IOSR Journal Of Humanities And Social Science (IOSR-JHSS)
Volume 21, Issue 4, Ver. I (Apr. 2016) PP 67-80
e-ISSN: 2279-0837, p-ISSN: 2279-0845.
www.iosrjournals.org

Moving health forward: Communication and elimination of Obstetric Fistula in Kenya

Hezron Mogambi
Senior Lecturer, School of Journalism and Mass Communication, University of Nairobi.

Abstract: *The goal of this study was to establish the effectiveness of health communication in mitigating Obstetric Fistula(OF) among women in Kenya.This research concentrated on how communication been used to improve ways of addressing OF in Kenya. The study relied mainly on primary data sources to collect information gathered through IDIs and FGDS using semi-structured interview guides.Stratified sampling technique was used to come up with sample respondents. The study also employed qualitative research methods to explore the perspectives of the respondents on their experiences and beliefs about the impact of Communication on OF. The findings demonstrated that maternal health is very fundamental and must be considered to effectively address OF. Others factors that need to be considered when addressing OF include culture – both religious and traditional, socio-economic status, access to information and health care facilities, political good was and relevant infrastructure: transport and communication. The study also established that there is insufficient information about OF among respondents indicating the need for improved access to information and education on OF and the related issues. The study also revealed that Mass Media and Group Communication were the most preferred channels of communication for IEC materials and activities on the subject. The study concludes that communication can be effective in mitigating OF among the women and girls in Kenya. It is however very crucial to educate and fully inform members of the public about OF to increase individual learning and empowerment, capacity building, critical consciousness and support. Health service providers need training to properly handle cases of OF and to inform pregnant women during ANC visits to avert OF. The Government and other development partners should also organize media campaigns and group communication to sensitize, educate and inform the public about OF.*

Keywords: *Obstetric fistula, prevalence, impact, Women, communication.*

I. Introduction

Obstetric fistula is one of the most neglected issues in the field of women's health and rights. Despite more than a decade of work on "safemotherhood" internationally, millions of girls andwomen still die in childbirth or live with maternalmorbidities such as fistula. The World HealthOrganization(WHO) estimates that approximately two million girls and women live with fistula worldwide and that an additional 50,000-100,000 girls andwomen are affected each year (Murray & Lopez,1998). Experts on fistula working in the fieldreport that this is likely to be a seriousunderestimate of the problem considering the fact that this is only based on the women who actually have access to health facilities.

Data also suggests that fistula can be caused inhospital settings themselves, through impropercaesarean section (surgical trauma) and negligence, poorly performed abortions, pelvic fractures, cancer or radiation therapy targeted at the pelvic area, inflammatory bowel disease such as Crohn's Disease and ulcerative colitis, or infected episiotomies after childbirth (Nicol, 2005). Appropriate information dissemination (communication) can bridge gaps because if people are informed, then they have better opportunities to develop themselves (Bekenstein,2013).Development communication has been labeled the Fifth Theory of the Press, with "social transformation and development," and "the fulfillment of basic needs" as its primary purposes(Flor, 1995).

Development Communication can also be seen as a way to amplify voice, facilitate meaningful participation and foster change. This encompasses access to and exchange of information, dialogue, creation of knowledge and open access to knowledge, communication for development, strategic communication, participatory communication, expressive culture, media, information and communications infrastructure and technologies. It is conservatively estimated that more than two million women are currently living with obstetric fistula, almost all of whom reside exclusively in Africa, Southeast Asia, and the Arab region (WHO 2006).

Maternal mortality and morbidity remain a conspicuous and stark challenge to public health in developing countries. Each year, pregnancy- related complications claim the lives of 500,000 women worldwide, with around 99% of these deaths occurring in developing countries (WHO 2005). Current best estimates indicate that for each woman who dies from pregnancy- related complications, 15 to 30 women are seriously impaired and disabled from childbirth related complications in less developed countries. In sub-

Saharan Africa alone, between 30,000 and 130,000 of women giving birth develop fistula each year (UNFPA 2008).

Globally, an estimated 600,000 women die every year due to pregnancy related complications, 99% of them in the developing countries and for every maternal death,30% or more women suffer disabling and humiliating injuries including obstetric *fistulae*. While it is a global problem, it appears to be particularly common in Africa - a low resource setting. Unrelieved obstructed labour, which has social, nutritional and health care dimensions, is the main cause of obstetric fistula. ***S***tudies in Africa have shown that 58-80% of women with obstetric fistulae are under the age of 20, with the youngest patient only 12 or 13 years of age. The vulnerability of young girls to the development of Obstetric Fistula is closely related to their physical immaturity and the less developed pelvis. In this context, the need to raise the age of marriage and avoid teenage pregnancy is key in preventing development of Obstetric Fistula.

Obstetric fistula is one of the most serious and disabling complications of child birthwhich has virtually been eliminated in developed counties but still prevalent in thedeveloping world. While 92.2% of VVFs in Kenya are due to obstetric trauma, only 12.3% of such fistulas in the UK are due to this cause compared to 70% from surgery(Mbanji, 1996).

Fistula in Kenya

Kenya's maternal mortality ratio, according to the 2008-09 Kenya Demographic and Health (KDHS) Survey, is 488 maternal deaths per 100,000 live births. Maternal deaths represent 15 percent of all deaths to women of reproductive age (15-49 years). Between 294,000 and 441,000 Kenyan women and girls suffer from maternal morbidities. The majority of deaths are due to direct obstetric complications, including hemorrhage, sepsis, eclampsia, obstructed labor, or unsafe abortion. Unsafe abortion alone is thought to cause at least a third of all maternal deaths. The government had set targets of having the Maternal Mortality Ratio at 230 by 2005, and 170 by the end of 2010.

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. These developments have been made against a backdrop of demographic milestones such as the increase in population from 9 million in 1969 to 31.5 million in 2002. Of significance is the fact that 43% of this population is below 15 years of age. Equally a significant number of young women enter childbearing and this is evidenced by the data from the KDHS 1993 and 1998 where 44% and 55% of girls aged 19 years respectively had already began childbearing. Maternal mortality ratio has increased from 365/100,000 live births in 1993 to 590/100,000 in 1998.

Reviews of existing literature indicate that in Kenya, Obstetric Fistula is a big problem even though the actual prevalence and incidence remain unknown. From documented reports (UNFPA,2005), it had been noted that there is an annual incidence of about 3000 fistula cases in Kenya; with an estimated repair rate of less than 500 cases per year, the backlog could be growing. According to the report on the Kenya Country Situation (presented at the 2nd Meeting of the Working Group of the Prevention and treatment of Obstetric fistula in Addis Ababa, Ethiopia (October-November., 2002), the number of VVF operations done annually during the ten years between 1992 and the year 2001 increased steadily from a low of 36 cases in 1992 to a high of 479 cases in 2001. AMREF conducts outreach fistula surgery in five site in Kenya namely KNH, Mutomo, Garissa, Ortum, and Mumias hospitals. The Amref fistula surgeon noted that there are areas in the country where the problem of obstetric fistula is 14% more pronounced particularly the pastoral regions of West Pokot, Turkana, Garissa and in South Nyanza.

Few studies on obstetric fistula have been done in Kenya. Between 1965 and 2003 only four studies have been conducted nationally. These include Mati (1968), Orwenyo(1984), Amoth (2001) and Mabeya (2003). Orwenyo (1984) found that in KNH 36.6% of the patients were primigravidas (women who are pregnant for the first time) and they constituted the single largest group of patients who developed obstetric fistula. In the West Pokot study (Mabeya 2003), primigravidas constituted 62.7%. These studies underscored the need to address thecausative factors of OF such as malnutrition, low literacy levels, early sexual debuts (marriages) andaccess to EmOC while improving access to repair services.

The findings indicate that obstetric fistula is a common problem. All the 66 women studied were married and a majority (66.4%) was below 20 years and also primigravida. The youngest patient was 14 years and the ages ranged from 14 to 38 years with a mean of 20.5 years. Amoth (2001) in his study at KNH found that 26.6% of the cases were 20 years and below and 81.3% were 30 years and below. According to Mabeya's (2003) study the main cause of fistula was obstructed labour. All the cases delivered at the health facility and the outcome in 67.7% of the cases was stillbirths. The duration of labour lasted four days in 81.8% of the patients and only one patient had elective caesarean section with subsequent development of VVF.

Kenya has put forth efforts to eliminate vesico-virginal or obstetric fistula through the introduction of The Kenya National Obstetric Fistula Training Curriculum for Health Care Workers which was developed in

2006, with funding and technical support from UNFPA. This was founded so as to train service providers using a multi-disciplinary approach for effective management of obstetric fistula. This approach entails training of medical personnel, which include a doctor, nurse, anesthetists, physiotherapists, and social workers. There are various centers in Kenya where one can access this service.They include Cherangany Nursing Home in Kitale, Womenand DevelopmentAgainstDistress in Africa (WADADIA) in the regions of West Pokot, Mt. Elgon and Siaya,Jaramogi Oginga Odinga Teaching and Referral Hospital (formerly known as Nyanza Provincial General Hospital), Kisumu ,Gynocare Fistula Centre, Eldoret, Jamaa Mission Hospital, Nairobi and Kenyatta national Hospital.

The Kenya government has taken some positive steps in improving women's and girls' reproductive and maternal health. These initiatives include eliminating charges for public family planning services, antenatal and postnatal care, and prevention of mother-to-child HIV transmission. The government has also eliminated charges for delivery in dispensaries and health centers to encourage women to deliver in medical facilities with a skilled birth attendant. In addition, by introducing a system of full or partial fee waiver for access to government hospitals, the government has taken steps to increase access to health care for indigent patients. However, through the voices of fistula survivors, many women and girls, particularly the poor, illiterate, and rural, are not fully enjoying the benefit of these policies, and there is urgent need to reevaluate and scale up many of the responses.

In 2004, the government conducted a fistula needs assessment that showed lack of awareness about fistula in communities as a barrier to its prevention and treatment. Six years later, the government has not taken adequate steps to educate the population, nor to correct the myths that exist about fistula in many communities. The Kenya government's efforts to ensure affordable maternity care for poor rural women and girls have fallen far short of even its own goals.

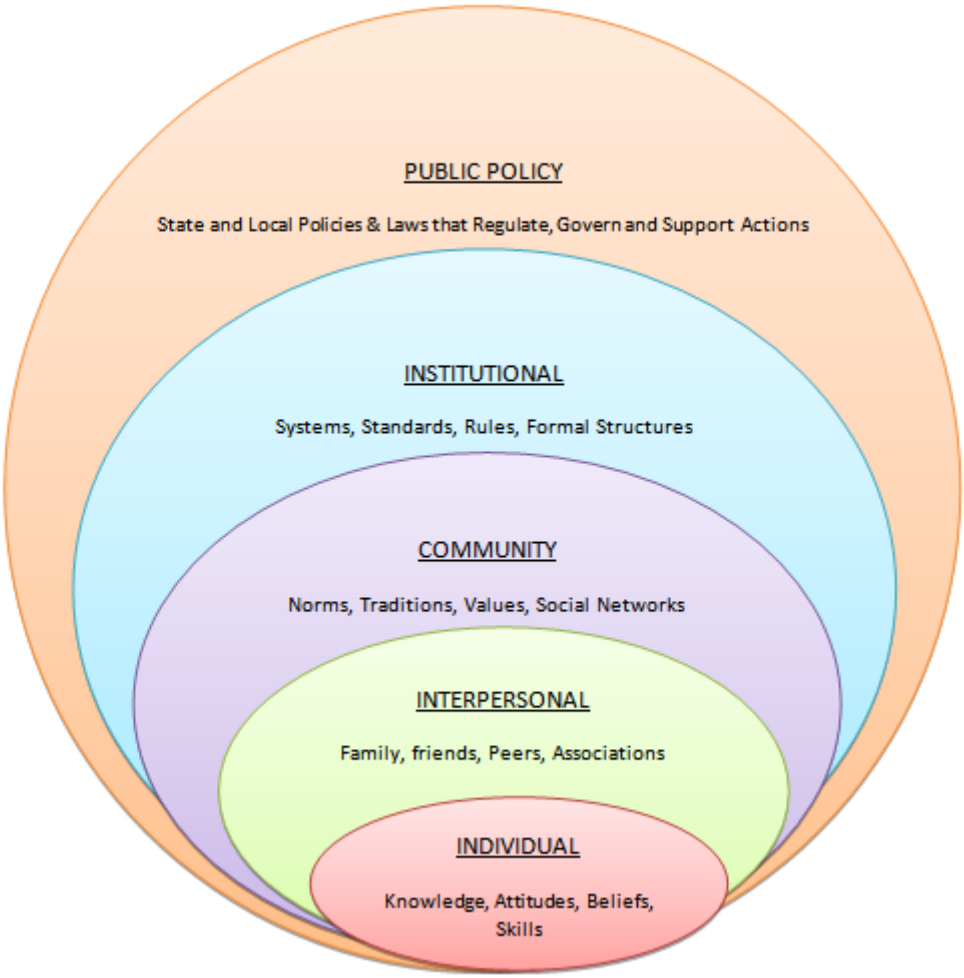
The health user fee waiver policy does not work for several reasons: lack of awareness of the policy among patients and some health providers, some facilities' reluctance to publicize the waivers and deliberate withholding of information when requested by patients, and vague implementation guidelines, including the criteria for determining the financial needs of a patient. The Kenyan government statistics have shown that capacity to manage complications during childbirth is weak in many health facilities, including referral facilities such as hospitals. Currently available statistics show that less than 10 percent of all medical facilities in the country are able to offer basic emergency obstetric care, and only 6 percent offer comprehensive emergency obstetric care.

Health Belief Model (HBM)

The Health Belief Model (HBM) remains one of the most widely recognized in the field. It was developed in the 1950s by a group of U.S. Public Health Service social psychologists who wanted to explain why so few people were participating in programs to prevent and detect disease. *The Health Belief Model (HBM)* addresses the individual's perceptions of the threat posed by a health problem (susceptibility, severity), the benefits of avoiding the threat, and factors influencing the decision to act (barriers, cues to action, and self-efficacy).

To find an answer, the social psychologists examined what was encouraging or discouraging people from participating in the programs. They theorized that people's beliefs about whether or not they were susceptible to disease, and their perceptions of the benefits of trying to avoid it, influenced their readiness to act. In ensuing years, researchers expanded upon this theory, eventually concluding that six main constructs influence people's decisions about whether to take action to prevent, screen for, and control illness. They argued that people are ready to act if they: believe they are susceptible to the condition (*perceived susceptibility*); believe the condition has serious consequences (*perceived severity*); believe taking action would reduce their susceptibility to the condition or its severity (*perceived benefits*); believe costs of taking action are outweighed by the benefits (*perceived barriers*); are exposed to factors that prompt action e.g., a television ad or a reminder to seek health care (*cue to action*); are confident in their ability to successfully perform an action (*self-efficacy*).

Health motivation is the central focus of the HBM in addressing problem behaviors that evoke health concerns. Together, the six constructs of the HBM provide a useful framework for designing both short-term and long-term behavior change strategies at the individual level.



II. Methodology

Area of Study

The researchers' location of the study is Tiwi. This is a village located in Coast of Kenya, Kwale County. It is situated along the Southern Coast, just before Ukunda-Diani. Tiwi has a population of around 19,000 people. Most of the residents of Tiwi are the Digo– a part of the Mijikenda group. The residents are predominantly Muslims at 90%, with the remaining 10% being Christians.

The majority of Tiwi residents are very poor. There is no major economical venture that brings in income to better the living standards of the people. They mainly depend on raising money through selling cashew nuts and tapping coconut for palm wine. About 80% of women in Tiwi village are illiterate, hence do not have jobs or well managed businesses to bring home income to help take care of their families. Most of them deal in small trade businesses such as kiosks, selling khangas (lesos), roasting cashew nuts, making mats to make ends meet.

The young girls are given off for marriage to old, wealthier men so as to get good bride price and also to receive monetary favors and gifts from the in-laws as is common with most Kenyan cultures. Some of the women and young girls are forced by their husbands to engage in prostitution to earn money and live comfortably or to contribute to the family income. The rugged physical and expansive landscape, harmful cultural practices, illiteracy and poverty inthis community interact synergistically to precipitate the occurrence of obstetric fistula.

Research Design

The research problem having been formulated in clear-cut terms, the researcher employed qualitative methods in this study such as In-Depth Interviews (IDIs) and Focus Group Discussions (FGDs)to collect information and assess attitudes and perceptions about fistula, andin order to establish the impact and effectiveness of development communication, specifically health communication in mitigating obstetric fistula among the women and girls in Kenya.

This paper uses qualitative research methods because they majorly focus or explore behavior, perspectives, experiences and feelings of people, they also emphasize on the understanding of these elements (Holloway and Wheeler; 2002: 30).

Sample and Sampling Procedure

The actual sample to be studied was be drawn from the women and girls suffering from fistula, medical and care providers, local leaders, pregnant women and the residents of Tiwi Village. The study was use a stratified sampling technique to come up with a sample of 100 respondents. The target population was be put into sub-groups, namely: patients, general residents, pregnant women, leaders and health providers.

Random sampling was then be used in choosing respondents from the sub-groups in the target population. From a target population of 500, This study choose 50 respondents from the general residents, 20 patients, 10 pregnant women, 10 leaders and 10 health providers. The goal of the stratified random sampling is to achieve the desired representation fromvarious sub-groups in the population.

The choice of stratified sampling technique would exude the advantages of focusing on important sub-populations and improve the accuracy of estimation. However the technique has the setback of requiring accurate information about the population, or introduction of bias. According to Mugenda and Mugenda (2003), stratified randomsampling ensures the inclusion in the sample the sub-groups that would otherwise be omitted if other sampling methods are used owing to the relatively small numbers in the population.

Research Instrument

Data was majorly gathered through interview schedules for the IDIs and FGDs. Interviews permit the interviewer to ask the respondent direct questions, and allow further probing and clarification as the interview proceeds.This flexibility is invaluable for gaining private views and feelings about the phenomenon and exploring new issues that emerge during the interview.Interviews are usually conducted one-to-one but can be carried out in a group, which can save time and allow people to build on other's responses.Group interviews (FGDs) may, however, inhibit respondent's answers if trust is an issue.The richness and validity of information from FGDs or IDIs usually depend on the extent that trust exists.

Interviews or Focus Group Discussions can however consume a great deal of time if interviewers take full advantage of the opportunity to hear respondents out and change their questions accordingly.The nature of the question and the interactions between the interviewer and the respondent may also discourage or encourage certain kinds of responses.

Data Collection Procedure

The data was gathered using semi-structured interview guides. Other data was collected from records at the Ministry of Health, Kenyatta National Hospital and Msambweni District Hospital.

Data Analysis

Descriptive statistics was used in the analysis. The raw data was pre-coded before filling it into statistical package for social scientists. This enabled reducing and organizing data for effective analysis. The frequency distribution needed to examine the pattern of response to each independent and dependent variable under study. Three research questions have been posited in this study were measured in multiple ways, the use of tables, bars, and pie charts, including gender, age, marital status, religion affiliations, and levels of education and sources of support for women.

III. Results

This study targeted 100 respondents in collecting data in regards to the effectiveness of health communication on the mitigation of OF among women and girls in Kenya. From the study, a total of 82 respondents out of the 100 sample respondents participated in the interviews making a response rate of 82%.According to Mugenda, Mugenda (2003) a response rate of above 60% is considered appropriate for credible results.

Demographic Information

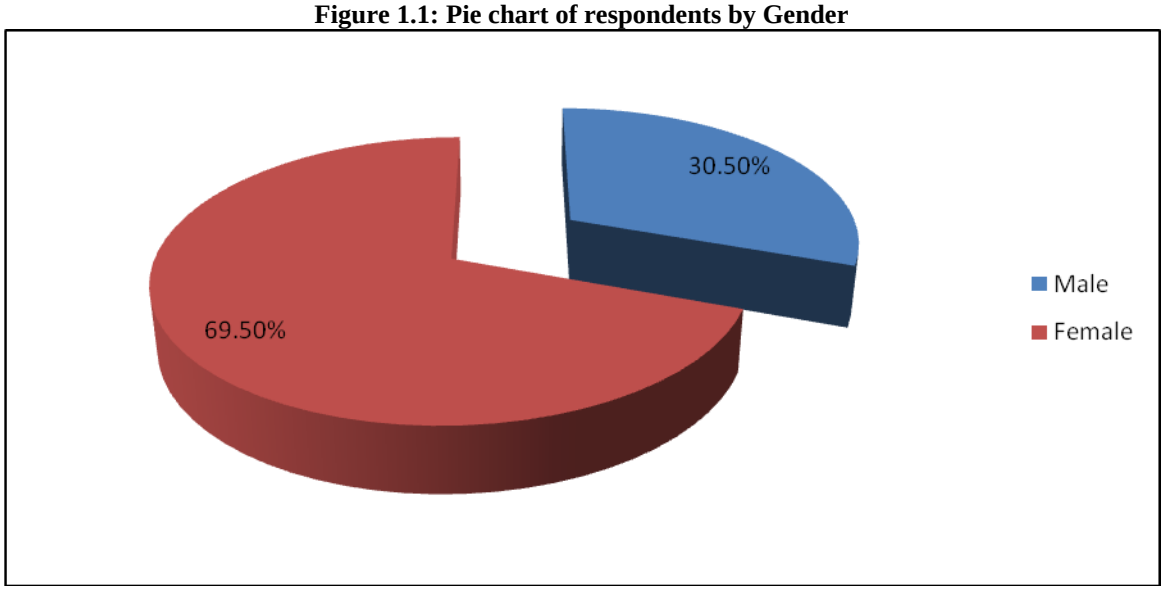
These are the information on the characteristics of the respondents. They included age, gender, marital status, level of education, average income and other occupation.

The study sought to find out the gender of the respondents. According to the finding, 69.5 of the respondents were female, while 30.5% were male. This implies that the majority of respondents were female being that they were largely affected by the subject of the study and therefore a high interest to participate in the study. Table 1.1 and Figure 1.1 below show the distribution of respondents by gender.

Table 1.1: Gender distribution of respondents

Gender	No. of respondents	Percentage
Male	25	30.5%
Female	57	69.5%
Total	**82**	**100%**

Figure 1.1: Pie chart of respondents by Gender



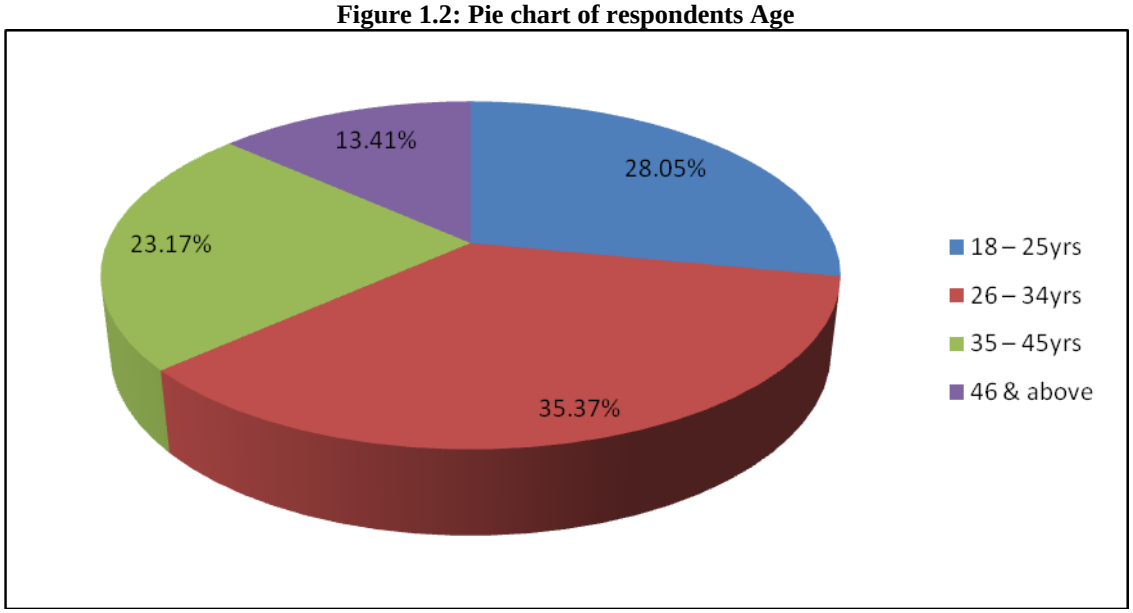
Age distribution of the respondents

The study sought to find the age of the respondents. From the findings 86.59% of the respondents were aged between 18 years and 45 years. It can be depicted from this finding that these are the highly reproductive age groups in Tiwi Village and would be expected to have a higher level of sexual and reproductive health concern. Table 1.2 and Figure 1.2 below illustratethe distribution of Age of the respondents.

Table 1.2: Distribution of age of respondents

Age	**18 – 25yrs**	**26 – 34yrs**	**35 – 45yrs**	**46and above**	**Total**
Frequency	23	29	19	11	**82**
Percentage	28.05%	35.37%	23.17%	13.41%	**100%**

Figure 1.2: Pie chart of respondents Age



Marital status of the respondents

The study sought to find out the Marital status of the respondents. According to the findings, 43.90% of the respondents were married, 21.95% were single, 17.07% were widowed, 10.98% were divorced, while 6.10%

were separated. From the finding it can be drawn that most of the respondents were in stable marriages. The study also found out that 21.95% of the respondents were single depicting that a lot of very young people were engaging in sexual activities at a very early age. (Refer to Table 1.3: Marital status of respondents).

Table 1.3: Distribution of the Marital status of respondents

Marital Status	Frequency	Percentage
Single	18	21.95%
Married	36	43.90%
Separated	5	6.10%
Divorced	9	10.98%
Widow/er	14	17.07%
Total	82	100.00%

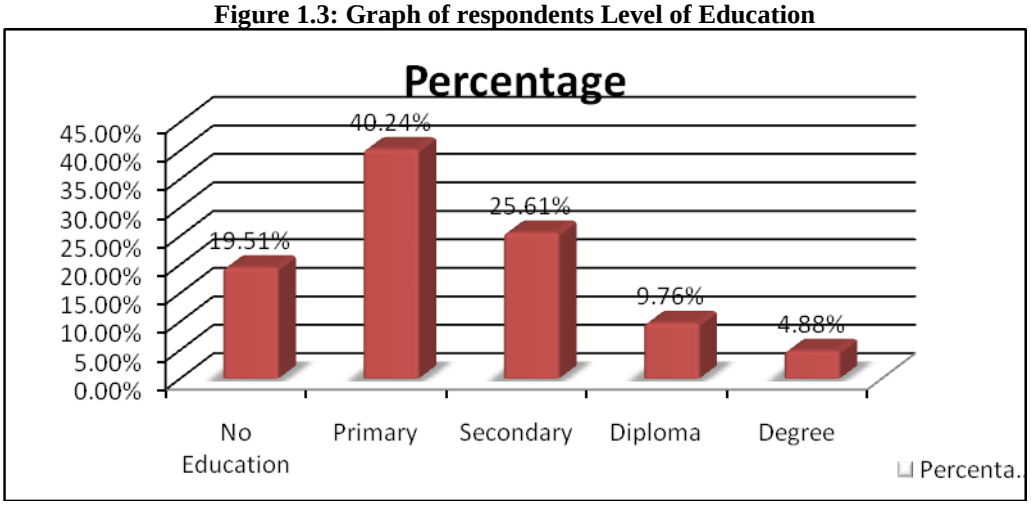
Level of education of the respondents

The study sought to find out the Level of Education of respondents. According to the study the highest percentage of respondents at 40.24% had primary level of education, while 19.51% had no formal education. This depicted lack of awareness and information on OF. From the findings 40.35% of the respondents had at least a secondary or a higher education portraying an improvement on their socio-economic status, awareness level and access to information. The study illustrates that there is a correlation between the Level of Education and socio-economic status. (Refer to Table 1.4 and Figure 1.3: Distribution of respondents Level of Education)

Table 1.4: Distribution of respondents Level of Education

Level of Education	Frequency	Percentage
None	16	19.51%
Primary	33	40.24%
Secondary	21	25.61%
Diploma	8	9.76%
Degree	4	4.88%
Total	**82**	**100.00%**

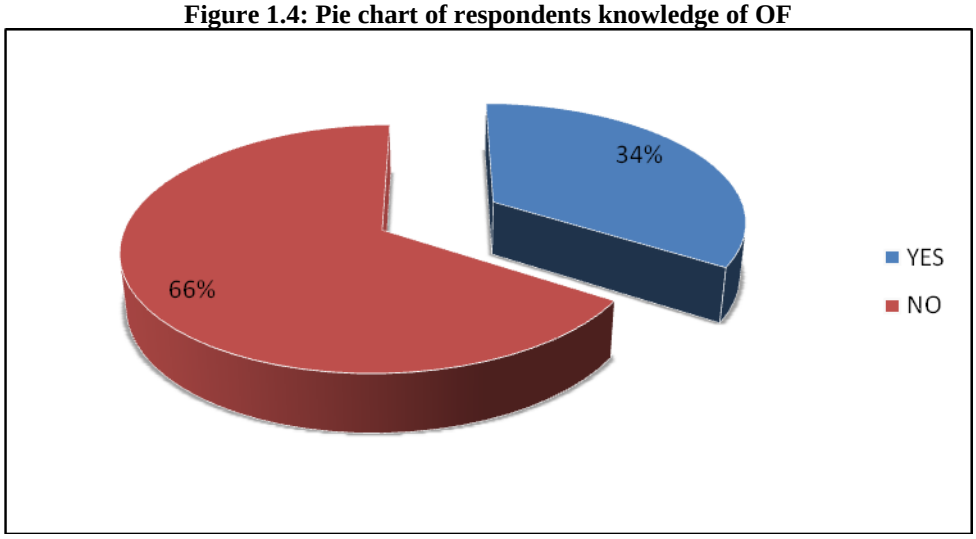
Figure 1.3: Graph of respondents Level of Education



Respondents Knowledge about OF

The study also sought to determine the respondents knowledge and awareness about obstetric fistula. From the findings 34% of the respondents reported that they know or have heard about obstetric fistula, while the majority of the respondents at 66% had no knowledge of OF. According to the findings, 60% of the respondents who had some knowledge about OF know of or have seen someone who suffers fistula.

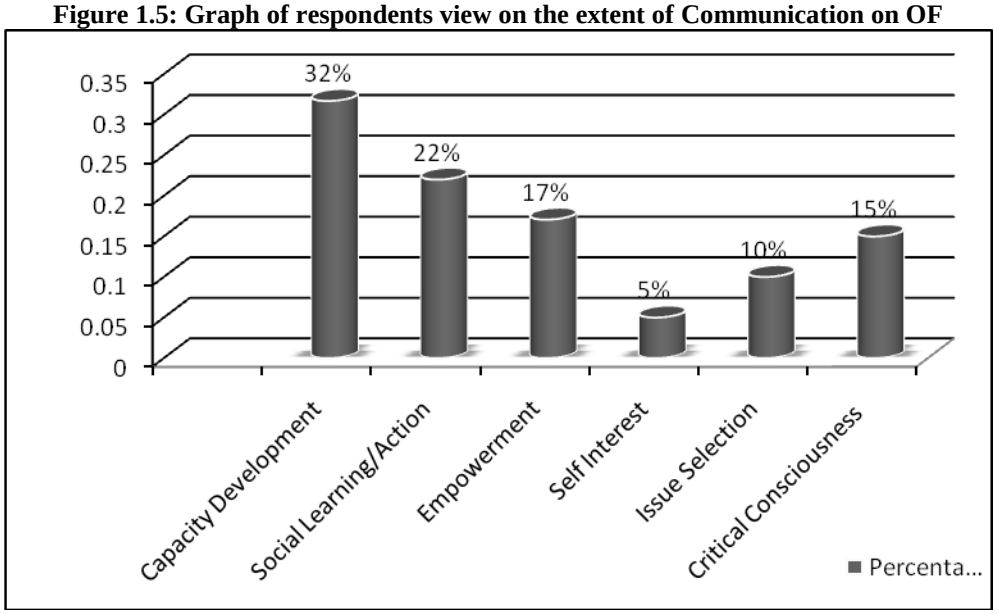
Figure 1.4: Pie chart of respondents knowledge of OF



Extent of Development Communication

This study intended to inquire from the respondents the extent and effectiveness of development communication's contribution towards the mitigation of OF, from the findings, the majority of the respondents at 32% agreed that capacity development contributed to a large extent towards mitigation of OF. Other components of communication such as social learning, empowerment and critical consciousness were also quoted to greatly contribute to the mitigation of OF.However some respondents at 5% also indicated that self-interest did not contribute as much to the mitigation of obstetric fistula.

Figure 1.5: Graph of respondents view on the extent of Communication on OF



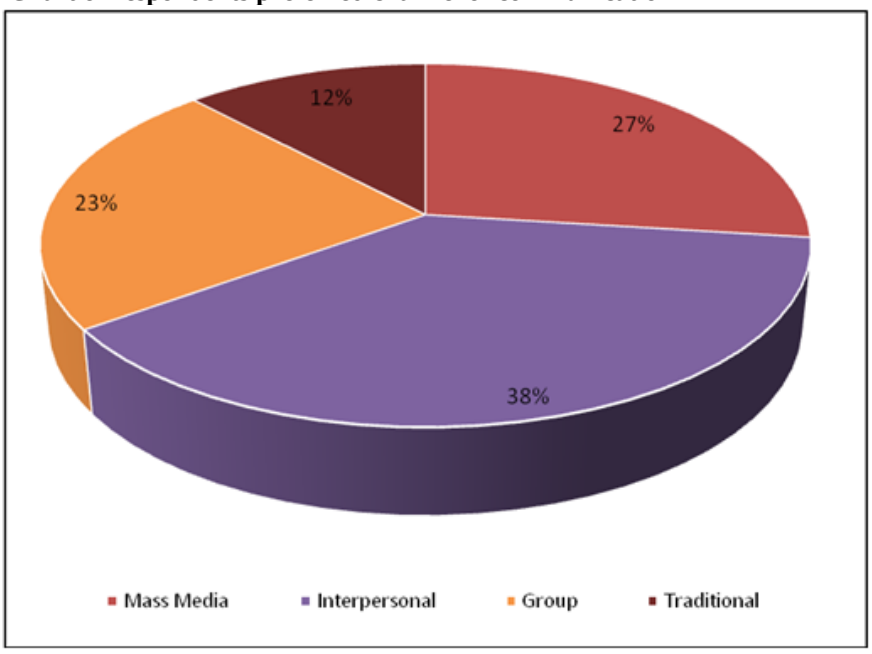
Preferred channel of communication

The study also sought to examine the respondents preferred channel of communication. The majority of the respondents at 38% preferred interpersonal communication, especially counseling by the health service providers. These were mainly the victims of OF and the pregnant women. They reported that this was the most private way to discuss and share their health secrets without feeling judged. 27% of the respondents preferred mass media, citing that it was impersonal and was able to reach most of the community members. The other respondents preferred group and traditional means of communication as illustrated in (Table 1.5. and figure 1.6)

Table 1.5: Distribution of respondents preferred channel of communication

CHANNEL OF COMMUNICATION	PERCENTAGE
Mass Media - TV, Radio, Newspaper	27%
Interpersonal - counseling, gossips, discussions	38%
Group - Barazas, audio visuals, social gatherings	23%
Traditional - folklore, songs, plays, testimonies	12%

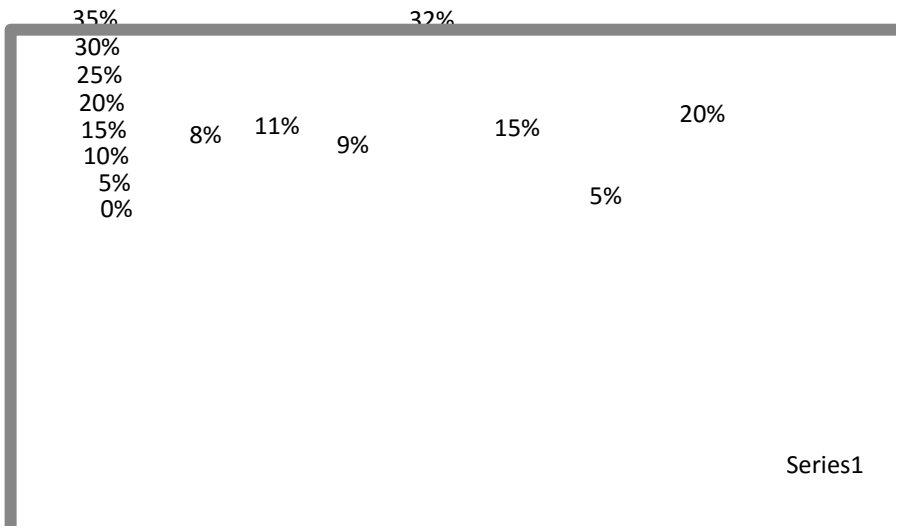
Figure 1.6: Pie Chart of respondents preferred channel of communication



Trusted sources of information

This study purposed to find out the respondents trusted source of information. From the findings, majority of the respondents at 32% trusted the healthcare providers to share their health issues and to seek opinion and advice on health, especially maternal health. 20% of the respondents trusted the Media to give them credible information on OF and health matters. The NGO's and Government were also fairly trustworthy sources of information (Refer to figure 1.7)

Figure 1.7: Graph of respondents trusted source of information

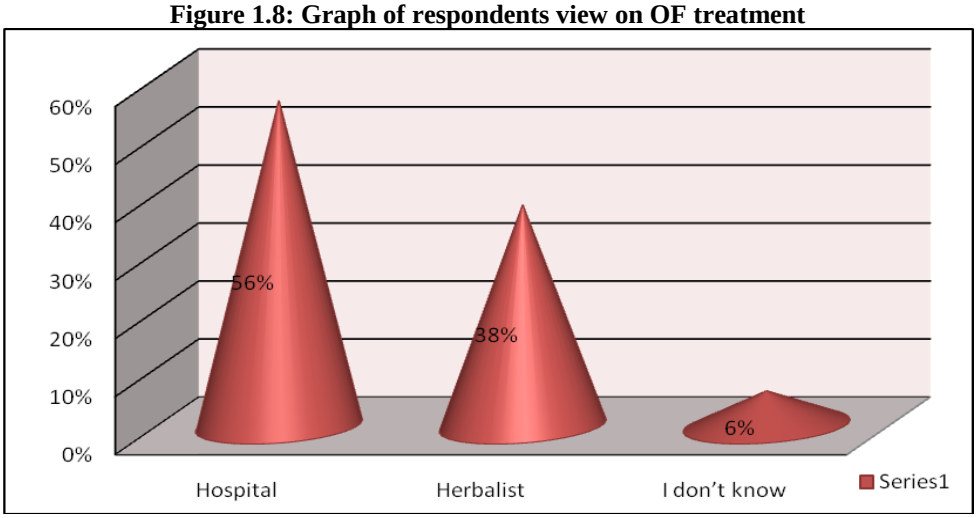


Respondents view on OF treatment

The study also intended to examine the respondents view on the treatment of obstetric fistula. According to the findings, 56% of the respondents believed that OF is treatable in hospital. The majority of the

respondents who held this view were the victims of fistula and some pregnant women who were educated about fistula at the health facility when they sought treatment. 38% of the respondents however believed that OF could be treated by the traditional herbalist because fistula was caused by sorcery or witchcraft. Majority of the respondents who held this view were the elderly and traditional leaders. Some of the respondents however agreed that they did not know whether OF is treatable or not. (Refer to Figure 1.8)

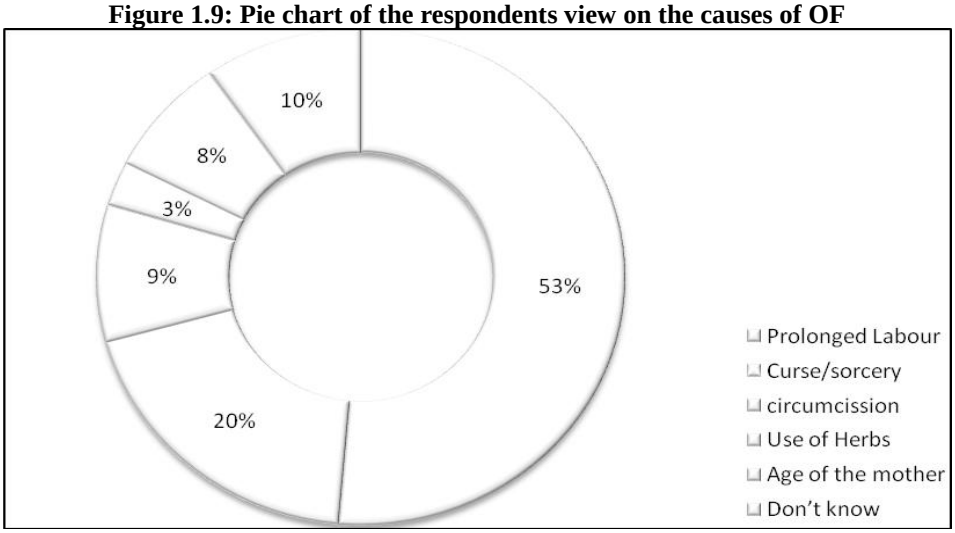
Figure 1.8: Graph of respondents view on OF treatment



Respondents view on the causes of OF

The study also sought to find out the respondents view on the causes of obstetric fistula. Majority of the respondents at 53% agreed that OF was caused by pregnancy related complications, mainly prolonged labour. 20% of the respondents especially the elderly respondents trusted that OF is caused by sorcery or a curse. Other respondents believed that OF is caused by either circumcision, age of the mother or prolonged use of herbs. 10% of the respondents did not know about OF or what causes it. (Refer to Figure 1.9 below)

Figure 1.9: Pie chart of the respondents view on the causes of OF



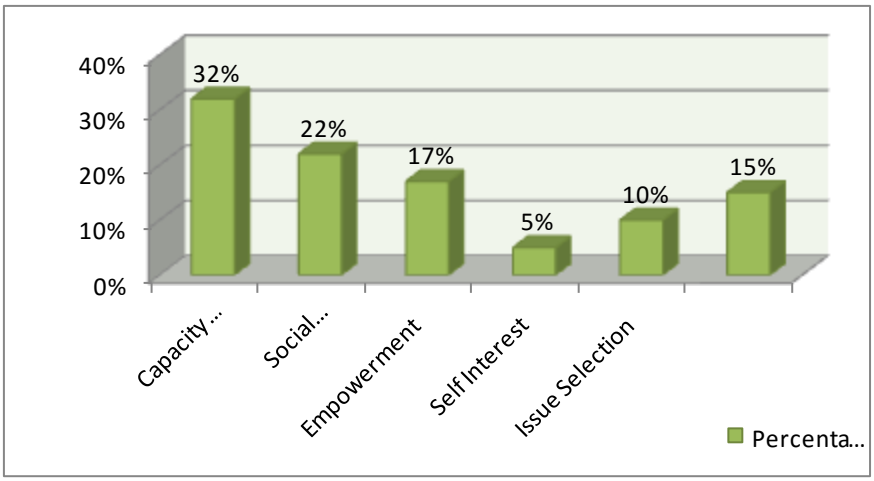
Effectiveness of BCC in addressing OF

This study set out to determine the effectiveness of elements of behavior change communication employed in addressing obstetric fistula. (Referring to Table 1.6), it was determined from the respondents that capacity development is the most effective element of BCC when addressing OF at 32%. This depicted that to be able to effectively and efficiently address OF, it was critical to build capacities of all stakeholders, from the victims, spouses, family and friends, the healthcare providers and the community at large. Social learning and empowerment were also highly rated at 39% to be effective elements of BCC in addressing OF. Self-interest was determined to be less effective at 4% in addressing by the respondents (Refer to Table 1.6 and Figure 1.10)

Table 1.6: Elements of BCC in addressing OF

Behavior Change Communication (BCC)	Frequency	Percentage
Capacity Development	26	32%
Social Learning/Action	18	22%
Empowerment	14	17%
Self Interest	4	5%
Issue Selection	8	10%
Critical Consciousness	12	15%

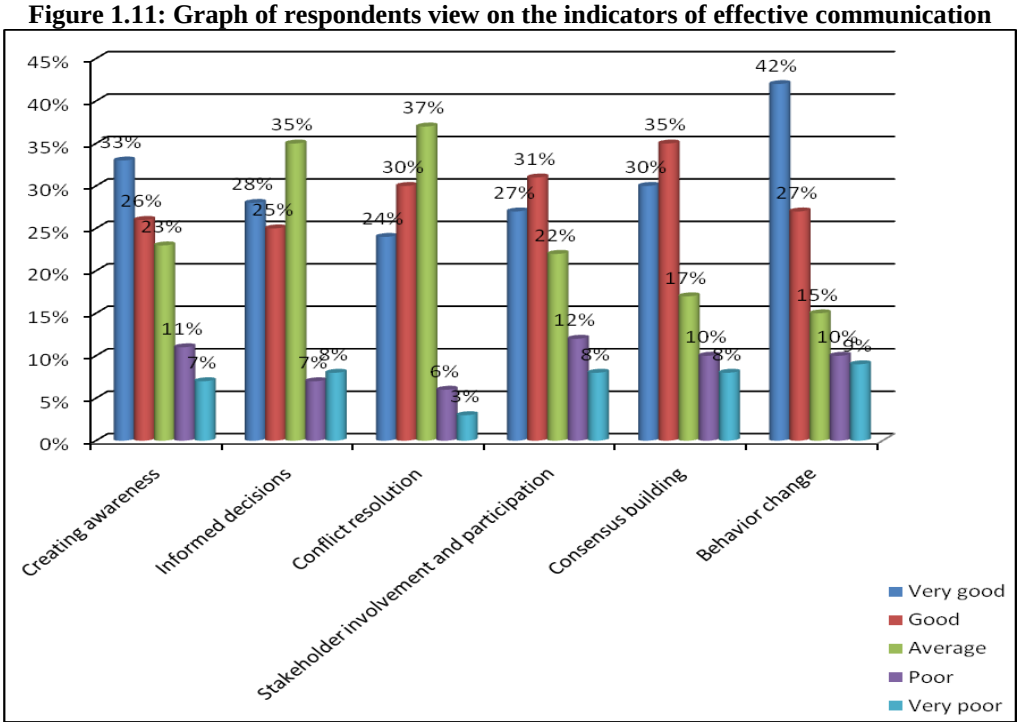
Figure 1.10: Graph of the elements of BCC in addressing OF



Indicators of effective Communication Strategies

This study also intended to find out the indicators of effective development communication strategies. According to the findings, the respondents reported that increased awareness about OF was a very good indicator that communication strategies are effective. The respondents also agreed that positive behavior change and making informed decisions especially to seek skilled maternal care and attending ante-natal clinics were good indicators of effective communication strategies. Stakeholder participation and involvement, consensus building and conflict resolution, especially among spouses were also viewed by the respondents to be good indicators of effective communication strategies. (Refer to Figure 1.11 below)

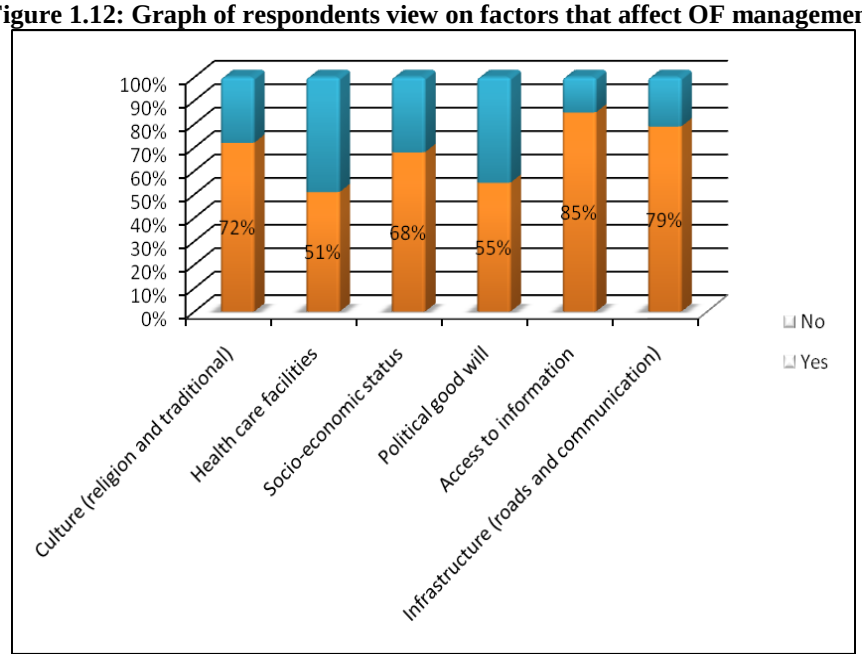
Figure 1.11: Graph of respondents view on the indicators of effective communication



Factors that affect OF management

The study also sought to find out factors that affect and should be considered in managing obstetric fistula. From the findings, the respondents agree at over 50% that the following factors greatly influence the effective management and mitigation of OF and should be highly considered when addressing OF. Culture both religious and traditional should be highly respected when addressing OF because of their delicate and sensitive nature. Access to information, policy and infrastructural development should be critically considered if OF management were to be successful. (Refer to Figure. 1.12 below)

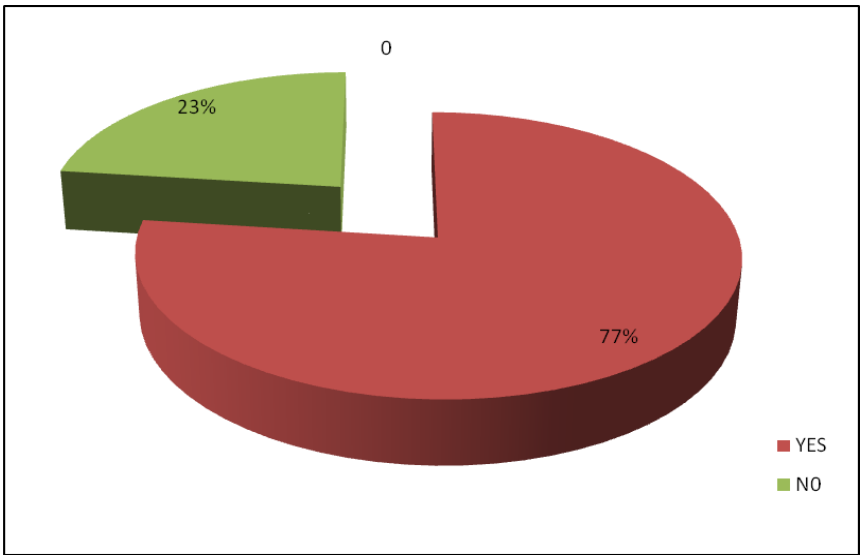
Figure 1.12: Graph of respondents view on factors that affect OF management



Effectiveness of C4D strategies in addressing OF

The study also sought to find out in general what the respondents views were on the communication for development strategies in addressing obstetric fistula. From the findings an overwhelming 77% of the respondents believed that communication for development strategies would be very effective in addressing OF. This study determined that strategic communication was the missing link in the quest to effectively mitigate obstetric fistula among the girls and women in Kenya. Lack of information and the low level of awareness (ignorance) on what OF was, causes, where to seek help and lack of proper infrastructural systemswere the major contributions to the increase of fistula cases and maternal deaths. (Refer to Figure 1.13)

Figure 1.13: Pie chart of the effectiveness of C4D in addressing OF



IV. Discussion of findings

The study revealed that maternal health practice remains a very critical factor to be considered when addressing obstetric fistula. These practices include ante-natal care visits during pregnancy and the making the decision to seek skilled care during child birth as a precursor to prevent obstetric fistula. The study also established that the knowledge about OF among the community members of Tiwi was very inadequate. Only 34% out of the 82 respondents indicated that they have heard about obstetric fistula. However all the health service providers interviewed indicated that they were aware of obstetric fistula.

This study also found out that the 53% of the respondents believed that OF was majorly caused by pregnancy and childbirth related complications such as prolonged labour, caesarian section or age of the mother. Other respondents however believed that obstetric fistula was caused by sorcery or a curse. These superstitions and cultural practices were determined to be further endangering the ability and right of a pregnant woman to seek skilled delivery services and expose them to risk of obstetric fistula.

According to the findings, majority of the respondents mentioned that the health care providers made efforts to educate and inform their clients on challenges related to maternal healthand the four delays that causes maternal morbidities including OF. However, it was established that these information were skewed towards the pregnant women – meaning the other community and family members, such as the spouses who played critical roles in decision making were left out.

The study also revealed that none of the health facilities had any IEC materials on OF and that accounted for the inability of the health service providers to effectively educate the community members about obstetric fistula, further compounding the poor levels of OF in the community. The study also established that mass media and group communication were the major channels of communication at 50% suggested by the respondents to be the most appropriate to disseminate IEC messages and activities on obstetric fistula.From the findings, 38% of the respondents, majority being women preferred the interpersonal communication to share, discuss and seek advice concerning maternal health, citing that it was more private as obstetric fistula was a taboo topic in that community.

This study also established the importance of factoring in culture, both religious and traditional, family and community members, political good was and the necessary infrastructural policies when attempting to address obstetric fistula. This is because all these factors affect and influence one way or the other the efficiency and effectiveness of a successful management and mitigation of obstetric fistula.

On determining the extent of development communicationusage on OF related issues, the study revealed that capacity development contributes to a very large extent towards the sensitization of OF among the community members,especially the women. interpersonal communication and individual learning also contribute a lot towards the development of OF among the women. Lack of information about OF causes and effects, need for personal learning, and collective social processes have to some extent been the major components of Behavior change communication focused on towards addressing OF among Kenyan women.

This study established that communication for development strategies are very fundamental and effective in increasing access to information through creating awareness, personal learning, behavior change, consensus building, stakeholders involvement and support, and making informed decisions in the process of addressing obstetric fistula

V. Conclusion

The Ministry of Health in Kenya needs to map out the extent of Obstetric Fistula in Kenya. Majority of the health services visited did not have statistics on women suffering from obstetric fistula. This is crucial because without these numbers, the government or other interested organizations cannot do a comprehensive job in addressing this health problem. According to the findings, the knowledge levels of the respondents about OF is very low, begging the need to do an extensive campaign to the raise awareness and sensitize Kenyans about obstetric fistula. This was go a long way in mitigating and managing obstetric fistula.The government should take the initiative to adequately inform and train the health service providers and the TBAs since they are the first in contact with the pregnant women before referrals are necessary.The government and other relevant stakeholders should organize advocacy and media campaigns to sensitize and raise awareness of the public on obstetric fistula, and educate fully on the causes, effects to avoid stigmatization of the victims, and support the reintegration of survivors in the community. The government should also ensure that the necessary infrastructural facilities are in place to reduce the risk of maternal morbidities such as obstetric fistula.

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