verdaasdonk and Vierhout, 2008; Danso, Martey, Wall and Elkins, 1996; Kelly and Kwast, 1993). If the angry mothers looking to blame someone propagate their perceived misconception that healthcare providers cause OF, chances are that more women will end up with the condition as a result of low utilization of health facility births and emergency obstetric services. Similar findings have been reported in a study in Tanzania (Mselle, Moland, Mvungi, Evjen-Olsen, Kohi, 2011 and 2013) whereby (real or imaginary) bad birth care experiences might undermine the reputation of the healthcare system, lower community expectations of facility birth, and consequently reduce health facility births.

It is apparent that the women needed to express their anger about their condition and also to blame someone for their woes. The persons bearing the blame were the witches who did not want the baby to be born and so “closed the baby’s path”, the health providers in the labour wards who “cut me badly” and the baby who “tore my bladder”. Low levels of education and lack of knowledge of reproductive mechanism are illustrated again in these three scenarios.

Therefore, failure to recognize any one of the above reasons expressed in table 4.10 above, on the part of the would-be mothers and others present at a difficult/complicated birth, as the cause leading to OF rather than an episiotomy or other operation to relieve the complications, is unfortunate. This points to a
need for further sensitization of communities on the causes and prevention of OF and other labour related complications.

4.4.4 It Happened at Childbirth

Some of the women respondents perceived that their condition resulted from the birth process. During the interviews with the women respondents represented at 18%, their spouses represented at 14%, the elders represented at 17% and the health care providers represented at 36%, all agreed and understood that something went wrong during childbirth, the result being a loss of control of their bowels. The women respondents attributed their OF condition to the birth process when they opined that “I did not have this problem before I gave birth. Others attributed their condition to “the baby was stuck somewhere despite pushing hard” implying an obstructed labour. The health care providers attributed the development of OF on these women to a failure to recognize an obstructed labour that was unrelieved for many hours and a further failure to act promptly to seek qualified emergency obstetric care at a health facility.

4.4.5 Place and Mode of Delivery

Only 12% and of women respondents and 4% of their spouses cited home delivery as a cause of their condition. This came about as a result of labouring for many hours without any success. Women in the study area were expected to deliver at home, endure labour and deliver quietly, and follow the instructions of the “Karam”/traditional birth attendants or older women present at the birth without questioning. A “Karam” (“Karamach” pl.) is the native name of the local non-skilled birth attendants (non-SBA).
A home delivery among the Pokot, served three purposes. First, a home delivery was equated to a vaginal birth which demonstrated the strength of the woman giving birth. Second, all expectant women were encouraged to give birth within their husband’s compound in order to legitimize their offspring. Third, the actual birth of the baby indicated fidelity of its mother to her husband. Thus, in the event of any inexplicable mishap or tragedy which defies natural explanation to those present at a home delivery in a remote rural setting such as in most of West Pokot County, may be considered the result of witchcraft, bad omen, a curse, or evil-doings on the part of the mother. However, 36% of the health care practitioners and providers attributed the development of OF to a delay of those present at a home-birth to recognize that there were problems which needed to be resolved in good time such as obstructed labour. The health care providers also noted a further delay to seek prompt care from a health facility or qualified health care provider.

Study statistics revealed that 77% of the women preferred to have a home delivery with the help of a “Karam” and very few preferred to have a health facility birth at 23%. This points to a low utilization of health facility births and emergency obstetric services in the study area.
Figure 4.3: Preference of delivery location prior to Sustaining Obstetric Fistula

Prodded for more explanation on their preferred choice of delivery location, the respondents compared home births in contrast with health facility births. Most of the respondents, the women and their spouses expressed cost of transportation, the difficult topology of the study area and the great distances to be covered as a deterrent to accessing health facilities and the services therein. This is because most of the study respondents and their families were set in remote rural areas across the entire West Pokot County.

To make life bearable, the people have adapted and learnt to live with their current circumstances hence, the perception of childbirth as a natural, normal almost every day event that necessitated no cause for alarm. This perception was unanimously expressed by the study respondents as lusiya korr chik which means women deliver everyday. This causal reference to childbirth as an almost every day occurrence with no cause for alarm is ironical given the circumstances of the respondents and their families. It paints an event devoid of complications and if any occur, those in attendance can quickly resolve it through practical experience. The casual remark also points to lack of preparedness in the event of an adverse event in the birth process.
Other reasons cited by the study respondents militating against health facility births were those that touched on random HIV tests carried out as a matter of routine on all expectant mothers on presenting at a health centre during antenatal check-ups. Also, the women cited lack of privacy and the birth position imposed on them in the labour wards. The hospital environment and the attitude of healthcare providers were mentioned as compounding factors that discouraged health facility births whereby (actual or imaginary) bad birth care experiences were expressed. This further gave credence to the preference to have a home delivery assisted by the “Karamach” or non-SBAs.

For the study community and women, it is obvious that having a home delivery equals having a vaginal delivery. Thus, the study sought to find out the most preferred mode of delivery from the study respondents. From the interviews with the respondents, the study noted that 84% of the women and their spouses/caregivers preferred to have a vaginal delivery, 16% preferred a hospital-based-cesarean section delivery and none preferred a hospital-based-Instrumental Vaginal delivery.
Asked to elaborate on the high preference for a vaginal delivery the women interviewees expressed their need to experience vaginal delivery which was associated with quick recovery and resumption of duties. This was captured as: “It is natural. I will heal quickly and resume work early as opposed to the ‘operation’”. Still another woman respondent said that: “I prefer normal delivery because I got to feel childbirth as a woman. I am qualified to talk about it in the presence of other women”.

From the interviews with the women respondents, those living with or repaired of their OF, it was evident that a vaginal birth was something all of the women respondents looked upon as a rite of passage. It validated and crowned their womanhood, in a show of endurance and strength of a true woman. A few women opined that: “Vaginal delivery is dignified. I will be considered a true, real and strong woman through enduring the pain and pushing”. It emerged from the interviews with the women that those who experienced a failed natural birth were stigmatized in some way. A few women echoed this view: “It is (vaginal delivery) not stigmatized. God planned it that way”.

Figure 4.4: Preferred Mode of Delivery in the Study Area
From the above quotes, the study deduces that there are various connotations associated with a woman who had experienced a failed natural birth. These can be deduced as the reverse of the above quotes. The interviewees considered vaginal delivery as a natural phenomenon, since no interventions are required. In the present study, vaginal delivery was introduced as a manifestation of women’s power and ability to play the maternal role.

Home delivery was actually preferred over health facility births due to the prevailing cultural beliefs and to some extent the women’s own attitude towards birth, her expectations, and her personal and subjective attributed meaning to giving birth. All these could affect her feelings of satisfaction, strength, esteem, and achievement (Gibbons and Thomson, 2001; Simkin, 1991).

4.4.6 Circumcision

Represented at only 9%, some women respondents cited “circumcision” as a cause of their OF. Health care providers at 18% concurred that the wide spread practice interferes with the mechanisms of the birth process due to obstruction at the outlet. This may occur as a result of other accompanying complications such as scarring and tightening of the muscles and tissues in and around the outlet. “Circumcision” in this sense means mutilation of the female genitalia as a prerequisite for marriage in the Pokot community. Although all women respondents in the study had experienced FGM, very few attributed it to their condition. The few women represented at 9% who did attribute FGM to the development of their obstetric fistula during the interviews noted that “the muscles were too rigid because of a scar from circumcision” and yet others
opined that “I had a scar and an infection”. Majority of women respondents, their spouses and elders did not think that FGM could be a cause of OF. They noted that FGM is almost universal in the study area and women had been delivering normally without any complications. The study observed that the study respondents did not recognize that the tightening of the muscles of the vaginal opening and the development of keloids/scars were an obstruction that posed a direct mechanical barrier to the birth process. This calls to light the little knowledge on the relationship between body integrity and reproductive mechanisms among the study respondents.

Naturally, the female body and especially the tissues inside and surrounding the vagina and perineum are designed to gradually soften towards birth and at childbirth, stretch and expand to accommodate the baby’s head and shoulders. However, if much or all of this tissue is cut away, especially with Type III FGM (infibulations) as is practiced in West Pokot community, there is nothing to stretch resulting to serious difficulties including extensive tearing and ripping. Slow and incomplete healing of the wound and post-operative infection can lead to the production of excess connective tissue in the scar. These scars may form partial or total obstruction of the external genitalia which presents a direct mechanical barrier to delivery and interferes with other procedures required for both assessment and management during labour (WHO, 2001).

As such, women who have undergone FGM face a significantly greater risk of requiring a Caesarean section and/or an episiotomy to allow the birth of the
An episiotomy is an incision made in the perineum (the tissue between the vaginal opening and the anus) during childbirth.

4.4.7 Disease/Infection

During the interviews, the elders, represented at 33%, some women respondents affected by the condition represented at 14% as well as some of their spouses represented at 16% confused obstetric fistula with a sexually transmitted infection (STI). The fistula patients disliked this simplistic stigmatizing denomination and were eager to clarify how they got ill. It emerged during the interviews with the elders that OF was linked to the sin of the flesh only in the experience of unmarried women respondents living with OF, who refuted this claim.

Contracting a “taboo disease”, in this case a sexually transmitted infection (STI), constituted gross indiscipline, rebellion and demonstrated uninhibited sexual liberties on the character of a woman, which is contrary to the ideals of proper Pokot women. According to the “Kokwo”, a “taboo disease”/STI served as a stigmatizing marker for one who transgressed against set sexual norms. A woman thought of as being immoral in the African community, was not fit for marriage and thus deemed “unmanageable”. The need to control and manage women’s sexuality by society in order to conform to ideals of womanhood and to socially accepted sexual norms is the genesis of harmful traditional practices that affect body integrity such as FGM.
Therefore, unmarried girls were to guard their virginity and only their husbands were to “see their nakedness” in the confines of a matrimonial home and those who transgressed against the sexual norm, were inflicted with a “taboo disease” as a punishment. Hence, the misconception that unmarried women with OF were suffering from a taboo disease for transgressing against sex taboos.

The “Kokwo” explained that one, among the many roles that FGM plays in their community was the attenuation of a woman’s sexual desire. FGM is widely believed in the community to prevent a woman from being oversexed and save her from temptation and disgrace. However, this role FGM was disapproved by the young unmarried women in this study who not only engaged in sex but also got pregnant as proof of their sexual impropriety outside of the prescribed cultural norms. Thus, FGM does not curb a woman’s sexuality and desires and should be abandoned regardless of the justifications of the act.

This wrong misconception on the cause of OF and subsequent confusion of the condition with a STI can be traced back to the socialized roles of men and women with respect to sexual intercourse. Sex in most African communities was and is still regulated by different norms which include various sexual taboos. It is believed that in instances where these sexual taboos are ignored or transgressed, that a traditional disease such as a STI will result. Thus taboo sexual intercourse is believed to be a vehicle for different conditions or diseases (Green, Zokwe and Dupree, 1995).
However, the health care providers at 9% had a different view with respect to the development of OF among the women respondents. The health officers asserted that some diseases such as cancer and its subsequent treatment may cause OF but not sexually transmitted infections. They clarified that obstructed labour was the main culprit to the development of OF. They were quick to point out other causes of OF, such as sexual trauma through rape, sexual assault, or resumption of conjugal roles in the cases of women with newly repaired OF, may cause fistula though this was not common with most of the respondents.

4.4.8 Coitus

Coitus was cited as one of the factors associated with the cause of OF in the area by 9% of the women respondents and not by their spouses or elders. One particular woman opined that:

“My husband knew I had this problem but he did nothing about it. I attended the camp while he was away and got healed. The doctor advised to avoid sex for about 6 months. My husband noticed I was dry and not smelly. Since he had paid my bride-price, he came demanding for sex. How was I to deny him? He was so forceful, and now I am here again”. (Interview with a fistula patient from Kasei on 29/01/2015).

The above quote exposes a husbands’ uncompromised perception on the physical and social pain of his wife. The husband depicted above sought to gratify his libido with little regard about his wife’s morbidity or the doctor’s advice of sex abstinence for a period of about 6-months. Spouses of women affected by OF, noted that, staying away from a wife sexually for a long time makes them unhappy, hence the aggression and forceful sex for that matter. The forceful sex also shows gender-based violence tendencies on the part of the
husband who was unhappy with a wife’s morbidity and the fact that she was denying him his entitled conjugal rights by using a 6-months sex ban attributed to a doctor’s advice.

Although the risk factors and stressors leading to OF are myriad and far reaching, the study established that negative traditional practices, beliefs, superstitions and misconceptions about the causes of the condition abound in the community. To counter these there is a need to engage in massive public education on the risk factors predisposing young girls and women of reproductive age to gynaecological morbidities. Massive community education efforts must inform people that all women are potentially at risk of obstetric fistula. This also calls for the involvement of men and particularly husbands in the physical healing process of women afflicted with OF. To win the war against OF, a group effort is needed. It is paramount to seek and include men in the healing process because they may knowingly or unknowingly aggravate the situation.

4.5. The Effects of Obstetric Fistula on Womanhood in West Pokot

This section focuses on objective three of the study which sought to establish the effects of obstetric fistula on womanhood in West Pokot County. Asked if they thought that OF had any adverse effects on the affected women, a significant 110 respondents represented at 95% affirmed while 6 (5%) did not think so.
Figure 4.5: Effects of OF on the Ideals of Womanhood in the Community

Discussions with the affected women, their spouses, the elders and the local healthcare providers confirmed that there were adverse effects of OF on the women’s health and general well-being. Table 4.11 shows the identified effects of OF and the frequency responses of the study respondents.

Table 4.11: Multiple Response Frequency Table: Effects of Obstetric Fistula on Womanhood

<table>
<thead>
<tr>
<th>Effect of obstetric fistula</th>
<th>Women respondents</th>
<th>Spouses to affected women respondents</th>
<th>Health-Care providers</th>
<th>Elders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N Count</td>
<td>% of cases</td>
<td>N Count</td>
<td>% of cases</td>
</tr>
<tr>
<td>Stigma</td>
<td>37</td>
<td>65</td>
<td>25</td>
<td>51</td>
</tr>
<tr>
<td>Lost womanhood</td>
<td>37</td>
<td>65</td>
<td>40</td>
<td>82</td>
</tr>
<tr>
<td>Economic hardship</td>
<td>28</td>
<td>49</td>
<td>30</td>
<td>61</td>
</tr>
<tr>
<td>Isolation</td>
<td>49</td>
<td>86</td>
<td>25</td>
<td>51</td>
</tr>
<tr>
<td>Incontinence</td>
<td>57</td>
<td>100</td>
<td>49</td>
<td>100</td>
</tr>
<tr>
<td>Still births</td>
<td>27</td>
<td>47</td>
<td>27</td>
<td>55</td>
</tr>
<tr>
<td>Lost opportunity for marriage</td>
<td>47</td>
<td>82</td>
<td>20</td>
<td>41</td>
</tr>
<tr>
<td>Total response count</td>
<td>282</td>
<td>495</td>
<td>216</td>
<td>441</td>
</tr>
</tbody>
</table>

*a Multiple responses allowed

*a Dichotomy group tabulated at value 1.
4.5.1 Stigma

In this study, the respondents explained that feelings of shame led them to “hide” their condition. This “hiding” subsequently prevented them from care-seeking. Some though apprehensive, only choose to disclose their condition to their partners. Of the total number of women respondents, only 35% affirmed to have shared their OF predicament with others as illustrated in figure 4.6 below.

![Disclosure of OF status](image)

Figure 4.6: Disclosure of OF Status

Those who had disclosed their condition to others were observed to have a positive outlook at life simply because they experienced some degree of understanding and empathy. This category was comprised of the respondents who had been identified by the concerted efforts of the local field health officers at the Kapenguria County Referral Hospital at a previous fistula camp held in the study area.

Six-five percent attributed their non-disclosure of their OF status to fear of being “looked at differently” by significant others, who also affirmed that they were aware of the stigma associated with obstetric fistula. They further informed the study that this was because there were several deep seated notions associated with the cause of the condition in the community. A woman living with OF from Lelan lamented that:
“I was not allowed to seat on the grass because animals graze”. (Interview with former fistula patient from Lelan on 03/02/2015).

Yet another from Sigor tearfully noted that:

“*They said I am polluted and should be cleansed*”. (Interview with former fistula patient from Sigor on 03/02/2015)

The stigma was not directed to the women with unrepaired OF alone, but to other family members as well. This prompted the family to reject her. This was demonstrated in the following comment by a spouse of a woman with repaired OF:

“*Before she was cured it was very shameful to have her in the house. Wherever she was, there would be dirt*”. (Interview with husband of former fistula patient from Lelan on 05/02/2015).

The study deduced that there is an undeniable link between fistula and social stigmatization. This is because stigma is a powerful social process of devaluing people or groups based on a real or perceived difference (Ogden and Nyblade, 2005). Further prodding on why the high rate of non-disclosure, the respondents with unrepaired OF across the study site commented:

“The smell is too much for me, how about others? I fear others knowing that I am spoilt”.

“My husband does not know of my condition”.

“I don’t want others to know and later use my condition to belittle me”.

“I do not know of others with this condition. So how do I start to talk about it?”

“I keep to myself so that others may no view me as an outcast”. (Interviews with fistula patients from Kacheliba on 07/02/2015).
Non-disclosure was not only exercised by the women alone, but some husbands played along too. Husbands with wives living with OF and especially those in a monogamous marital relationship felt that it would be best not to disclose in order to save face in front of other men. One husband whose wife has an unrepaiured OF had this to say:

“How will I socialize with other men if my wife discloses this?”
(Interview with husband of fistula patient from Kacheliba on 07/02/2015).

Asked to clarify his comment, it emerged that men also have their own insecurities which were tied to others’ perception of their wives general outlook in society. A spouse to a woman with repaired OF from Sigor related: “As men, we pass time and discuss ‘manly’ issues, top on this discussion agenda is our own sexual life and exploits”. Thus, men found it difficult to have fellow men put them down through the association of a “spoilt and dirty” wife. In saving their face from disgrace from fellow men, these spouses unknowingly become an obstacle in their wives health seeking behaviour by prolonging the duration of enduring the pain of OF and the lag time to seek treatment.

To cushion themselves from adverse effects associated with “being different” the women chose to remain silent and horned their ability to conceal their predicament. Their fear of stigma encourages non-disclosure and so the true magnitude of the condition may not be known. Also, their silence may work against them because a problem shared is a burden halved. Those who open up about their problems find they have a better chance of being more informed about the condition, its causes, diagnosis and treatment or management. This
greatly improves their knowledge and health seeking behaviour on the condition and hence reduces the length of their suffering.

Ending the stigma surrounding obstetric fistula is a crucial precondition to ending the disability, and caring for survivors. This points to an urgent need for health education most especially on reproductive health issues targeting remote areas where the knowledge about fistula is low among women of reproductive age.

The fear to open up about their fistula status was also embedded in the negative notions attached to the perceived causes of their condition in the area. This is because, in every society, there exists various “beliefs” about the causes of disease and illness. Conrad and Barker (2010) argue that some illnesses are particularly embedded with cultural meaning, which is not directly derived from the nature of the condition that shapes how society responds to those afflicted and influences the experience of that illness. Obstetric fistula is therefore no different and there exists various misconceptions about its causes in the study area.

Asked if they knew others with the same condition and if they had shared their OF problem with others majority gave a negative response. Against the background of the preceding exposition, statistics of the study indicate that 63% did not know of others with the same condition. This is corroborated by figure 4.7 which, clearly shows that there is a high prevalence of non-disclosure leading to the misconception that “others do not suffer like me” among the
study respondents. Their fear of stigma encourages non-disclosure and so the true magnitude of the condition may not be known.

Those who knew of other women with the same predicament were 37%. These women disclosed to have met others “like them” as they solely and quietly sought a cure at the Kapenguria County Referral Hospital. This meeting of others “like them” was facilitated by the concerted efforts made by the County health system, AMREF-Health Africa and Bayer HealthCare officials, days before the fistula camp held between the 8th-14th November 2014.

![Awareness of other women with OF](image)

**Figure 4.7: Awareness of other women with OF**

### 4.5.2 Lost Womanhood

Women respondents at 65%, their spouses/caregivers at 82% and elders at 83% affirmed that OF had a direct affect on the women’s “womanhood”. Among the Pokot, women, attained womanhood through completion of the socialization rites into adulthood, marriage, child bearing and carrying out wifely and motherly duties while in their matrimonial homes. However, obstetric fistula heralded a negative domino effect on the loss of their ascribed gendered roles
which ushered in a cohort of other losses. These losses were signified as wife, mother and community member.

The typical story line indicates that OF obliterates intimacy and motherhood in the afflicted women. The women affected by OF reported that being childless coupled with a misunderstood condition invariably led to the disintegration of their marriages. First-time-would-be mothers who lost their only child and also sustained an OF were condemned for the poor reproductive outcome. They were out rightly rejected and returned back to their natal families. In most African communities, motherhood is regarded as a significant marker of womanhood because it confers so much power on a woman (Mungwini, 2008), power that childless women who also suffer from OF may not access. Motherhood thus provides a respectable social identity, an important set of child-rearing tasks, access to kin networks, and a space where authority, a sense of control and self-expression can be cultivated (Chaney, 2011).

The women respondents, both cured and those living with OF, expressed apprehension over their marital status and failed sex lives. They had strong negative feelings over their inability to be intimate with their husbands and partners, largely because of their need to reaffirm intimacy and bonding. This is because a lack of intimacy within a marital bond instills fear of rejection, separation or divorce in the affected women. One woman remarked that:

“*I know am his wife. But my husband and I are not intimate anymore because of this constant flow of urine*”. (Interview with fistula patient from Sigor on 03/02/2015).
Husbands with wives living with OF, reported a reduction in coital frequency. Polygynous husbands refused to continue intercourse with the affected wives, while those in monogamous unions though intimate in spite of the urine, were uncomfortable. Cook, Dickens and Syed, (2004) assert that vaginal injuries often made sexual intercourse impossible, and the constant leaking of urine made it otherwise unpleasant. However, during discussions with the affected women, it emerged that the presence of co-wives in polygynous settings ensured that a husband’s sexual needs were routinely met. This was well articulated by a polygynous husband with a wife living with unrepaired OF at the time of the interview. He said:

“It is good I have more than one (wife). With the second one, I noticed she smells of urine and wets the bed during intimacy. I asked her and she said it came after the stillbirth. I am uncomfortable being with her. So I keep to the other wives”. (Interview with husband of fistula patient from Alale on 13/02/2015)

The study deduced from the interviews with women cured of and those living with OF, that they were gradually neglected, rejected and eventually abandoned for new, able, clean and healthy “replacements”. The women respondents reported that they were neglected, separated or divorced from their husbands and that their marriages crumbled as a direct result of sustaining obstetric fistula coupled with an atrophy of empathy and sympathy from their husbands. Thus, it emerged from the interviews that some women planned to separate from their husbands after receiving complete treatment because of the maltreatment received during their morbidity. Husbands’ behaviour in this scenario appears to have affected their injured wives’ emotions and well-being. This is because in polygynous settings many wives ensured that there was no interruption to coital frequency.
for the husband. As such, women living with obstetric fistula affirmed that they experienced sexual and emotional neglect from their polygynous husbands.

Khan (2011) asserts that when the sexual relationship between a husband and wife has lost its harmony, and if the cause lies with the female partner’s maternal morbidity, then it creates dissatisfaction on the male’s mind and its consequences affect the female’s life. The differential socialization process of men and women has a firm grip on their attitude towards health and wellbeing. In conservative patriarchal settings such as the one in West Pokot, men have been portrayed as beings with no emotion with respect to their wives’ health. This is clearly demonstrated by “returning” a sick woman to her parents and moving on to marry another healthy one. Husbands’ ignorance, lack of knowledge and poor initiative illustrate the vulnerable situation of their wives. This vulnerable situation becomes worse when having an unhappy sexual life, lack of sharing because of shame, stigma and hidden violence (Khan, 2011).

Therefore, in communities where socio-cultural norms enforce gender asymmetry and a hierarchical organization of unequal gender power relations, it is important to understand husbands’ perceptions about maternal morbidity. This will go a long way in ensuring that intervention strategies would include and encourage males’ participation in women’s health by echoing the importance of openly discussing any ailments, and seeking prompt medical help.
4.5.3 Economic Hardships

All the study respondents in varying percentages agreed that there was some form of economic hardship incurred by the affected women and their households in seeking quality health care for and the daily management of their OF condition. This is illustrated in table 4.11 above. The economic hardship incurred by the affected women and their households is corroborated by the estimated incomes reported by the women respondents, as indicated in table 4.8. The estimates confirm that they lived well below the poverty line of less than one dollar a day. The study observed that the meagre incomes posted could not sustain the expenses involved in the daily management and hospital based treatment of OF. During the interviews, it emerged that most of the women respondents were unaware of how much money their husband’s or partners made per month. Also, all the women were found to be dependent on either their husbands or other members of the extended family owing to the low household incomes illustrated in table 4.8. A common denominator to their sentiments was that they experienced an increase of their dependence on significant others while reducing their sources of independent income. Thus, for them to regain a sense of economic independence, they felt a strong need to work.

However, the women respondents living with obstetric fistula noted that the condition had a negative impact on the choice of and ability to actively engage in the labour market as observed in Table 4.7. The study women observed that many jobs required close interpersonal contact with other people, and those
among them living with unrepaired OF shied away because of the overpowering stench of urine and/or faeces that puts off such a close interaction. A similar finding was observed by Fasakin (2007) in Nigeria among women living with OF.

Going by the estimated incomes reported by the women respondents, should all the women experience divorce or abandonment as a result of sustaining an OF, about 95% of them would sink into a deeper state of poverty. This is because the majority of the households where these women came from as indicated in table 4.8 live well below the poverty line of less than one dollar a day. Going by the length of time the affected women have lived with the condition as illustrated in table 4.9, OF becomes a chronic disease. The affected families thus struggle to cope with chronic illness but with time it becomes unmanageable and beyond their capabilities.

Husbands and other care givers observed that they had to alter their day-to-day activities and this brought out resentment toward the OF patient. This was captured in the following husband’s comment:

“My work is unattended when I take this girl for reviews. My time consumed by too many travels to hospital”. (Interview with husband of fistula patient from Alale on 13/02/2015).

Caring for someone suffering from a chronic condition becomes financially impossible for many impoverished rural households because the expenses involved exposed them to additional burdens and with time, this caring gesture dwindled (Goitom, 2008) prompting abandonment or divorce. In such
circumstances, the threat of gender-based violence is very real as significant others vent their anger and frustrations. It should be noted that the women participants both cured and those with unrepaired OF at the time of the interviews could not afford the treatment whose cost was approximated to US$450 or KShs. 45,700 including surgery, post-operative care, and physical rehabilitation. The fistula camp held at the Kapenguria County Referral Hospital in conjunction with AMREF-Health Africa doctors was subsidized by the county government of West Pokot and other interested private donors. It is undeniable that this low level of income exhibited by the study respondents has serious implications on all aspects of their lives, including their health, nutrition, transport, day-to-day expenses, etc.

4.5.4 Isolation

In addition, these women suffered discrimination and isolation that is attached to stigma at all levels of society because of the magnitude of shame and stigma attached to the condition. The women respondents experienced isolation perhaps because of the reactions of others or their own discomfort with their condition. Study participants were asked if they had faced any adverse reactions due to their condition and many of the women represented at 86% explained that family members were the first to discriminate against them although not immediately. Some relatives forced the women to self-isolation by providing a separate room/hut for the affected women to sleep in. The women explained that the disease was stubborn and resources and patience were being depleted and so they were left to their own devices.
Ironically, isolation and especially self-isolation was employed by the women respondents as a 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. Community misperceptions about the cause of their condition often results in isolation and ostracism. The stigma was not directed to the women with unrepaired OF alone, but to other family members as well, prompting the family to reject her. The constant ridicule and shaming prohibited women from enjoying basic pleasures, such as gossiping with their peers. This is often a “dehumanizing” experience for the women, which causes shame and feelings of ‘disorder’ with other women in her family and community. Therefore, physical body integrity and the right to have an intact body is important because it is one of the capabilities in the total characteristics of being and functioning. The women with unrepaired OF felt degraded, rejected and dehumanized.

Interviews with healthcare professionals who were key informants in the study, confirmed that these women avoided any form of social contact. They pointed out that during screening and at the last fistula camp held at the Kapenguria County Referral Hospital, the fistula patients avoided sitting at the waiting bay/benches and instead preferred to stand at a short distance away from other regular patients. Some married women respondents reported to have imposed self-isolation in their home environment to cushion themselves and in extension, their family members, against social ridicule. They cited taboos such as:

“I am not allowed to sleep with husband on same bed because I am dirty”.
“I am allowed to cook or milk for myself but not for other family members, especially the husband”.

“I can only fetch water after others later on in the day because I may contaminate the source with urine”. (Interviews with fistula patient from Kapenguria on 05/02/2015).

The above comments glaringly spell out stigma. Although some of the married respondents with unrepaired OF still lived within their marital homes, they nevertheless experienced a denial of social roles by other family members who cited cultural taboos. Among the Pokot, a woman who is already marked as “dirty and polluted” was not allowed to undertake simple, taken-for-granted everyday tasks within the home such as cooking, milking, fetching water, among others, unless she did so for herself. Such women’s vulnerability increased when the husbands directly complained about their wives’ morbidity. This was true for one respondent living with the condition when she disclosed that the husband had complained that “I am not a strong woman as he thought”. This comment was “crashing” for this particular woman because she shaped her self-identity on the evaluation of her spouse and his understanding of her predicament.

The constant leaking of urine and accompanying smell that “cannot be hidden” was also a factor that impeded social interaction and participation. Although the unrepaired respondents were welcoming at the point of interview, it was not lost to the research team that the interviewees choose to remain upstanding while maintaining an approximate 2-metre distance through the entire 50-minute exercise. This demonstrated a fear to offend others which may in turn prompt verbal and non-verbal violence against them. They chose to remain secluded in an effort to salvage the little dignity left and protect themselves from mockery.
and humiliation. This was demonstrated by a respondent at Alale in northern West-Pokot when she said that “I do not move much. I do not want to offend or be offended by others”.

4.5.5 Experiences with Incontinence

During the interviews, all the 57 women in the study, represented at 100%, reported that they had experienced urine and/or fecal incontinence. They described a constant trickle of urine and/or faeces and accompanying stench. The spouses/caregivers and many of the respondents explained that women with obstetric fistula led a life of seclusion as they avoided social interaction with family, friends and neighbours. They were effectively excluded from engaging in social gatherings due to the pungent smell of the urine. Adulthood in most parts of the world is associated with having control over bodily functions. However, women with unrepaired OF are stripped off this control, and are faced with the embarrassment of being incontinent. In most instances women living with OF compared themselves to children. Just like in young children with no-toilet training, leaking of urine without control produces “matter out of place”, and dirt, hence this produces a polluted and spoilt identity for the affected woman.

In many parts of the world, a woman’s beauty is associated with not only cleanliness, neatness, and sweet smell, but also with the capacity to assume domestic, marital, and social roles (Mselle et al., 2011). However, women affected by OF in the study saw the reverse in themselves. They cited the
embarrassment they suffered because of their inability to control their bowel movement. The women’s departure from body norms attracts acute and chronic social, economic and psychological consequences as well as stigmatization. The smell of urine and faeces that surrounds these women along with strong community misperceptions about the cause of their condition often results in isolation and ostracism. This is often a “dehumanizing” experience for the women, which causes shame and feelings of ‘disorder’ with other women in her family and community.

4.5.6 Stillbirths

Discussions with elders, the affected women and their spouses revealed that community members held deep seated negative perceptions about stillbirths. This was so especially if the stillbirth occurred in a first-birth in a would-be-first-time mother, who also sustained an OF in the process. The loss of a child in a first-birth is interpreted as a bad-omen among the Pokot. The woman is condemned and isolated for the poor reproductive outcome, especially by in-laws, who encourage their son to “return” her to her natal family and remarry. Women who fell in this category of loosing a baby and suffering an OF in a first-birth were out rightly “rejected” and “returned” to their natal families so that the husbands could wade off the bad-omen from their homes. This was also the case with some of the study respondents’ marital situation. One respondent noted that in-laws advocated for separation, in most cases regarding the woman as a bad-omen and a curse that needed to be removed from their home and son. She commented that:
“The baby died and then came this urine. They returned me to my old mother saying I was cursed”. (Interview with fistula patient from Sigor on 05/02/2015).

Women who had had other live children before sustaining an OF, were “rejected” as wives but allowed to stay on in the matrimonial home to cater for their children. This is because motherhood, and to a lesser degree fatherhood, confers societal value and is considered to be a respectful position in society. Participants noted that a stillbirth steals happiness from a family and may cause social disintegration or separation (Mungwini, 2008; Kiguli, Namusoko, Kerber, Peterson, Waiswa, 2015).

The African cultural norms and values encourage reproduction and celebrate parenthood; therefore, the loss of a child becomes a potentially stigmatising event, which can adversely affect the identity and interpersonal relationships of the grieving mother and the people around her (Larsen, 1996; Gage-Brandon, 1992). In Sub Saharan Africa the traditional belief systems based on continuity of lineages place a high premium on fertility (Caldwell and Caldwell, 1987; Van Zandvoort and De Koning, 2001; Donkor and Sandall, 2007). This helps to explain why the societies that are witness to the trauma of women birthing stillborns would direct their anguish and confusion towards the woman, forsaking the fact that she is infinitely worst off than they from the experience. Instead of providing her the empathy and moral support she deserves, she is viewed as “a scapegoat who can be held responsible for the tragic event” (McFarlane & Van der Kolk, 2007).
4.5.7 *Lost Opportunity for Marriage*

The consideration of women with unrepaired OF as ‘dirty and polluted’ due to the constant dribbling and foul smell of urine was not lost on the community and immediate family members especially the husbands. This constant flow of urine that did not stop, despite a longer period of local treatment definitely had a direct negative impact on the marital unions of those involved.

Although the study established that over 50% of the women respondents were still married despite their OF condition, they nevertheless experienced difficulties in their marital lives. The women respondents brought to light a new meaning of divorce/separation within their marriages. They explained that among the Pokot, ‘true’ divorce was experienced more by young first-time-would-be mothers. This was so especially if a stillbirth occurred in a first-birth with the presence or absence of any other obstetrical morbidity in the first-time-would-be mother. A stillbirth was interpreted as a very bad omen by the concerned husband and his kinsmen and as such the affected woman was “returned” to her natal family and the man encouraged to remarry. The husbands in most instances did not ask for a refund of the bride-price due to “guilt” and also as a way to evade responsibility. When probed to clarify on the “guilt”, the women living with OF opined:

“From our fathers houses and upon marriage, we were clean. We only became ‘dirty’ when giving birth in our husbands compounds. The husbands feel the bride-price should suffice as compensation”. (Interview with unwed former fistula patient from Kapenguria on 13/02/2015).

The second divorce as explained by the women happened when a married woman with other live children sustained a fistula. She was allowed by her
husband to remain in his compound to care for her children, although he had nothing to do with her as a woman. The indifference displayed by the husbands concerning their wives condition and its impact on the individual women was interpreted as “divorce”. The affected women affirmed that their presence within their marital compound was simply to take care of the children they had had, prior to sustaining OF. For the married women, they were gradually neglected, rejected and eventually abandoned for new, able, clean and healthy “replacements”. One woman remarked:

“I may as well be divorced. My husband has nothing to do with me as a woman. I’m in my husband’s compound, emotionally divorced, simply to take care of the children I had before this condition”. (Interview with fistula patient from Alale on 16/02/2015).

On the other hand, some of the spouses to women repaired of or living with OF opined that they were not entirely to blame. They noted that the condition did put a strain on their marital relationships with the affected wives. This is demonstrated by the following comments from spouses across the five locations of the study site:

“When she got the disease I had to stay at my other wives homes because we could not share the same bed”. (Interview with husband of former fistula patient from Lelan on 05/02/2015).

“She stinks. I can’t go to that house because of her smell”. (Interview with spouse to a fistula patient from Alale on 16/02/2015).

“My wife keeps away from me most of the time. She does not want me to get close to her”. (Interviews with fistula patient from Kapenguria on 05/02/2015).

“My wife is not free and social as she was before getting the condition”. (Interview with spouse of a fistula patient from Sigor on 05/02/2015).
“We have a strained sexual relationship. I think now she hates men and says they hurt”. (Interview with husband of fistula patient from Kacheliba on 07/02/2015).

The spouses’ sentiments above confirm strained sexual relationships between married couples as a direct result of OF. The strain on conjugal responsibilities in the above scenario because of a wife’s incapacity to perform sexually due to illness, creates a dissatisfaction on the male’s mind and its consequences affect the female’s life. The effects manifest as neglect, rejection, separation and divorce.

The “rejected” or “returned” women had to endure mockery which was often centered on the fact that they were childless in the case of first-time-would-be-mothers, signifying that their position in society was reduced, or that they had been abandoned by their partner and were living in their natal household, also symbolizing a loss of honour (EngenderHealth, 2012). This social public ridicule aroused extreme feelings of disgrace and general rejection and a lowering of the affected women’s self-esteem, forcing them into isolation in an attempt to hide the condition and protect themselves from further humiliation.

The study also interviewed 18% of unwed women respondents affected by the condition. These women respondents expressed concerns that their OF condition further diminished their opportunities for future marriage because it was interpreted differently from that of other women. They intimated that they were seen to have transgressed against set sexual norms in the community, and as a punishment were inflicted with a ‘taboo disease’. They expressed a felt fear
of being single forever and never forming long-term marital bonds with men because of OF. One young woman lamented that:

*Our plight is a bit different from that of other women. We were unfortunate to have fallen pregnant. In addition, we got this ‘urine’ before marriage. They think we are prostitutes. No one wants us as wives.* (Interview with unwed fistula patient from Sigor on 03/02/2015).

It is evident in this scenario that in a community where married status is extremely important, it is nonetheless dramatic how swiftly the obstetric catastrophe is translated into a social exclusion. Women who sustained an obstetric fistula during a first birth were abandoned more frequently than older women who had had multiple successful births, perhaps because the latter had a child at home and a more established marriage and family, reducing the risk of social disruption (Muleta *et al.*, 2010).

It is obvious that OF causes major disruptions in the lives of the affected women. The women’s departure from body norms had a negative domino effect on their identity, gender-roles, social capital and economic opportunities. This is because obstetric fistula whose impact was on the negative functioning of individuals as well as on social relations in the society, occurred on socially defined and culturally constructed women. Thus, conforming to cultural ideals of womanhood and adherence to socially accepted sexual norms was the genesis of almost permanent inconsistencies between their lived experiences with the condition versus socio-cultural norms they had been socialized to live up to.
4.6. Coping Strategies Employed by the Afflicted Women to Manage Obstetric Fistula among the Pokot.

This section focuses on the fourth objective of the study which sought to establish the coping strategies employed by the afflicted women to manage obstetric fistula among the Pokot. Asked what they used to conceal the constant flow of urine with, all the women recalled devising various coping mechanisms as presented in table 4.12.

Table 4.12: Multiple Response Frequency Table: Women Respondents’ Strategies for Coping with Obstetric Fistula

<table>
<thead>
<tr>
<th>Coping Strategy</th>
<th>Women respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N Count</td>
</tr>
<tr>
<td>Use of home-made padding</td>
<td>57</td>
</tr>
<tr>
<td>Limiting water and liquid-food intake</td>
<td>5</td>
</tr>
<tr>
<td>Frequent bathing</td>
<td>46</td>
</tr>
<tr>
<td>Sexual abstinence</td>
<td>36</td>
</tr>
<tr>
<td>Marital separation</td>
<td>2</td>
</tr>
<tr>
<td>Self-isolation and social withdrawal</td>
<td>48</td>
</tr>
<tr>
<td>Immobility/isolation</td>
<td>10</td>
</tr>
<tr>
<td>Total response count</td>
<td>204</td>
</tr>
</tbody>
</table>

*Multiple responses allowed

4.6.1 Use of Home-Made Padding

As illustrated in table 4.12, 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 et al., (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.

4.6.2 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.

4.6.3 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.

4.6.4 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.

![Resumption of conjugal duties by women repaired of obstetric fistula](image)

_Figure 4.8: 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.

4.6.5 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 is 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).

4.6.7 Self-isolation and social withdrawal

Self-isolation and social withdrawal was 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, Taulo and Tsui, 2009; Pope, Bangser & Requejo, 2011; Khisa & Nyamongo, 2012).

4.6.8 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.

The findings of this study indicate that the women affected by obstetric fistula had to adopt and adapt to a number of coping mechanisms. The community needs to improve their knowledge about the nature and risk of OF, so that community understanding and social interactions are not influenced by stereotypes, prejudices, and unfounded speculations. There is a need to demystify the perceptions held by the community on the effects of OF that impede uptake of services and emergency obstetric care.
CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

This chapter presents a summary of the study findings, emerging implications and conclusions relating to the study objectives. The chapter also presents recommendations.

5.2. Summary of Findings

This section contains the key findings of the study based on the objectives which were specifically; to explore the social construction of womanhood among the Pokot; to identify perceived contributing factors to the development of obstetric fistula among women; to determine the effects of obstetric fistula on womanhood and to assess the coping strategies adopted by afflicted women to cope or live with obstetric fistula in West Pokot County, Kenya.

The study established that social maturity as opposed to physical puberty was more important in female initiation ceremonies in the community. As a consequence of “social maturity” young pubescent girls were exposed to early marriage, early coitus and subsequent early pregnancies when their bodies were not yet ready to cope with the demands of pregnancy and childbirth. As such, their physical immaturity was a major factor that predisposed them to obstetric fistula, a condition that caused massive disruption in the lives of the affected women. This is because obstetric fistula whose impact was on the negative functioning of individuals as well as on social relations in the society, occurred
on socially defined and culturally constructed women. Thus, conforming to
cultural ideals of womanhood and adherence to socially accepted sexual norms
was the genesis of almost permanent inconsistencies between their lived
experiences with the condition versus socio-cultural norms they had been
socialized to live up to.

Although the risk factors and stressors leading to OF are myriad and far
reaching, the study established that negative traditional practices, beliefs,
superstitions and misconceptions about the causes of the condition abound in
the community. In addition to these, healthcare providers and the unborn child
were also cited among those who contributed to the occurrence OF. These
misconceptions about the cause of OF carried with them a “discourse” tinged
with social stigma, which accounted as major factors for social exclusion of the
women from domestic and public spaces. This stigma added to the suffering
inherent in the illness experience and was extended to the woman living with
the illness and her other family members. The stigma attached to the perceived
causes hindered care seeking behaviour in the affected women.

The effects of obstetric fistula affected women in various ways which were
manifested in lost womanhood signified in a series of loses in gender roles of
wife, mother and community member. Thus, urine and/or fecal matter
incontinence, a direct manifestation of OF, produced an altered identity and
prohibited social participation due to stigma and consequently reduced the
affected women’s opportunities for marriage. The affected women were
characterized as “spoilt, dirty and contaminated”. They became physically and morally offensive to their husbands, families, friends, and neighbours. Obstetric fistula also affected the women’s choice of and ability to participate gainfully in economic engagement. Therefore, physical body integrity and the right to have an intact body are important because it is one of the capabilities in the total characteristics of being and functioning.

Women living with or recovering from OF experienced neglect and social stigma. To cope with their new realities with the condition, 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.
5.3. Conclusion

The study concludes that the socialization and initiation ceremonies provide girls with a consistent view of themselves as wives, mothers, and providers. Thus, through culture, young pubescent ‘socially mature’ girls are thrust into the roles of wife and mother when they are physiologically immature. It is evident in this study that adherence to social and cultural norms have helped to perpetuate and increase the prevalence of obstetric fistula in women.

The risk factors and stressors leading to OF are myriad and far reaching. However, misconceptions on the causes of OF among the community abound. This is because of how communities and individuals socially construct illness and how it disrupts one’s concept of self-identity. These misconceptions about the cause of OF carried with them a “discourse” which includes social stigma attached to the illnesses.

Conforming to cultural ideals of womanhood and adherence to socially accepted sexual norms was the genesis of almost permanent inconsistencies between the women’s lived experiences with obstetric fistula and the socio-cultural norms they had been socialized to live up to. As such, the women with obstetric fistula experienced a loss of social identity; loss of marriage opportunities and stigmatization and ostracisation by the community from domestic and public spaces.
Women with obstetric fistula were challenged physically, socio-economically, psychologically and sexually. Their lives were full of adjustments to cope with their new identities, the stigma, social isolation, and marital challenges. They used both problem- and emotion-focused coping as they lived with obstetric fistula.

5.4. Recommendations

To tackle the prevention and treatment of obstetric fistula there is need for a multi-disciplinary and multi-sectoral approach. The study recommends to:

**County Health System should:**

Mandate the community health workers to mobilize and engage the public in massive public health education on the risk factors predisposing young girls and women of reproductive age to gynaecological morbidities. It should be made explicit that unrelieved obstructed labour, which has social, nutritional and healthcare dimensions, is the main cause of obstetric fistula. It should also be reiterated that all women are potentially at risk of obstetric fistula. This will help dispel the various misconceptions about the causes of OF in the community.

With reference to health workforce, the county health sector should also improve on obstetric care in this setting through in-service and re-training of medical officers to improve on surgical capabilities. This will ensure that qualified help can perform the necessary medical procedures to prevent fistula
and that women in need of emergency obstetric care and/or treatment can access adequate and timely medical attention when they need it. The county health system should also seek to address the three delays, through the health information and dissemination department regarding the danger signs to watch out for during delivery and a plan to get rapid access to obstetric emergencies.

In addition to the above, the county health system should provide professional counseling through the Service Delivery Systems in order to help women affected by OF and their families members cope with anxiety and depression caused by the condition. With the help of community health workers, the health system in the county may also consider exploring the socio-cultural context of childbirth and familiarize with factors that deter utilization of health facilities and the services therein from the community.

**County Education system should:**

Facilitate provision of information on sexual and reproductive health of adolescents within the school set-up and to parents and the community in general by taking the initiative to sensitize the community on socio-cultural shifts in order to view girls and women as more than vehicles for enrichment and reproduction. This can be done by exposing cultural and social pressures that limit access to healthcare and uptake of available services as well as those that purport to conform to ideals of womanhood but instead predispose pubescent girls and women to chronic gynaecological health problems.
Concerted efforts by the county education system should strive to improve the community’s knowledge about the nature and risk of target health problems, so that laws and health policies minimize stigma and that community understanding and social interactions are not influenced by stereotypes, prejudices, and unfounded speculations. This can be done by demystifying the perceptions held by the community on the effects of OF and by removing ideological norms that impede uptake of services and emergency obstetric care.

**Medical NGOs such as AMREF-Health Africa and Bayer HealthCare who support and provide OF repairs should:**

The medical NGOs and other like-NGOs in the area should institute and engage in prevention strategies which must be participatory so as to integrate the community’s views and concerns as well as provide information for building locally appropriate solutions. In engaging with the public, the NGOs should address stigma at all levels, from individual behaviours to broader social and cultural levels. Stigma must be addressed in its external and internalized dimensions. This requires working with the stigmatized as well as with the stigmatizers.

With the backing of the county government, medical NGOs such as AMREF-Health Africa and Bayer HealthCare, can compliment hospital efforts in reducing the backlog of obstetric fistula cases in an integrated hospital based fistula care services approach. Obstetric fistula treatment must become a routine hospital service with a resident trained surgeon who deals with OF cases on a
walk-in-basis as opposed to scheduled and periodic treatment camps. This cuts the waiting period and helps put affected women back on the road to recovery faster.

**Private stakeholders, the donor fraternity who provide funding for OF repairs should:**

Ensure that quality fistula repair services are made available and accessible to women, and at highly-subsidized or no cost given their economic realities.

### 5.5. Further research

Based on the scope and the findings for this study, the following are recommendations for future research:

a) A qualitative study exploring the experiences and perceptions of husbands and partners of women suffering from chronic diseases and how the diseases affect inter-personal relationships at the household level.

b) A study on the socio-economic devastation of chronic gynaecological diseases among married women.
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APPENDICES

APPENDIX 1: FORMAL CONSENT GUIDE

My name is Geraldine Musyoki. I am a Ph.D. student from Kenyatta University. I am conducting a study for my thesis examination titled “The Effects of Obstetric Fistula on Womanhood: The Case of West Pokot County, Kenya”. The information will be used for academic purposes. You may ask questions related to the study at any time.

Your participation in the study is voluntary. Participation in this study will require that I ask you some intimate questions which may be embarrassing or make you uncomfortable. If this happens, you may refuse to answer these questions if you so choose. You can also terminate the interview if you feel unable to continue at any time without any consequences.

The information you give in this study will help others have a better understanding of this condition and its associated social consequences to women and their families. This information will have broader benefits in guiding the development of policies and programmes related to reducing maternal mortality and morbidity and better serving your community.

During the interview, I will record your answers to my questions in a questionnaire-guide/interview schedule. Your identity and all your responses will be anonymous on the questionnaire-guide/interview schedule and in the report.

If you have any questions about this research, you may contact the Kenyatta University Ethical Review Committee Secretariat on chairmail.kuerc@ku.ac.ke, secretary.kuerc@ku.ac.ke, ercku2008@gmail.com

Participant’s statement
I confirm that I understand the information for the above study. I understand that my records will be anonymous and that I can leave the study at any time with any consequences. I also understand that my participation in this study is entirely voluntary and that I agree to take part in it.

___________________________ ________________ ______________
Name of participant Signature or thump-print Date

Investigator’s statement
I, the undersigned, have explained to the volunteer the procedures to be followed in the study and the risks and benefits involved in a language s/he understands.

___________________________ ________________ ______________
Name of participant Signature or thump-print Date
Appendix 2: Map of Kenya Showing the Location of West Pokot County and its Administrative Divisions

Source: Created at the Department of Geography, Kenyatta University, 2016.
Appendix 3: Guided Interview for Women Living with Obstetric Fistula
(Obstetric Fistula Patient (Not Cured))

Particulars of respondent:

Interview Guide No.: _______________ Date ________________
Location of interview ____________________________________

Occupation of the Respondent: ____________________________________________

Age of respondent: □ Under 20 years □ 21-35 □ 36 – 50 □ 51 and above
Age of respondent at time of first delivery: ______________________________
Age of respondent at the last pregnancy prior to sustaining an obstetric fistula: __

Respondent’s Educational level:
□ No Formal Education □ Primary Incomplete
□ Primary Complete □ Secondary Incomplete
□ Secondary Complete □ Post-Secondary Education

Estimate monthly family income: ____________________________

No. of living children (if any) before sustaining obstetric fistula: ______
No. of additional living children (if any) after sustaining obstetric fistula: __
1. Who do you live with currently? Explain ________________________
2. Where do you live with currently? Explain ________________________
3. What is your marital status?
□ Single □ Married □ Separated
□ Widowed □ Divorced □ Other (Specify) _____
4. How old were you at time of marriage? _________________________
5. What is/was the type of marriage?
□ Monogamous □ Polygamous □ Other (Specify) ______________________
6. During your marriage:
   • What was your husband’s age at time of marriage to you? ______
   • What is/was your husband’s occupation? _________________________
   • What is/was your husband’s level of education? ___________
7. If married, do you still live with your husband in the same house? _____
8. If divorced, were you divorced before or after the condition?_________
9. If, was the condition of obstetric fistula the cause of the divorce?_______

Social construction of womanhood among the Pokot

10. At what cycle of the social construction of gender does the definition of
womanhood start? (Probe for specifics in each stage)
□ Early Childhood 2-5 years ________________________________
□ Childhood 6-12 years ________________________________
□ Teenage 13-19 years ________________________________
□ Early Adulthood 20 years ________________________________
□ Late Adulthood 35 years and above ________________________________

11. In your opinion, what are the qualities of an ideal Pokot woman? Explain

12. Are there any taboos against a woman with obstetric fistula? □ Yes □ No

13. If Yes, what are those taboos? __________________________

14. What is your preferred type of delivery and why? (Probe for specifics in
preferred type of delivery)
□ Normal vaginal delivery ________________________________
Hospital-based-Instrumental vaginal delivery ____________________
Hospital-based-Cesarean section delivery ______________________

Causes of obstetric fistula and socio-cultural explications of obstetric fistula on Womanhood
15. What do you think caused your current condition? Explain___________
16. After delivery how soon did the problems start?
   ☐ 2–10 days ☐ 2 weeks ☐ 2 – 4 weeks ☐ 1 – 3 months
   ☐ 3 – 6 months ☐ 6 months – 1 year ☐ After 1 year
17. How did these problems (obstetric fistula (OF)) start? _____________
18. After what order of delivery did your condition manifest?
   ☐ 1st delivery ☐ 2nd delivery ☐ 3rd delivery ☐ 4th delivery
   ☐ 5th delivery ☐ Other (Specify) ________________
19. Where did you go for delivery prior to your condition?
   ☐ Home delivery ☐ Health centre/clinic ☐ Hospital delivery
20. What led to your choice of place of delivery? Explain_______________
21. Who assisted you at the time of delivery and why? (Probe for specifics in person who offered assistance)
   ☐ No one _______________________________________
   ☐ Family/friend __________________________________
   ☐ Untrained TBA _________________________________
   ☐ Trained TBA _________________________________
   ☐ Nurse/Midwife ________________________________
   ☐ Doctor _______________________________________
22. What are the problems and challenges you have been experiencing since you sustained this condition (obstetric fistula)? Explain _________

Perceptions
23. For how long have you been living with this condition (obstetric fistula)?
24. Do you think there is a cure for your condition? ☐ Yes ☐ No
25. If Yes, by what means? Explain___________________________
26. At what point in time did you seek for medical assistance?___________
27. What sought of treatment have you been seeking?
   ☐ Home remedies ☐ Traditional healer ☐ Hospital services 
28. What led you to seek that particular treatment? ______________________
29. Is the child who was born alive? ☐ Yes ☐ No
30. If the child is not alive, did you face any problem at your home or in the society related to the death? ☐ Yes ☐ No Explain________________________
31. What caused the death of the child? Explain ________________________

Perceptions of women and men on the impact of obstetric fistula on womanhood
32. Does your condition affect the ideals of womanhood according to your community? ☐ Yes ☐ No
33. If yes, how is this affect manifested? _____________________________
34. In your opinion does your condition hinder your normal physical activities now as a woman? ☐ Yes ☐ No (Probe for both Yes and No answers) ______
35. Have you shared your obstetric fistula problems with others? ☐ Yes ☐ No
36. If Yes, with who? ______________________________________
37. Beside the persons with whom you have shared your problems, who else knows about your problems? ____________________________
38. How is your condition perceived by others? (Probe for Partner, Family and Community members)
   - Your Partner ____________________________
   - Your Family ______________________________
   - Community members ______________________
39. What made others feel this way towards you? ____________________________
40. Has your condition affected intimate relations with your husband? ☐ Yes ☐ No
41. If Yes, explain ____________________________

Social networks (People remained close after obstetric fistula)
42. Are you facing any social criticisms from the community? ☐ Yes ☐ No Explain ____________________________
43. If Yes, what are those criticisms? ____________________________
44. Are you a member of any community group? ☐ Yes ☐ No Explain ______
45. Are you still active in the community group? ☐ Yes ☐ No Explain ______
46. If Yes, how do you participate? (Probe for impact of the condition on participation) ____________________________

Social coping strategies
47. Do you know of any other women with the same condition as you? ☐ Yes ☐ No
48. If Yes, how did you know about them? ____________________________
49. How do you cope with your condition on a daily basis? ____________________________
50. What problems do you encounter in coping with your condition on a daily basis? ____________________________
51. In your opinion how can this problem be avoided? (Probe for impact of the condition on participation)
   - Individual responsibilities ____________________________
   - Community/Social responsibilities _______________________
   - Government/Stakeholder responsibilities ___________________
   - Medical responsibilities ______________________________
52. Is there anything else you would wish to tell me about experiences of women and Obstetric Fistula? ____________________________

Thank you for your input and time
Appendix 4: Guided Interview for Women Healed of Obstetric Fistula
(Obstetric Fistula Patient (Cured))

Particulars of respondent:
Interview Guide No.: ___________________ Date __________________
Location of interview __________________________________________
Occupation of the Respondent: __________________________________
Age of respondent: □ Under 20 years ___ □ 21-35 □ 36 – 50
□ 51 and above ________
Age of respondent at time of first delivery: ______________________
Age of respondent at the last pregnancy prior to sustaining an obstetric fistula: _
Respondent’s Educational level:
□ No Formal Education □ Primary Incomplete □ Primary Complete
□ Secondary Incomplete □ Secondary Complete □ Post-Secondary Education
Estimate monthly family income: _______________________________
No. of living children (if any) before sustaining obstetric fistula: _________
No. of additional living children (if any) after sustaining obstetric fistula: ___

1. Who do you live with currently? Explain ____________________________
2. Where do you live with currently? Explain __________________________
3. What is your marital status?
□ Single □ Married □ Separated
□ Widowed □ Divorced □ Other (Specify) ________
4. How old were you at time of marriage? ____________________________
5. What is/was the type of marriage?
□ Monogamous □ Polygamous □ Other (Specify) ____________
6. During your marriage:
   ● What was your husband’s age at time of marriage to you? ________
   ● What is/was your husband’s occupation? ______________________
   ● What is/was your husband’s level of education? ________________
7. If married, do you still live with your husband in the same house? ___
8. If divorced, were you divorced before or after sustaining the condition?
9. If divorced, was the condition of obstetric fistula the cause of the divorce?

Social construction of womanhood among the Pokot
10. At what cycle of the social construction of gender does the definition of
    womanhood start? (Probe for specifics in each stage)
□ Early Childhood 2-5 years ________________________________
□ Childhood 6-12 years _________________________________
□ Teenage 13-19 years ________________________________
□ Early Adulthood 20 years ______________________________
□ Late Adulthood 35 years and above ______________________
11. In your opinion, what are the qualities of an ideal Pokot woman? Explain
12. Are there any taboos against a woman with obstetric fistula in your
    community? □ Yes □ No
13. If Yes, what are those taboos? ________________________________
14. What is your preferred type of delivery and why? (Probe for specifics in
    preferred type of delivery)
□ Normal vaginal delivery ________________________________
Hospital-based-Instrumental vaginal delivery _________________
Hospital-based-Cesarean section delivery _________________

15. Is the child who was born alive? □ Yes □ No
16. If the child is not alive, did you face any problem at your home or in the society related to the death? □ Yes □ No
17. If Yes, what are those problems_______________________________
18. What caused the death of the child? Explain ___________________

Knowledge on place of and outcome of treatment
19. Did you know anything about obstetric fistula before diagnosis at health centre? □ Yes □ No (Probe for both Yes and No answers) _______________
20. What did you think caused your condition:
   • Before you went for treatment? ______________________________
   • After you went for treatment? _______________________________
21. After delivery how soon did the problems start?
   □ 2 –10 days □ 2 weeks □ 2 – 4 weeks □ 1 – 3 months
   □ 3 – 6 months □ 6 months – 1 year □ After 1 year
22. After what order of delivery did your condition manifest?
   □ 1st delivery □ 2nd delivery □ 3rd delivery
   □ 4th delivery □ 5th delivery □ Other (Specify) ____________
23. Where did you go for delivery prior to your condition?
   □ Home delivery □ Health centre/clinic □ Hospital delivery
24. What led to your choice of place of delivery? Explain____________________
25. Who assisted you at the time of delivery and why? (Probe for specifics in person who offered assistance)
   □ No one _______________________________________________
   □ Family/friend ___________________________________________
   □ Untrained TB ___________________________________________
   □ Trained TBA ___________________________________________
   □ Nurse/Midwife ___________________________________________
   □ Doctor __________________________________________________
26. How did these problems (obstetric fistula (OF)) start? _________________
27. For how long did you live with the obstetric fistula before seeking treatment?
28. Did you know that there was a cure for your condition then? □ Yes □ No (Probe for both Yes and No responses) __________________________
29. Do you think that there were delays in your seeking treatment? □ Yes □ No
30. If Yes, what were some of the reasons for delays of seeking treatment for obstetric fistula?
31. At what point in time did you seek for medical assistance? _____________
32. What sought of treatment did you seek?
   □ Home remedies □ Traditional healer □ Hospital services
33. What led you to seek for that particular treatment? ___________________
34. Do you have any symptoms of the obstetric fistula after treatment? □ Yes □ No
35. If Yes, what are those? __________________________________________
How do women and men perceive obstetric fistula survivors after cure

36. What do you consider the worst thing about living with obstetric fistula?
37. Now that you are cured, have you resumed your normal physical activities as a woman? □ Yes □ No  
   (Probe for both Yes and No responses) _______
38. If No, have you shared your fears and problems with others? □ Yes □ No
39. If Yes, with who? __________________________
40. Are you sexually active after treatment? □ Yes □ No  
   (Probe for both Yes and No responses)________________________
41. How do you perceive yourself after treatment? __________________
42. Now that you are cured, how do others perceive you? (Probe for Partner, Family and Community members)
   - Your Partner __________________________
   - Your Family ____________________________
   - Community members ______________________
43. What makes others feel this way towards you? Explain___________

Social networks (People remained close after obstetric fistula)
44. Now that you are cured, are you facing any social criticisms from the community?
   □ Yes □ No
45. If Yes, what are those criticisms? _________________________
46. Are you a member of any community group? □ Yes □ No  
   Explain
47. Are you active in the community group? □ Yes □ No  
   Explain
48. If Yes, how do you participate? (Probe for impact of the condition on participation) ______________________________

Social coping strategies
49. How are you sustaining yourself after treatment? ________________
50. Do you know of any other woman having similar symptoms as you did?
   □ Yes □ No
51. If Yes, how did you know about them? ______________________
52. In your opinion how can this problem be avoided? (Probe for impact of the condition on participation)
   - Individual responsibilities __________________________
   - Community/Social responsibilities ___________________
   - Government/Stakeholder responsibilities ____________
   - Medical responsibilities __________________________
53. Is there anything else you would wish to tell me about experiences of women and Obstetric Fistula? ___________________

Thank you for your input and time
Appendix 5: Guided Questionnaire for Spouse/Caregiver of Obstetric Fistula Patient

Mind Map of Spouse/Caregiver of Woman Living with / Cured of Obstetric Fistula

**Particulars of respondent:**

Questionnaire No.: __________________ Date ________________
Location of interview: ____________________________________
Age of respondent: ______________________________________
Age of respondent at time of marriage:________________________
Respondent’s Educational level:_____________________________
No. of living children if any:________________________________
No of stillbirths if any: _____________________________________
Marital status of the respondent:
- Single
- Married
- Separated
- Widowed
- Divorced
- Other (Specify) _______
Type of marriage:  □ monogamous   □ polygamous
If polygamous, how many wives do you have besides the one with obstetric fistula? _______ wives

Relationship with the patient:
- Husband/partner: __________________________________
- Relative (Specify):  ________________________________

Respondent’s occupation:______________________________
Estimate monthly family income: ___________________________

**General**

1. Before your wife sustained an obstetric fistula, had you heard about the condition before? □Yes □ No
2. If Yes, explain _________________________________
3. Do you know any other woman with the same condition as your wife/relative? □Yes □ No
4. If Yes, how did you get that information?_______________
5. When did you learn about the problem of your wife? ______________
6. How did you learn about the problem of your wife? __________________
7. When did her problem started? ___________________________
8. How did her problem start?___________________________
9. What was your primary concern with regard to the problem of your wife?
10. Did you make any plans on how to deal with the problem of your wife? □Yes □ No
11. If Yes, what were those plans? __________________________
12. Do you think there is cure for your wife’s condition? □Yes □ No
13. If Yes, what do you think is the appropriate treatment for your wife’s condition? _____
14. Do you know if your wife has tried to seek treatment for her condition?  
   □Yes □ No
15. If Yes, Explain _________________________________
16. For how long has your wife been living with this condition? __months _ years
17. Has there been a delay in your wife seeking treatment for her condition?
   ☐ Yes  ☐ No
18. If Yes, what are the factors contributing to the delays in seeking skilled and professional help for your wife’s condition? ______________
19. Do you think that this problem could be avoided? ☐ Yes  ☐ No Explain
20. If Yes, how? ________________________________

**Relationship with Wife**
21. Has the condition affected your relationship with your wife? ☐ Yes  ☐ No
22. If Yes, explain nature of affect ________________________________
23. What coping mechanisms do you use to deal with changes in your relationship with wife? ________________________________
24. Have you received any form of support from other people? ☐ Yes  ☐ No
25. If Yes, what form of support did you receive? ________________________________
26. Have you faced any adverse reactions from the community members as a result of your wife’s condition? (shame, uncomfortable, stigma, etc) ☐ Yes  ☐ No (Probe for Family and Community members)
   - Family members ________________________________
   - Community members ________________________________
27. What makes others feel this way towards you? Explain ________________________________

**Impact on Family**
28. What changes have you made in your family life in relation to your wife’s condition?
29. How did this change affect your wife’s life? ________________________________
30. Does your wife distance herself from other family members due to her condition? ☐ Yes  ☐ No
31. If Yes, how do other family member perceive this distance your wife has created between her and them? ________________________________
32. Have other family members distanced themselves from your wife due to her condition? ☐ Yes  ☐ No
33. If Yes, how does your wife perceive this distance your other family member have created between them and her? ________________________________

**Impact on Daily activities**
34. Has your wife’s condition affected your daily household activities? ☐ Yes  ☐ No
35. If Yes, explain ________________________________

**Economic**
36. Has your wife’s condition had any economic effects on household? ☐ Yes  ☐ No
37. If Yes, explain ________________________________
38. Are there any changes in family economic situation due to your wife’s condition? ☐ Yes  ☐ No
39. If Yes, explain ________________________________
40. What coping strategies do you have in place to deal with your wife’s/relative’s condition? ____________________________

41. In your opinion how can this problem be avoided? *(Probe for responsibilities as below)*
   - Individual responsibilities _______________________________
   - Community/Social responsibilities ___________________________
   - Government/Stakeholder responsibilities _______________________
   - Medical responsibilities ___________________________________

42. Is there anything else you would wish to tell me about experiences of women and Obstetric Fistula? ____________________

*Thank you for your input and time*
Appendix 6: Key-Informants Guided Questionnaire for Medical Personnel and Members of the Council of Elders in the Study Area.

Particulars of respondent:
Questionnaire No.: ____________________ Date_____________
Location of interview ___________________________________
Age of the respondent: _________________________________
Marital status of the respondent:
☐ Single ☐ Married ☐ Separated
☐ Widowed ☐ Divorced ☐ Other (Specify) __________
Occupation of the Respondent: __________________________
Years of working experience: ____________________________
Monthly family income: _______________________________

Information on obstetric fistula:
1. In your work, have you encountered women with Obstetric fistula? ☐ Yes ☐ No
2. What caused the Obstetric fistula? _______________________
3. On average how long do they remain with the condition, before they come for treatment? _________________________________
4. Mostly, what is the age group of these mothers who sustain an obstetric fistula? _________________________________
5. What health complications do these mother encounter as a result of sustaining an obstetric fistula? _________________________________
6. How does the problem of obstetric fistula manifest itself in these women? _________________________________
7. What kind of treatment is available for these women? _________________________________
8. Where can they get this treatment? _________________________________
9. Do you think this condition can be avoided? ☐ Yes ☐ No
10. If Yes, how? _______________________________________

Impact on Daily and Economic Activities
11. From your work experience, does the condition of obstetric fistula have any effect on the women’s ability to perform their daily physical activities? ☐ Yes ☐ No (Probe for both Yes and No answers) ________
12. Does the condition of obstetric fistula affect the economic situation of these women? ☐ Yes ☐ No
13. If Yes, explain ______________________________________

Perceptions of obstetric fistula by affected women and community members
14. What are the general beliefs about the condition in the community? ________
15. Does the community feel that these women need to be cared for? ☐ Yes ☐ No
16. How do the women with obstetric fistula perceive themselves? __________
17. Why do they believe it happened to them? _________________________________
18. What coping mechanisms do women with obstetric fistula use to deal with changes in their lives? _________________________________
19. Do women with obstetric fistula face any adverse reactions from the others as a result of their condition? (shame, uncomfortable, stigma, etc) □ Yes □ No (Probe for Partner, Family and Community members)
   • Partner ______________________________
   • Family members _______________________
   • Community members ____________________

Prevention:
20. Is obstetric fistula problem preventable in the county? □ Yes □ No (Probe for both Yes and No answers)
21. Is there awareness about the prevention/causes of the problem? □ Yes □ No (Probe for both Yes and No answers)
22. Do you take any preventive measure if you suspect that a patient may develop obstetric fistula? □ Yes □ No (Probe for both Yes and No answers)
23. In your duty, how do you raise awareness regarding the problem of obstetric fistula:
   • Among women? ___________________________
   • Among men? _____________________________
   • Community? _____________________________

Treatment:
24. Is obstetric fistula problem treatable? □ Yes □ No (Probe for both Yes and No answers)
25. Apart from medical treatment and management of obstetric fistula, what other mechanisms for addressing obstetric fistula do you offer your patients?
26. Along with treatment what kind of rehabilitation do you think should be given to obstetric fistula patients?
27. In your opinion how can this problem be avoided? (Probe for responsibilities as below)
   • Individual responsibilities __________________________
   • Community/Social responsibilities _______________________
   • Government/Stakeholder responsibilities ___________________
   • Medical responsibilities _______________________________
28. Is there anything else you would wish to tell me about experiences of women and Obstetric Fistula? ________________________________

Thank you for your input and time
Appendix 7: Observation checklist

1. Note posture of respondent at time of interview - Standing □ Seated □ Lying □
2. Note walking difficulties by respondent – presence of Foot-drop from Peroneal nerve injury - Yes □ No □
3. Note the range of mobility of respondent - Passive □ Active □ Assisted □
4. Note any visible stains of urine/feces leakage on clothing or legs - Yes □ No □
5. Perceive odour from respondent - Yes □ No □
6. Respondent demonstrates understanding of the cause of her condition - Yes □ No □
7. Respondent observes and describes reactions of others in relation to her OF status clearly - Yes □ No □
8. Respondent demonstrates awareness of cure of her condition - Yes □ No □
9. Type of housing - Permanent □ Semi-permanent □ Temporary □
10. Note presence of other people/family members who live with or assist respondent Yes □ No □
Appendix 8: Research Authorization

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone: +254-20-2213471,
2241349, 310571, 2219420
Fax: +254-20-3182495, 318249
Email: secretary@nacosti.go.ke
Website: www.nacosti.go.ke

When replying please quote Ref. No.

NACOSTI/P/14/6001/4484

Geraldine Kalekye Musyoki
Kenyatta University
P.O. Box 43844-00100
NAIROBI

7th January, 2015

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on “Impact of Obstetric - Fistula on Womanhood: The case of West Pokot County, Kenya,” I am pleased to inform you that you have been authorized to undertake research in West Pokot County for a period ending 15th April, 2015.

You are advised to report to the County Commissioner, the County Director of Education and the County Coordinator of Health, West Pokot County before embarking on the research project.

On completion of the research, you are required to submit two hard copies and one soft copy in pdf of the research report/thesis to our office.

SAID HUSSEIN
FOR: SECRETARY/CEO

Copy to:

The County Commissioner
West Pokot County.

The County Director of Education
West Pokot County.

The County Coordinator of Health
West Pokot County.
Appendix 9: Research Permit

CONDITIONS

1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit.
2. Government Officers will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimen are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two (2) hard copies and one (1) soft copy of your final report.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice.

THIS IS TO CERTIFY THAT:
MISS. GERALDINE KALEKYE MUSYOKI
of KENYATTA UNIVERSITY, 22324-400
NAIROBI, has been permitted to conduct research in West Pokot County.

on the topic: IMPACT OF OBSTETRIC-FISTULA ON WOMANHOOD:
THE CASE OF WEST POKOT COUNTY, KENYA

for the period ending:
15th April, 2015

Applicant’s Signature

Permit No: NACOSTI/P/14/6001/4484
Date of Issue: 7th January, 2015
Fee Received: Ksh 2,000

Secretary
National Commission for Science, Technology & Innovation