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SCHOOL OF PSYCHOLOGY

**ASSESSMENT OF THE ROLE OF COUNSELING SERVICE DURING
PRE AND POST TREATMENT OF FISTULA PATIENTS AT ADDIS
ABABA FISTULA HOSPITAL**

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Assessment of the Role of Counseling Service during Pre and Post
Treatment of Fistula Patients at Addis Ababa Fistula Hospital

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Acronyms

AAFH: Addis Ababa fistula Hospital

BDI: Beck depression inventory

DHS: Demographic health survey

DSM: Diagnostic and statistical manual of Mental Health

FGD: focus group discussion

HDS: Hamilton Depression Scale

HFE: Hamlin Fistula Ethiopia

IJGO: International journal of gynecology and obstetric

MOH: Ministry of Health

PSS: Post-traumatic stress disorder symptom scale

PTSD: post-traumatic stress disorder

RVF: Recto vaginal Fistula

SPSS: statistical package for social science research

UNFPA: United nation population fund

VVF: Vesico vaginal Fistula

Abstract

The study is meant to assess the role of counselling service during pre and post treatment of Fistula Patients at Addis Ababa Fistula Hospital. Exploring the effectiveness of counselling services is also another objective of the research. The researcher involved patients who came to Addis Ababa Fistula Hospital to get treatment and the service provider who serves as a counsellor at the Addis Ababa Fistula hospital as a study population. Mixed approach is used as a research design to gather the necessary data from forty sample patients who came for surgery during the data collection period. Data also collected from six available counsellors by administering structured questioners during the study period.

The quantitative data was analysed by using SPSS version 20 computer software. Tables and percentage presented in case of quantitative information and narration for the qualitative data collected with focus groups discussions. The result of this study shows that, the pre and post treatment counselling services undertaking at Addis Ababa Fistula hospital have a valuable contribution for the patients to cope their difficulties in relation to psychological health by helping them to decrease their level of depression symptoms and enhancing their self-esteem.

There is a good practice of counselling service which follows the standards of fistula counselling manuals with certain challenges. Although there are rooms for counselling it is not found that they are not convenient for counselling as they are not separated from hospital wards. There is also a lack of mechanisms to prevent burn out of counsellors and refreshment trainings which would possibly affect qualities of counselling given for the patients.

Finally based on the result and reviewed related literature, it is recommended that the counsellor's needs to be capacitated with intensive counselling trainings and the rooms should be organized in a conducive way for counselling. The Hospital should continue its effort in providing Holistic treatment by placing counselling unit. This unit would promote multicultural counselling approach to satisfy the needs of diversified patients who came from different regions of Ethiopia.

CHAPTER ONE

INTRODUCTION

1.1. Background

Pregnancy related complications are pervasive in the world's poorest regions. Early childbearing, frequent and high risk pregnancies hamper the health and well-being of reproductive aged women in developing countries. Estimate of maternal morbidity indicate that over 2 million women worldwide are suffering from obstetric fistula, the majority of which resides in Africa and south Asia (Abrams et al, 2012). Prevalence of obstetric Fistula estimated between 50,000 and 100,000 women sustain fistula during child birth around the world annually (Muleta et al, 2012).

“Obstetric fistula is one of the degrading and debilitating morbidities and yet entirely preventable. This condition results from obstetric labor, which is not relived in time by a cesarean section. Therefore, the prolonged pressure of the baby's head against the mother's pelvis cuts off blood supply to the tissues to necrotize and a hole to form, leaving the women inconsistent of urine, feces, or both” (Sunil &Sanga, 2009 p.110).

In Sub Saran Africa country such as Nigeria bears one of the greatest burdens of high prevalence of fistula with approximately 1 million of women living with the condition. Although the occurrence of obstetric fistula is preventable, it remained a major public health treat for money women in Ethiopia and other developing countries around the world. The incidence rate of obstetric fistula in counties with high maternal mortality could be high as 2 to 3 cases per women (Sunil &Sanga,2009).

In Ethiopia it is estimated that between 26,000 and 40,000 women's suffers from obstetric fistula (Muleta, et al, 2007). "Only about 50% of the general population in Ethiopia has access to primary health care services, and only about 7 % to 10% of all births are attended by skilled personnel. The median age at first marriage in Ethiopia is 16 years, and 31% of women are married by age 15. About 12% of the total fertility rate in Ethiopia derives from births to women aged between 15 and 19 years" (Muleta, et al, 2007 p 46).

Apart from socio economic consequences,not only does the problem of fistula affect the productivity of a country, community, and household, it also changes the life of the affected women forever. As cited by Muleta, 2012 Kelley describes the plight of social rejection around north Gondor when he suggested first treating the blindness of a blind patient with fistula, she replied:

"Cure my fistula first. If I am blind people will sit with me and talk to me, but no one will come near me because I am wet and I smell"

Women with fistula are no longer able to successfully fulfill their societal role of wife and mother, and are often deserted by husbands and family and stigmatized by society. As one qualitative study conducted in Pakistan (kohi Goth women hospital)the participant reported family members including husband and children do not like to spend time with them (Farid, et al, 2013).

Psychological and emotional consequence of fistula is more unbearable for the victims. Very few studies have examined the women's emotional and psychological status. "Women with obstetric fistula experience physical, psychological, religious, relationship, and financial challenges. These challenges adversely impacts on living status of women" (Farid, et al, 2013 p.829).Not only is that mourning a dead child. Almost inevitable for a woman with a fistula from obstructed labor, but she soon finds herself fighting for her own survival, social position, and value.

In a study conducted in Ethiopia, among the total of 218 women with fistula in North West Ethiopia who were tested with Beck Depression Inventory scale 97.0% of them had depressive symptoms (Zelege, et al, 2013).

Low self-esteem, feelings of rejection, depression, stress, anxiety, loss of libido and losses of sexual pleasure were commonly reported by fistula affected women. Three recent articles further document the presence of these problems in women with fistulas. In 2007 article on the health and social problems of women with fistulas in Ethiopia reported 69.2% of fistula victims were divorced. Depression has a high prevalence in patients with obstetric fistula as a result of isolation and divorce.

Fistula management and care need to be addressed through holistic approach since its impact is all rounded. “counseling should be seen as an opportunity for health providers to understand the socioeconomic, psychological and physical experiences that are faced by girls and women living with fistula, before and after surgery, so that they may give meaningful help”(Abrams et al,2010 p.14). Preliminary data gathered from the Hospital indicate that, Prevention, treatment, Rehabilitation and Reintegration is the three pillars of fistula management and care in Addis Ababa Fistula Hospital (HFE, 2014). Starting from pretreatment the patients who came to the hospital offered counseling services up to their discharge. Rehabilitation and reintegration is mainly concerned with the post treatment care of fistula patients including counseling services.

Thus this study tries to assess the role counseling service of at Addis Ababa Fistula Hospital. Identify the major challenges in delivering counseling services at the Hospital is also the purpose of this study by administrating mixed research approach and forward the possible recommendations depending on the outcome of the study.

1.2. Problem statement

Apart from the devastating maternal health problem, obstetric fistula severely affects the victim's psychological wellbeing. As Esegbona, et al (2012) indicates Psychological situation of the women's with fistula in her literature review that women experiences as a result of losing their status and value in the society, as well as the stigmatization which can cause many isolate themselves out of shame.

“Some women even contemplate suicide or express constant worry about their future, such as not being able to have more children, never being able to marry again, or never being repaired”(Esegbona, et al, 2012 p.194).

As cited by Ahmed and Holtz (2007), Islam and Begum conducted an extensive study on the psychosocial consequences of having a fistula in Bangladesh in 1992. A majority of women (61.4%) reported embarrassment in their social lives, 39.4% reported feeling constantly ill, and 33.3% reported difficulty in maintaining a sexual relationship. About 50% reported a significant decrease in libido; 59% a reduction in the frequency of coitus; and 45% a delay in experiencing orgasm. Moreover, 52% of the husbands expressed a loss in sexual pleasure with their wives. Regarding their social lives, 87% reported embarrassment; 67.4% an inability to perform their prayers; and 62% unhappiness in their married life. Dyspareunia was reported by 37.9% of the women. Another recent psychosocial study in Bangladesh suggests low self-esteem in women with fistulas, with many reporting depression and anxiety.

According to Wall LL cited by Fanta (2010), Women affected with obstetric fistulas are "the most dispossessed, outcast, powerless group of women in the world"(Wall LL, 1996 p.30).

Having a fistula changes a woman's quality of life forever. Only a few studies have examined the adverse social, economic, and psychological consequences of fistula; nonetheless, these studies provide some empirical evidence that treatment, counseling, social support, and rehabilitation may significantly improve the physical and mental health of affected women,

and provide these women with a second chance at participating in family life. However, the vast majority of the women with fistulas do not have access to medical care or to any social services (Ahmed & Holtz, 2007).

Inequity in health-care access is an underlying cause of maternal morbidity in general. Fistula tends to affect the most marginalized members of society: young, poor, illiterate women living in remote areas. Contributing factors for obstetric fistula include poverty, malnutrition, inadequate health systems, detrimental traditional practices, and lack of skilled attendants, limited access to emergency Caesareans, unequal gender relations, and the contributing factors of an often poor economic situation. It is important to note however, that fistula can affect all women, not only adolescents. The consequences of obstetric fistula are life shattering (Goitom, 2008).

Due to the odor and stigma associated with the condition many women live separately from or are rejected by spouse and relatives and are not seen in public or social gatherings. Arrow smith, 2007 study reported that in Ethiopia women suffering from such conditions leave their villages and migrate to city or monasteries (Goitom 2008).

A study conducted by Muleta, et al (2008) in rural Ethiopia Feelings of depression were reported by 36 of 39 untreated women, and six of 13 treated women reported these feelings to persist after treatment. Suicidal ideation was experienced in more than half of women with feelings of depression. Treatment decrease feelings of depression and suicidal ideation but did not eliminate it. Thus this study recommended that counseling and psychological assistance should be a major part of the treatment for women with obstetric fistula.

Counseling is necessary for reintegration to occur because of the psychological traumas women experience as a result of losing their status and value in society, as well as the stigmatization which can cause many to isolate themselves out of shame. For instance it has

been shown that as many as 97% of women screen positive for depression and anxiety that could lead to other forms of mental health dysfunction (Esegbona,2012).

Interventions should be done with counseling from the time the sufferer comes to seek help, through to when she returns to her community. The counseling will form part of a whole package of rehabilitation with ideally should start with the treatment but not end with it only by this approach can bring complete healing for those suffering with obstetric fistula (Mourad, et al, 2012).

After surgery, counseling also helps assess her level of reintegration in to her family and community as well as help to identify women who require additional assistance. This counseling probes whether they have regained normality in their life at home, which questions related to social interaction working ability, marital status, sexual intercourse, menstruation and sub subsequent pregnancies(Esegbona,2012).

Thus this study tries to assess the contribution of counseling services which is given at Addis Ababa Fistula hospital in helping the patients to promote their psychological conditions so as to help to reintegrate with their families and communities.

1.3. Research questions

1. How is pre and post treatment counseling provided at Addis Ababa Fistula Hospital? Did the counseling is conducted as per the standard?
2. What is the role of counseling for the patient in decreasing depression and PTSD faced by the victims of obstetric fistula?
3. How did the counseling services contribute to decrease client's aggressive behavior?
4. What are the common challenges in delivering counseling services among the counselors and the clients?

1.4. Objective

Over all this study is to assess counseling service in promoting psychological well-being of obstetric fistula patients during pre and post treatment period at Addis Ababa Fistula Hospital.

1.4.1. Specific objectives

- To explore the significance of counseling service in promoting the psychological well-being of the fistula patients through assessing post-traumatic stress disorder and depression among the clients during pre and post treatment period.
- To assess the effectiveness of counseling service in ensuring psychological well-being for women suffering from obstetric fistula injury at Addis Ababa Fistula Hospital.

1.5 . Delimitation of the study

The scope of this study did not include other health institution which provides fistulatreatment. It is limited to the experience of forty patients at Addis Ababa Fistula Hospital. Also this study mainly focuses on the impact of counseling service in relation to depression symptoms and PTSD among the subjects.

1.6. Limitations of the study

In conducting this study, the sample was drawn from the available patients during data collection period. For this reason making generalization is difficult about the diversified obstetric Fistula patients. Socio cultural diversity of the patients could also be the limitation of the study. Such as language barriers in understanding the patients with full context.

1.7. Operational definitions

Counseling services: refers to the overall approach, strategies and the steps to follow used in delivering counseling service for the client in the hospital.

Client: a fistula patient who specifically seek counseling services on voluntary or referral bases.

Pre-treatment counseling: refers to the overall emotional care given for the client including psycho social need assessment, provision of information about the treatment options and potential out comes, side effects, complications and risks.

Post-treatment counseling: refers to the counseling services in relation to post-operative care pain management, future family planning needs including In cases where surgery was not successful, based on the client's condition, counseling related to reintegration: why the surgery failed; possible future procedures and options; complications and/or infections; personal hygiene and nutrition; management of incontinence; and the need to delay pregnancy until after a future procedure.

Psychological conditions: refers to the patients experience in relation to post traumatic stress disorder and depression

CHAPTER TWO

LITRATURE REVIEW

2.1.Overview

About 800 women die from pregnancy or childbirth-related complications around the world every day. For every woman who dies of maternal related causes, it is estimated that at least 20 women experience a maternal morbidity, one of the most severe forms of which is obstetric fistula. Generally accepted estimates suggest that 2-3.5 million women live with obstetric fistula in the developing world, and between 50,000 and 100,000 new cases develop each year. All but eliminated from the developed world, obstetric fistula continues to affect the poorest of the poor: women and girls living in some of the most resource-starved remote regions in the world (UNFPA, 2007).

2.2 The concept of obstetric Fistula

Obstetric fistula is a childbirth injury that has been largely neglected, despite the devastating impact it has on the lives of affected girls and women. It is usually caused by prolonged, obstructed labour, without timely medical intervention typically an emergency Caesarean section. During unassisted, prolonged, obstructed labour, the sustained pressure of the baby's head on the mother's pelvic bone damages soft tissues, creating a hole or fistula between the vagina and the bladder and/or rectum. The pressure deprives blood flow to the tissue, leading to necrosis. Eventually, the dead tissue comes away, leaving a fistula, which causes a constant leaking of urine and/or feces through the vagina (UNFPA, 2012).

2.3.Types of Obstetric Fistula

Vesico-vaginal Fistula (VVF)

VVF occurs when the blood supply to the tissues of the vagina and the bladder is restricted during prolonged obstructed labor, the tissues die between these organs, forming holes

through which urine can pass uncontrollably. VVF is also sometimes referred to in the literature as Vesico-vaginal Fistula and Vesico Vaginal Fistula.

Recto-vaginal Fistula (RVF)

RVF occurs in a similar way to VVF however, holes form between the tissues of the vagina and rectum, leading to uncontrollable leakage of feces. RVF is also sometimes referred to as Recto-vaginal Fistula and Recto Vaginal Fistula.

Urethra and uretero-vaginal Fistula are defects connecting the vaginal canal with the ureter respectively

Vasico-uterine and vesico-cervical Fistula: connects the bladder to the uterine cavity and cervical canal respectively and urine passes through the cervical os and vagina.

VVF and RVF fistulas are common worldwide compare to other fistula cases while RVF alone less common (muleta, et al., 2010).

2.4.Psychosocial impact of Obstetric Fistula

Psychological trauma, deteriorating health, increasing poverty, and social stigmatization by family and friends can and often do occur. As Mourad, et al, (2012) describes the psychosocial impact of fistula in relation to family relationship, urinary and fecal incontinence can lead to such disability and dependency that family or home care givers have difficulty coping and responding increased demands. Health deterioration of primary care giver and impaired interpersonal relationships are common.

Sufferers may give up or restrict certain house hold chores, churches or holy places attendance, shopping or entertainment events. Spousal relationships also appear to be most

impaired, perhaps because of an additional adverse effect on sexual relationships. Even incontinent home bound women, have significantly fewer social interactions, particularly with family members (Mourad, et al,2012).

2.5. Psychological impact of fistula

“Women with urinary or fecal incontinence show depression, anxiety and abnormal level of situational life stresses. It is likely that psychological changes are related to the symptom and related disability and distress than to specific urogynecologic conditions. Feeling of insecurity, anger, apathy, dependence, guilty, indignity, feeling of abandonment, shame, embracement, depression and denial are also common. Women feel loss of self-confidence and self-esteem (Mourad, et al, 2012, p.164)”.

Apart from the family relationship which is characterized by the economic worries burdens of care giving and emotional distress, sexual life of the victim also became difficult. Spousal relationships appear to be most impaired, perhaps because of an additional adverse effect on sexual relationships. “The close anatomic proximity of the bladder, urethra, and rectum with the vagina allows for an association between lower urinary tract or anorectal dysfunction and sexual difficulties. The effect can be bidirectional; sexual activity can cause or aggravate bladder or anorectic problems, and bladder or anorectal problems can leads to sexual dysfunction. Urinary symptoms may be a direct cause of sexual difficulties, where none previously existed (Mourad, 2012, p.165)”.

The cross sectional study was conducted in North West Ethiopia to determine the prevalence of depression among obstetric fistula patients outpatient clinic of Gondar university referral hospital 67.7% of women obstetric fistula had symptoms of depression (Megabiawet .al, 2013). Authors of this study strongly recommended that the need for supportive counseling for the patients with obstetric fistula.

Social situation in relation to marital issues is another burden for fistula patients and their families for example in a Nigerian study of 31 fistula patients, the divorce rate, even after repair was 55%; 87% of these women had a stillbirth (Mourad, 2012). Another study conducted by Kelly in Ethiopia Addis Ababa fistula hospital showed that previously married women with fistula repairs among 79 women's 59 of them are divorced and 19 of them are abandoned by their husband (Mourad, et al, 2012).

Another study also indicate that the need for counseling To facilitate the social reintegration of fistula patients, individual level counseling on clinical, psychological social and economic issues is vital (Esegbona and Mehammed, 2012).

2.6. Situation of obstetric fistula in Ethiopia

The study conducted by Muleta (1997) who was fistula surgeon at the Addis Ababa fistula hospital, the main etiological factors contributing to the existence of fistula is the absence of health care facilities and lack of available transport for patients. As it is indicated in an extensive case studies conducted by the Addis Ababa Fistula hospital the women who have these injury are young, illiterate and of a lower socioeconomic back ground and almost half of the women in the study were divorced as a direct result of their inconsistency (Giotom, 2007).

As Fanta cited in her study conducted in 2010 at Addis Ababa Fistula hospital, women affected by obstetric fistula are often abandoned by their husband, stigmatized by their community, physically debilitated and even blamed for their condition. Social isolation and abandonment often lead to low self-esteem, depression and prolonged emotional trauma (Wall, 2006). Regarding early marriage, as Fanta (2010) cited, a study conducted on fistula patients admitted to the AAFH between May 1999 and February 2000 indicated that 83% of those who were married at average age of 15 had fistula at delivery before they reached the age of 20.

An effective fistula treatment should be comprised of healing the wound and accompanied by psychosocial therapies to assist women in regaining their self-esteem and to facilitate possible socio-economic reintegration (Wall, 2006). Fanta (2010) indicate in her study Obstetric fistula victims are prone to worsened poverty, economic dependence on relatives or family members and deep social stigma that is likely to drive them towards depression.

Obstetric fistula is one of the most neglected issues in the field of women's health and rights (Engender health, 2006).The victims are mostly unaware of the existence of the fistula treatment hospital due to their extreme isolation from society and hence a lack of access to information. If a woman is aware of the hospital services, she is then likely to lack transportation to the facility or the resources to obtain transportation. The practical policy interventions sought by the government of Ethiopia seem to be over shadowed by other more prevalent and therefore priority maternal health issues. Nonetheless, the AAFH (with its subsidiary mini hospitals) is the only center delivering free treatment and post treatment rehabilitation including psychosocial therapy and skills training to victims despite the magnitude of the complication(Fanta, 2010).

2.7.The role ofcounselingin medical settings

As Karademas, et al (2007) cited counseling As a developmentally based specialty that emphasizes building on person's strengths, treating persons with respect and care, taking into consideration and incorporating environmental factors and resources, using psycho-education in treatment, employing the bio psychosocial model for understanding health and managing health problems, and being familiar with interdisciplinary collaboration, counseling psychology can significantly contribute in health-related applications.

Counselors has significant role in medical settings in identifying psychological need of the patients with necessary interventions "As experts in human behavior, counseling psychologists can assume a diversityof roles within health care services. They may evaluate

and assess the psychological functioning of the patients; act as advisors for the treatment team; provide training; organize and implement research projects; provide counseling or other types of psychosocial interventions to the patients and their families” (Evangelos C. and Karademas,2009 P.20).

Counselors are expected to perform the assessment which is related to psychological conditions of the patients in order to assist the medical team by providing the necessary information about the patient’s cognitive, emotional as well as behavioral status. Knowing such assessment results would affect the treatment process but the need and result of the assessment would not be paid attention by medical personals. As layered asserts that “Medical staff is rarely ready to identify and, of course, address psychological difficulties (Layard, 2005). Therefore, the role of the psychologist in assessing and addressing psychosocial problems, as well as in alleviating the frustration that medical personnel often feels when dealing with such problems, is crucial and in favor of both patients and staff” (Evangelos C. &Karademas, 2009 p. 20).

Apart from the assessment and need identification, Counselors have critical input in providing counseling for the patients in different condition of their hospital stay starting from pretreatment up to discharge.

According to Bennett (2000), and Belar&Deardorff (1995),“a psychologist can offer substantial help at every level of the patients functioning. Physical level (e.g., pain and other symptoms management, reduction in psychophysiological arousal), emotional level (e.g., stress management, dealing with symptoms of depression and anxiety), cognitive (e.g., provide information, help in changing dysfunctional thoughts), and behavioral (e.g., modification of maladaptive behaviors, increase adherence to medical therapy)” (Evangelos C.&Karademas, 2009 P.20).

2.8.Theoretical models

For the purpose of this study Bio Psychosocial health care model is selected to rich to the necessary theoretical articulation. As this model follows the major themes of definition of health “Health is a state of well-being with physical, cultural, psychosocial, economic and spiritual aspects, not simply the absence of illness”(Marks et al, 2010 p. 6)

I use the Bio psychosocial model to interpret the findings of this study as well as to conceptualize discussion of the results of the research.

2.8.1. The Bio Psychosocial Model

The bio psychosocial approach systematically considers biological, psychological, and social factors and their complex interactions in understanding health, illness, and health care delivery. It is a new integrated approach to human behavior and disease as compared to Biomedical model which is based on pure scientific aspects of medicine (Dogar, 2007).

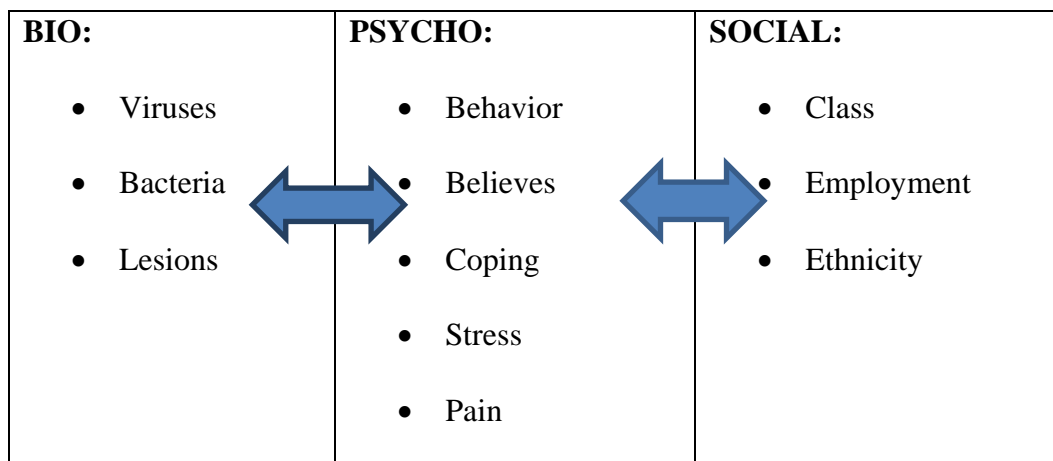
In 1977 Engel stressed an integrated approach to human behaviour and disease, the biopsycosical model as a responses to biomedical model (Dogar, 2007).

“Biological psychological and social factors influence the prevention cause and presentation management and out come of the disease” (Dogar, 2007 p 11). Engles postulate that each system affects and is a direct result of psychological and sociocultural make up but rather promotes a more comprehansive understanding of the disease and treatment.

Life style and health related behaviour have imoportant role in many condition according to Biopsyco social model. For instanace,as samuel (2007), cited that this model looks at health and illness as a combination of a varity of contributing factors such as lifestyle factors,behaviour,family relation ship,social support and genetic predispostion (lopez and jones,2006; Suls and Rothman,2004). For example, in case of fistula tretment counseling have a great role in assesing a paitents life style and related behaviour which indirectly contributes to ocurrence of obstetric fistula among the victims.The avaiability of social

services such as availability and accesability of health Institution which provieds the ceserian insection services durng the time of laboure could be a determinant factor for the ocuurence of Obstetric fistula among the victim. This showes how the health and illness are interrelated with one of the components of bio psyco social model.The following Figure, 1 demonastrates the interaction between the three core components of this model.

Figure 1. Bio Psycho social model of health and illness



Source:(Engel 1977, 1980) cited by, Ogden, 2004 Health psychology a test book published in 2004: p 6.

As cited by Samuel (2007), this model as its name implies, it's fundamental assumption is that health and illness are consequences of the interplay of biological, psychological, and social factors.

Bio psycho social model asserts that to understand the patients need there has to be Holistic approach which includes assessing all rounded psychosocial as well as Biological cause of certain illness.

2.8.2.The Bio Medical model

The Biomedical model assumes that psychological and social processes are largely irrelevant to the disease process. Although the biomedical model has undeniable benefits for studying some diseases, it has several potential liabilities. First, it is a reductionist model. That is, it reduces illness to low-level processes, such as disordered cells and chemical imbalances, rather than recognizing the role of more general social and psychological processes. Second, the biomedical model is essentially a single-factor model. That is, it explains illness in terms of a biological malfunction rather than recognizing that a variety of factors, only some of which are biological, may be responsible for the development of illness. Third, the biomedical model implicitly assumes a mind-body dualism, maintaining that mind and body are separate entities (Ogden, 2004).

Finally, Ogden (2004) summarizes limitations of the biomedical model clearly emphasizes illness over health. That is, it focuses on aberrations that lead to illness rather than on the conditions that might promote health. Thus, the shortcomings of the biomedical model are several. First, it has difficulty accounting for why a particular set of somatic conditions need not inevitably lead to illness. Why, for example, if six people are exposed to measles, do only three develop the disease? There are psychological and social factors that influence the development of illness, and these are ignored by the biomedical model. Whether a treatment will cure a disease is also substantially affected by psychological and social factors, and this cannot be explained by the biomedical model. As a consequence, researchers and practitioners have increasingly adopted the biopsychosocial model.

Figure. 2 Biomedical vs. Bio psychosocial model of Health and Illness

Questions	Biomedical model	Biopsycosocial model
<ul style="list-style-type: none"> • what causes illness? • Who is responsible for illness? • Who is responsible for treatment? • What is the relationship between health and illness? • What is the relationship between the mind and the body? • What is the role of psychology in health and illness? 	<ul style="list-style-type: none"> • Diseases come from outside the body, invade the body and cause physical changes within the body, or originate as internal involuntary physical changes. • Individuals are not seen as responsible for their illness. They are regarded as victims of some external force causing internal changes. • medical profession • Health and illness are seen as qualitatively different. • The mind and body function independently of each other. • Illness may have psychological consequences, but not psychological causes. 	<ul style="list-style-type: none"> • Individual is no longer simply seen as a passive victim. They may be held responsible for their health and illness. • Because the whole person is treated, not just their physical illness, the patient is therefore in part responsible for their treatment. • Health and illness are not qualitatively different, but exist on a continuum. • The mind and body interact. • Psychological factors not only as possible consequences of illness but as contributing to its a etiology. there is has a direct and indirect association between psychology and health

Source: Adopted from Ogden, 2004:Health psychology: text book third edition (p. 3, 5)

2.9. Psychosocial interventions of fistula care

Many studies suggested that psychological factors associated with urinary or fecal incontinence can be modified with therapy. Interventions to address the problem of fistula have to be one with holistic approach to include treatment rehabilitation and follow up in the community (mourad, 2012).

Mourad, also recommended the following steps

- Counseling (peer and professional), surgical treatment and appropriate pre and post-surgery nursing care.
- Residential rehabilitation where activities are coordinated and managed, to educate and train women on income generating skills
- Physical and psychological rehabilitation at the center and subsequent reintegration of women in to their communities, with 13 months follow up and monitoring of re – assimilation. This will ensure they create links with other women like themselves in an atmosphere of support and learning. The issues of the VVF are put in a structure of health, reproductive and sexual health and rights so that they understand what and how the VVF occurred and what to do in order to prevent it from happening again.

As cited by Esegbona (2012) in some women psychological dysfunction continues despite repair because of their reintegration experience may be impacted negatively, secondary to the degree of isolation and stigmatization experienced while living with fistula. This is in line with this study indicating that women who were repaired struggled with emotional distress such as losing their child during the pregnancy. Even a study which highlighted the improved quality of life and social reintegration after fistula disclosure found that one third of the women manifested ongoing distress on follow up.

Several reintegration programs offer counseling to aid women in defining their major problems.

As cited by Esegbona, (2012) Counseling is considered important to a woman's ultimate reintegration as it insures the dispelling of any myths and the minimization of behaviors' such as inappropriate and delayed treatment which may make recurrence more likely. For instance, there have been reports of women blaming their preexisting vaginal stenosis on the surgeon and the fistula repair a situation which is avoided by adequate counseling about the nature of the initial injury. And in several studies a diverse range of perceptions and misconceptions on the origins of fistula were cited by women with fistula and their families believed their condition was caused by factors related to delivery process itself.

One study developed by Engender health, evaluated the instant impact of the counseling. Women were interviewed both before pre-operative and again after post-operative counseling to assess their knowledge about fistula, self-esteem and their behavioral intentions for health maintenance and social reintegration following surgical repair. In addition, two focus groups were conducted with a total of 19 patients assessing their experiences with the surgical care and counseling. Data from the questionnaires revealed significant improvements in women's knowledge about the cause of fistula, fistula prevention, self-esteem and behavioral intentions following counseling. Focuses group data also suggested increased knowledge and self-esteem and behavioral intentions following counseling(Engender Health, 2012).

Biosocial implications of fistula are immense for women. Being married and to have children is important conditions for the women to define them self's as a women in their community.

Esegbona(2012) cited a number of studies point to the problems women may face reintegrating in to their local communities because of vaginal injuries that make intercourse painful, unpleasant or impossible such that their marriages are affected. For instance in Ethiopia when the sexual life of the women was inquired about in in-depth interviews, some sated that their sexual life was the major reason why they were separated from their

husbands. Out of 30 women 29 stopped sexual relations after the fistula occurred and moved in to their patient's house until they recovered (Girma Y, 2008).

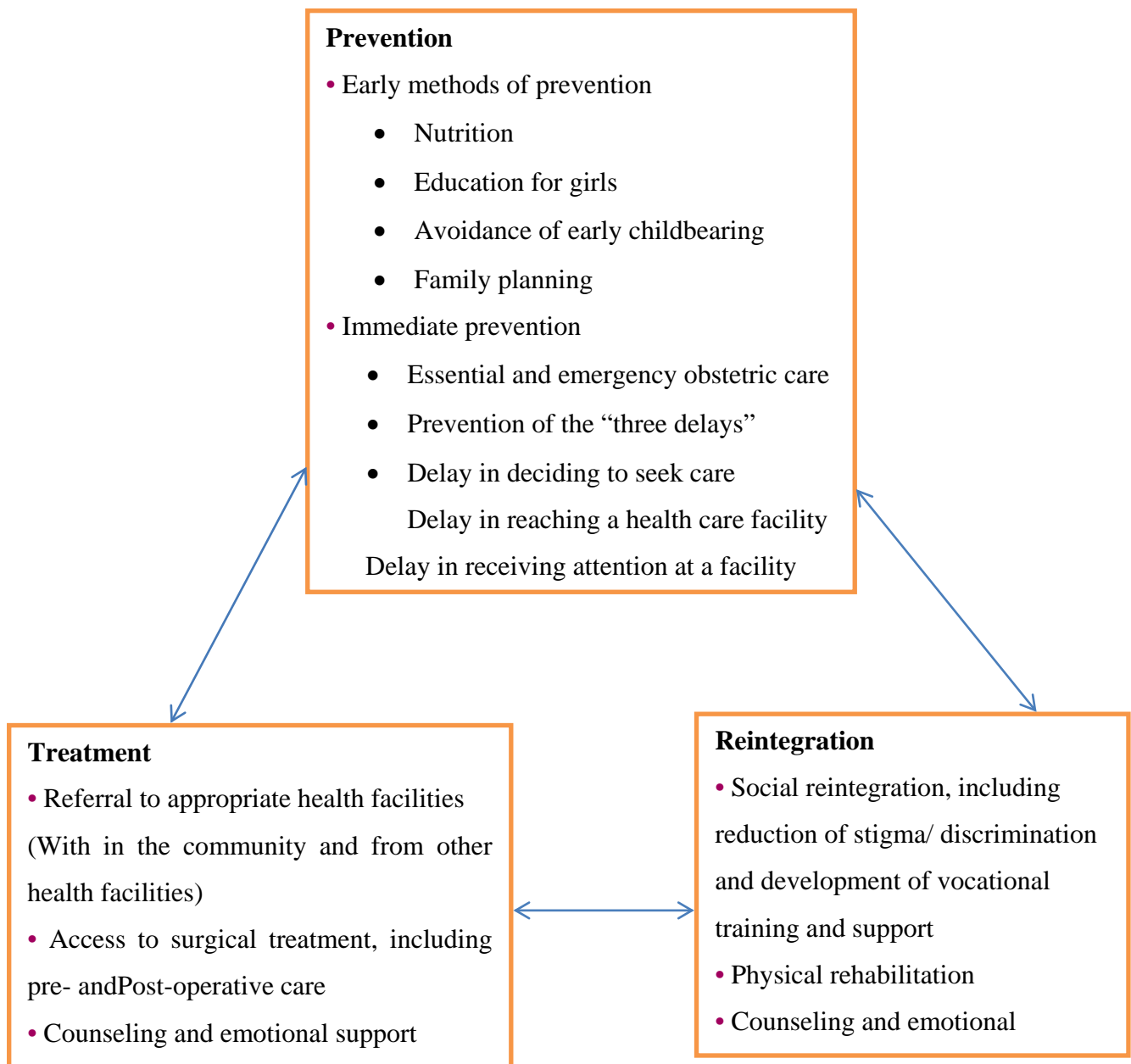
2.10. Components of fistula care

Counseling is an integral part of comprehensive obstetric fistula care services and is one set of functions conducted by nurses, midwives, and physicians providing care. Counseling is defined as a two-way communication process of helping clients make informed and voluntary decisions about their individual care. Counseling mainly involves a one-to-one interaction between the client and the provider, although it may also include the client's partner or another support person whom the client has requested to be present (Engender health, 2012).

There are three components of fistula care Prevention, Treatment, and Reintegration; According to the counseling manual for fistula patients developed by Engender health (2012), each of these components has a unique set of core counseling competencies involving individual and couple counseling and group education (with family members, community members, and other women living with fistula).

Surgery may reverse psychological dysfunction and go a long way in bringing about a return to community and a normal lifestyle. However, counseling is still thought to be essential for women with fistula as it enables their medical and social evaluation to ensure their needs are met (Esegbona, 2012).

Figure.3. Three comprehensive care of fistula management



Source: Engender health, 2012: counseling obstetric fistula, a training manualp.13

2.11. Steps of counseling

Preoperative Counseling

- Assess client's ability to give and receive information, and explore client's needs and feelings
- Provide information on the initial assessment, possible treatment options, potential outcomes, and possible side effects, complications, and risks
- Link client with a social support group and/or resources within the facility
- Maintain emotional support through verbal/nonverbal communication, using techniques to minimize fear and anxiety
- Provide information on client's expected postoperative role in self-care, catheter care, mobility, nutrition, pain management, complications/danger signs, physiotherapy, period of sexualabstinence, future childbearing, family planning needs, and need for close antenatal care and cesarean delivery with subsequent pregnancy(ies)

Intraoperative Counseling

- Protect client's privacy, and ensure respect and dignity
- Provide reassurance and comfort before administration of anesthesia
- Provide information about the anesthesia to be used, its risks, and the management of pain

Postoperative Counseling

- Maintain emotional support and monitor pain management needs during the immediate recovery period
- Provide information as indicated related to outcome of surgery, self-care, catheter care, mobility, nutrition, pain management, complications/danger signs, physiotherapy, period of sexual abstinence, future childbearing, family planning

needs, need for close antenatal care, and need for cesarean delivery with subsequent pregnancy(ies)

- Engage partners and/or others influencing decision making in the family about client's recovery needs, about the need for rest, follow-up at the facility, sexual abstinence, and use of family planning for delay of desired pregnancy until healing is complete, and about support for the client to receive close antenatal care and cesarean delivery with subsequent pregnancies)

Discharge Counseling

- Assess client's feelings, questions, concerns regarding the recovery phase and the future
- Provide discharge information according to postoperative management plan, and information on sexual abstinence, delaying pregnancy, and management of stress incontinence
- Provide follow-up date(s)
- Assess additional psychosocial needs, link client with additional counseling services or referral for additional services, and link client with community organizations that support women with fistula repair
- Counseling on Physical Therapy/Physiotherapy
- Explore client's feelings about her physiotherapy progress and progress to independence

Counseling on Community/Family Reentry

- Explore client's feelings about her acceptance and functioning within the family and/or community
- Link client with community and/or social services that address her changing needs

Counseling on Livelihood

- Link client with skills-building for income-generation opportunities and management of herResources

Source: Engender health, 2012: counseling obstetric fistula, a training manual p. 2, 3

CHAPTER THREE

METHODS

3.1. Research design

The researcher use mixed approach as a research design in order to get better result to meet the study objectives. Since the participants patents are homogenous in their socio demographic status for example, the patients are mainly characterized by low level of educational status, the researcher uses focus group discussion to get better information on their experience in relation to the hospital counseling service.

3.2. Local (study site)

The study conducted at Addis Ababa Fistula hospital. The Hospital is found in Addis Ababa administrative city in Lideta sub-city. The Hospital gives free treatment for women who suffer from child birth injury. And the hospital provides counseling services with permanent psychiatry, Nurses and hospital Chaplin who is responsible for spiritual counseling. The study was conducted from September/2014 up to April /2015.

The Addis Ababa Fistula Hospital was co-founded by Drs. Reginald and Catherine Hamlin in 1974 to treat women suffering from obstetric fistula. This childbirth injury is caused by prolonged and unrelieved obstructed labour and causes incontinent if left untreated.

The Hamlins come to Ethiopia from Australia in 1959 to set up a midwifery college on a three year contract with the Ethiopian government. However they soon discovered the plight of the fistula patients and dedicated their lives to this work. Today, the Addis Ababa Fistula Hospital and its five regional centers in Bahr Dar, mekelle, yirgalem, Harar and Metu have the capacity to treat more than 3000 women a year (HFE, 2014).

Hamlin Fistula Ethiopia is a center of excellence, the annual report says providing surgical procedures with a 95% successful closure rate. “Desta Mender” joy village is Hamlin fistula Ethiopia’s rehabilitation and reintegration center for patients who will have to stay to close to the hospital due to their ongoing medical care and management. Here the residents learn micro business skills including farming hospitality and life skills as well as literacy and numeracy and occupational therapy (HFE, 2014).

3.3. Population

The populations of this study were the patients who came from different regions of the country to get treatment from AAFH during the study period from January 15 to march 31, 2015. The staffs of the hospital who serves as a counselor, is also another participant of the study.

3.4. Participants (sample)

The participants are 40 clients who came to the hospital to get surgery during data collection period (January, 15 2015 to march, 31 2015). The patients who come for follow up and other treatment services were excluded from the sample. The six staffs that serves as a counselor are also the participant of this research were the researcher used the available staffs during the data collection time.

3.5. Tools

3.5.1 Questionnaires

In order to gather important information from the representative sample, the researcher used structured questionnaires with available counselor at a time of data collection. In order to measure depression level of the Fistula patient’s, the latest version - Beck Depression Inventory - II (BDI - II) was used. The BDI - II is a self-report analysis of depressive symptoms or an instrument for measuring the severity of depression in adolescents 13 years of age and up, as well as adults. This version of the test is specifically designed to address

DSM - IV criteria for depression not included in the two previous versions. The test contains 21 items designed in the form of a multiple - choice questionnaire where each question is accompanied by four answers to choose from, most of which assess depressive symptoms on a Likert scale of 0 - 3. All answers are given a rating starting from zero progressing to three depending upon the nature and intensity of the depressive symptoms.

Beck Depression Scale or BDI - II has been found to be extremely efficient in assessing and evaluating the severity of depression in people since it covers both the emotional and physiological aspects of depression. Therefore, the subject matter contained in BDI - II is representative of clinical depression in its entirety and is in concurrence with other scales like the Hamilton Depression Scale (HDS).

Reliability

Several types of reliability can be demonstrated with BDI - II, in terms of the internal consistency and stability of the instrument.

Test - Retest Reliability

A one week test - retest correlation of .93 resulted from a study of 26 outpatients who had been referred for depression and took the BDI - II during their first and second therapy sessions. This would lend support to the BDI - II being a measure for one construct, depression.

Internal Consistency

In a study with both white Mexican - American subjects, an internal consistency coefficient of .80 was computed for the BDI - IA. No significant differences were found between participants from the two cultural backgrounds therefore supporting the test's reliability across ethnic groups and aging populations (Ames, Gate wood - Cole well and Kacz Mark,

1989). The BDI - II yields a coefficient alpha of .92 for the outpatient population (n = 500). The coefficient alpha for the college students (n=120) in the sample was .93

Source: www.realdepressionhelp.com/beck.

Validity

Concurrent Validity

BDI-II total scores have been correlated with scores on other psychological tests. Beck et al, (1996) found the BDI - II is positively related to the scale for Suicide Ideation ($r = .37$, $n = 158$) as well as the Beck Hopelessness Scale ($r = .68$, $n = 158$). The BDI - II was also positively correlated with the Hamilton Psychiatric rating scale for Depression ($r = .71$, $n = 87$) and the Hamilton Rating Scale for Anxiety ($r = .47$, $n = 87$) this would lend support for the convergent validity of the BDI – II

Source: www.realdepressionhelp.com/beck.

Discriminate Validity

The diagnostic efficiency of the BDI - II as a tool studied. It is found that a diagnostic efficiency study using a clinical college sample of 127 students yielded a 93% true positive rate and 18% false positive rate. Therefore, the BDI - II could be considered useful as a diagnostic tool and for screening individuals who may be in need to counseling.

Construct Validity

Psychometrically, studies of the BDI - II indicate excellent internal consistency and one - week test - retest reliability on clinical samples, as well as substantial diagnostic efficiency and correlations with other tests purporting to measure the construct of depression

Source: www.cps.nova.edu/~epphelp/BDI.html.

Scoring

- Scores between 0 and 13 are indicative of people experiencing minimum symptoms of depression.
- Scores between 14 and 19 are indicative of people experiencing minor symptoms of depression.
- Scores between 20 and 28 are indicative of people experiencing average levels of symptoms of depression.
- Scores between 29 and 63 are indicative of people experiencing major or severe form of depression.

Source: www.cps.nova.edu/~epphelp/BDI.html.

To identify the level of PTSD among the participant patients, PTSD Symptom Scale was used. PTSD Symptom Scale a self-report measure designed to assess the severity of post-traumatic stress disorder among children and adolescents, ages 8 to 18. The measure has a total of 24 items and includes two parts; the first has 17 items and measures the type and frequency of PTSD symptoms (mapping directly on to DSM-IV criteria), while the second has 7 items and measures the degree of functional impairment these symptoms cause (Foa, et al, 2001).

Scoring

Higher scores indicating more severe symptoms, a clinical cutoff of 15 or greater is appropriate for diagnosing PTSD. Scores for the functional impairment items (the last 7 questions) are scored dichotomously as absent (0) or present (1). Scores range from 0 to 7, with higher scores indicating greater functional impairment.

A total score for the 17 items corresponding to the DSM-IV criteria is rated on a scale from 0 to 3 (0=not at all; 1= once a week or less/once in a while; 2=2 to 4 times a week/half the time;

and 3=5 or more times a week/almost always). Therefore, the range of the total score is 0 - 51. Higher scores indicating more severe symptoms. A clinical cutoff of 15 or greater is appropriate for diagnosing PTSD.

Scores for the functional impairment items (the last 7 questions) are scored dichotomously as absent (0) or present (1). Scores range from 0 - 7, with higher scores, indicating greater functional impairment.

Validity and reliability

This measure shows strong preliminary psychometric properties (Hawkins & Radcliffe, 2006); a 2001 study (Foa, Johnson, Feeny, & Treadwell, 2001) found the tool to have strong internal consistency/reliability (Cronbach's $\alpha = .70 - .89$ for the total and subscales symptom scores) and good-to-excellent test-retest reliability (.84 for the total score, .85 for re-experiencing, .63 for avoidance and .76 for hyperarousal). Convergent and internal validity was also high.

3.5.2. Focus Group Discussion

To present the data from focus group discussions I used the tape-based analysis since Focus group results produce large amounts of data, this type of analysis is helpful because the researcher can focus on the research question and only transcribe the portions that assist in better understanding of the phenomenon of interest (Anthony J, et al, 2009).

The focus group discussions were conducted during post treatment period while the patients are on their rehabilitation. Two focus groups were conducted 10 participants of each group to substantiate the data which is collected quantitatively with administration of standardized tests. Both groups were homogenous in language.

The discussions were conducted by the researcher with guiding FGD questions designed to explore the experience of clients during post treatment counseling. Discussions were audio taped with the consent of the participant. The records were transcribed verbatim and translated in to English. After that thematic analysis was conducted.

3.6. Procedures

3.6.1. Validation

The pretest was conducted before the actual study without involving the sample population. This helped the researcher to check the validity of the questions to be asked.

3.6.2. Analysis

After data once collected the quantitative data was analyzed with latest version 20 SPSS computer software. Qualitative data was also transcribed from the tape recorder coded and categorized each questions. After this, thematic contents also formulated based on the research questions and presented by narratives.

3.7. Ethical considerations

Throughout the research process, the issue of individual's anonymity and confidentiality is considered to ensure that the respondents are comfortable in providing relevant responses. Accordingly, the researcher introduced the purpose of the study to the respondents. The respondents were informed that they can skip any question that they do not want to answer fully or partially and may also quit the interview process at any time and that their participation is voluntary. After assuring the confidential nature of respondents and obtaining informed consent from the respondents.

CHAPTER FOUR

FINDING AND DISCUSSION

4.1. Finding

This chapter deals with the analysis and finding of the collected data. It is presented in three parts. The first part presents the quantitative data which is collected from the participant clients. The second part illustrate the data gathered from the staffs of the hospital who serves as a counselor and the third part present the findings from focus group discussions with the participant clients. Discussion also incorporated in this chapter by interpreting the major findings from the data collected form the test results, questioners and focus group discussions with comparing the results of the study with the reviewed literature.

Part 1: participant client socio demographic profile, level of depression and PTSD

Table 4.1.Socio demographic profile of the clients

Age		
	Frequency	Percent
Under 18	40	100.0
Marital Status		
Married	5	12.5
Divorced	30	75.0
Single	3	7.5
Widowed	2	5.0
Total	40	100.0
Educational Status		
Illiterate	35	87.5
Basic education	4	10.0
Primary education	1	2.5
Total	40	100.0

Table 4.1 shows that all the respondents are under the age of 18 and majority of the subjects are divorced, which is 75 %. Only 12.5% is married and 5% is widowed while 7.5% is single. Regarding educational status, majority of the respondents cannot read and write, which is 87.5% and only 10% have basic education out of which 2.5% get primary education.

Table 4.2 Economic status of the clients

	Frequency	Percent
agriculture	34	85.0
petty tread	5	12.5
other	1	2.5
Total	40	100.0

Table 4.2 indicates that the livelihood of most of the respondents (85%) is agriculture. This implicate the fact that majority of the patients are from the rural Ethiopia. The rest 12.5% and 2.5 % engaged in petty tread and other activities respectively.

Table 4.3 Status of the clients in relation to occurrence of still birth

	Frequency	Percent
Yes	39	97.5
No	1	2.5
Total	40	100.0

Regarding their status of still birth which is the result of obstetric labor, 97.5% experienced stillbirth while only 2.5% did not.

Table 4.4 Depression score during pre-treatment

	Frequency	Percent
Minimum symptom	1	2.5
minor symptom	1	2.5
average symptom	6	15.0
sever symptom	32	80.0
Total	40	100.0

During the pretreatment period, 80% of the subjects have showed sever symptoms of depression level were the rest 15% have average symptom and 2.5% have minor, and 2.5% of them with minimum of level of depression (Table 4.4).

Table 4.5 Depression score during post treatment

	Frequency	Percent
minimum symptom	36	90.0
severe symptom	3	7.5
Total	39	97.5
Missing	1	2.5
Total	40	100.0

Becks depression test also administered for the participants after their treatment. As Table 4.5 indicates, depression symptoms decrease among the subjects with 90.0% of them have minimum level and 7.5% have severe symptoms of depression with 2.5 % of the respondent did not take the test after their treatment because of surgery complication during the data collection period.

Table 4.6 PTSD score during pre-treatment (part one of the scale)

Scores	Frequency	Percent
1	6	15.0
2	27	67.5
3	6	15.0
4	1	2.5
Total	40	100.0

Note: 15= clinical cut of point to diagnosis of PTSD symptoms(part one)

Participants have showed no symptoms PTSD during their pretreatment period. Table 4.6 revealed that 67.5% of the subjects have scored 2 whereas the rest 15% scored 1 while 2.5% scored 4 and other 15% scored 3. All respondents have scored below the clinical cut of point to diagnosis PTSD which indicative of none existence of PTSD symptoms for part one of the PSS (post-traumatic stress disorder symptom scale).

Table 4.7 Functional Impairment among the patients during pre-treatment (part two)

Scores	Frequency	Percent
8.00	1	2.5
14.00	39	97.5
Total	40	100.0

Note: Scores range from 0 -- 7, with higher scores indicating greater functional impairment (Foa, et al, 2001).

Participants have showed greater functional impairment during their pretreatment period. Table 4.7 revealed that 97.5% of the subjects have scored 14 whereas the rest 2.5 % scored 8 for part two of PSS.

Table 4.8 Post Traumatic Stress Disorder score of clients during post treatment (part one)

Scores	Frequency	Percent
0	32	80.0
1	3	7.5
2	2	5.0
3	3	7.5
Total	40	100.0

Note: 15= clinical cut of point to diagnosis of PTSD symptoms(part one)

PSS were also administered for the participants after their treatment.As Table 4.7 indicates, 80.0 % of them have scored 0 and 7.5 % scored 1 while another 7.5 % scored 3 and the rest 5% scored 2.

Table 4.9 Functional impairment among the participants during post treatment period

Scores	Frequency	Percent
10.00	1	2.5
Valid 14.00	39	97.5
Total	40	100.0

Note: Scores range from 0 -- 7, with higher scores indicating greater functionalimpairment (Foa, et al, 2001).

Respondents have showed high level offunctionalimpairment during post treatment period as of the pretreatment period. As Table 4.8 indicates, 97.5% of the respondents scored 14 while 2.5% scored 10.

Part two: counselor’s response regarding counseling practice

Structured questioners were developed for the purpose of collecting data in relation to the practice of counseling. All the questioners were filed by the counselors and summarized in Table 4.10.

Table 4.10 socio demographic profile of counselors at AAFH

Sex	
	Frequency
Male	1
Female	5
Total	6
Level of education	
Master’s degree	3
Bachelor degree	1
Diploma	2
Total	6
Profession	
nurse	4
Psychiatrist	1
Chaplain	1
Trainings on counseling skills	
Yes	4
No	2
Total	6

As shown in Table 4.10, majority of the counselors four of them are female. Half of the respondents have master's degree, one has first degree and two of the counselors have diploma. Professionally, four of them are nurses, one psychiatry nurse and another counselor is the hospital chaplain. In relation to counseling skills 4 of them have got basic counseling skill training while the rest two counselors have not.

Table 4.11 Practice of counseling at Addis Ababa Fistula Hospital

		Frequency	Percent
Is there a proper setting for counseling	Yes	0	0.0
	No	6	100.0
The counseling service given at the hospital support patients to enhance their coping to depression and other psychological issues	Strongly agree	2	33.3
	Agree	3	50.0
	Undecided	1	16.7
Are there any refreshment trainings to enhance your counseling skills	Yes	3	50.0
	No	3	50.0
Did you experience burn out in your practice	Yes	6	100.0
	No	0	0.0
Is there any mechanisms to prevent burn out	Yes	6	100.0
	No	0	0

In relation to counseling practice, Table 4.11 indicated that there is no proper setting for counseling at the hospital. However, majority of the respondents (50%) and were agreed that counseling service at the hospital did help the client to cop there psychological difficulties; specially, relive from or cope with depression. Although 16.7% of the respondents were not

undecided whether the counseling helped the client to cope, 33.3% of them were strongly agreed that the counseling did support the patient to cope their depression.

As Table 4.11 indicates, 50% of the respondents stated that there are refreshment trainings on counseling skills while 50% responded no. Furthermore, the table shows practitioners experienced burnout in their practice and there are no mechanisms in place to prevent it.

Part three: Findings from Focus Group Discussion

Although four focus group discussions were planned, two focus groups were conducted because of across group data saturation occurred since all participants are homogenous both in their socio demographic profile and experience in relation to obstetric fistula.

The researcher listened to the tape of the focus group and then prepared an abridged transcript. Notes also used to support the abridged transcript. FGDs with patients were analyzed, transcribed, categorized and summarized manually. The literal quotes and descriptions of responses are presented in this chapter.

Issues of confidentiality

The respondents were asked about whether there is an issues of confidentiality during the focus group discussion and except one participant who disclose that there was another person in addition to the counsellor during pre-treatment counselling, all of them agreed that there was no one in the counselling room except the health provider (counsellor)

Pre-treatment counselling service

To support the quantitative data, participants were asked to explain about the information that they received during the pre-treatment counselling to examine whether they received the pre-treatment counselling as per the guideline of Fistula counselling manual. Except one participant in the group, who disclosed that she did not understand the massages properly, all

participants explain what they received during the pre-treatment counselling. As one of the participants explain her opinion as follows:

“The counsellor was very much caring to me when she listened to my opinions and questions carefully and provides me with necessary information about my treatment plan and type of surgery and possible risks that helped me to get relief”

Importance of pre-treatment counselling

Participants were asked about their feelings and understanding of pre-treatment counselling and almost all of them agree that the counselling was so helpful to relief their stress and have successful surgery. But one of the participants could not able to express her opinions as she feels shy to talk to strangers and refused to see the researcher face, who tried to probe for reply.

Satisfaction in relation to the pre-treatment counselling

Participants were asked about their opinions about the level of satisfaction with the pre-treatment counselling and almost all of them said that they are very satisfied with counselling; except one client that said “I am satisfied but not as much as I expected because I was not clear about the situation”

Intra operative counselling

It is advisable to have on treatment counselling to have patients get relief from their intense anxiety and fear. To explore this issue, the respondents were asked about their feeling to give their consent to the surgery. All the respondents were able to express their feelings with the smile and bright face that they were comfortable with the psychiatry nurse counselling. One participant tells her experience as follows:

“I was so fearful during that time... I entered to the operation room with full of hesitation and worries that I might die when Anastasia administered to me as I have heart problem too. In the meantime Sr. Belaynesh encouraged me by telling me experience of similar patients who have survived the surgery and healed from their problem. She also told me to pray... oh, when I think of it now, here encouragement was really helpful.”

Other patients were also asked same question after their surgery while they are still in the recovery, they replied that they received the necessary self-care and pain management counselling with emotional support from the nurses as one participant describe the situation as follows:

“They advised me not to drink and take food after surgery until they told me to do so and the things that I should do when I feel pain and how to keep my personal hygiene as soon as possible”

Post treatment counselling

Post treatment counselling is important for the clients to facilitate the reintegration process. To explore the experience of post-treatment counselling, participants were asked about whether the post-treatment counselling was helpful and if so what are the benefits.

All the respondent were eager to speak and have a smile face when they tell their story and they agree the post counselling helped them to think in a different and better way about them self's. One client disclosed her experience as follows:

“Before I get treated and came to this hospital, I consider myself as a worthless woman in the village with low self-esteem. I even tried to kill myself taking Herbicide. However, I started valuing my life after I come here and talk to other patients and counsellors and get treatments. Thanks to pre-treatment counselling otherwise I could

have refused the surgery and remain in that very painful and ugly situation. I want to thank the counsellors and doctors for the unreserved help to cure my incontinence of urine; I am happy and ready to go back to my families now.”

All FDG participants confirmed that they have tried to commit suicide before treatment and even hesitant that the treatment could work. However, they are now happy and said “*we are now starting to rethink about our self’s in a better way thanks to the staffs of the hospital specially the doctors and the nurses who counselled us.”*

Another participant was also sharing her experience how the counselling helped her to decrease her level of depression as follows:

“I was very much depressed before I get treated, I refuse to eat and drink and prefer to be alone all the time. I had little sleep at night with horrible nightmares. I was not even able to feel any happiness with my friends in my village which I use to play with before. I feel sad all the time because my husband left me alone and married to other. I was very much aggressive to my mother. But after I came here I feel that I am not alone with this problem and saw others. I saw some changes of thought in myself because I am ready to go to my village and to have a baby like my friends since I am starting to make myself ready for marriage. The counselling and the treatment have helped me to cope with my situation.”

Another participant also explained the importance of counselling for her during her hospital stay as follows: “*I came here with so much shame and depression since my transportation is difficult because I have a bad smell when I was in the bus. That makes me stressful. I took all the counselling and medical procedure hoping that I will get cured. But unfortunately my surgery was not successful but I keep going because I have hope in my life. Even though my medical condition is still the same I sense that I started to change my stress and worries*

because there will be other treatment plan in the future and also I identified in the counselling session that it is not unique to me I have better hope than before.”

4.2. Discussion

The study was focused to assess the role of counselling service for the obstetric fistula patients in coping with their psychological situations which is characterized by depression and post-traumatic stress disorder during their stay in the hospital. Assessing the practice of counselling service at the Addis Ababa Fistula Hospital is also another objective of the study. This part discusses the major findings from the data collected from the test results, questionnaires and focus group discussions.

4.2.1. Psychosocial situation of participant women's with Obstetric Fistula

Apart from their physical injury, women's with obstetric fistula are subjected to different psycho-social and economic problems as indicated in the findings of this study. All the subjects are under the age of 18 which means they are obliged to get married since 87.5% of them are illiterate and have no power to make decision about their life. They have no income as the majority (85%) dependant on either their husband's agricultural income or their parents since they came from remote rural areas of the country. In addition to the devastating injury, they are suffering from the death of their newly born babies as the study found that 97.5% of the subjects have experienced still birth. As abrhamsdescribes the impact of obstetric fistula, "obstetric fistula, in itself, is a bad enough, but it is also inextricably linked with high infant death rate and maternal mortality rate" (Abrhams, et al p. 10). The multifaceted socio economic problems of women's who suffers from obstetric fistula worsen their psychological wellbeing.

The study tries to assess the level of depression and post-traumatic stress disorder as indicated in different literature that the women with obstetric fistula have prevalent to depression and traumatic problems. For instance, as recent study indicate that "women with

urinary or fecal incontinence show depression, anxiety and abnormal level of situational life stresses (Mourad, 2012, p.164)”.

The study finds out that Participants have highest level of depression symptoms during their pre-treatment period as 80% of the subjects have showed sever symptoms of depression. But in relation to PTSD, the finding indicates that participants have showed no PTSD symptoms for post-traumatic stress disorder symptom scale (part one) during their pre-treatment period as all the subjects have scored below the clinical cutoff for PTSD symptom. But participants have showed high level of functional impairment as a result of their physical health situation, which is incontinence of urine or faces.

4.2.2. Contribution of pre and post treatment counseling service

The role of counseling in helping the patients to cope with such psychological situation is one of the core objectives of this research. As Muleta, et al (2008) stressed the importance of counseling in treatment of fistula patients arguing that Treatment decrease feelings of depression and suicidal ideation but did not eliminate it. Thus this study recommended that counseling and psychological assistance should be a major part of the treatment for women with obstetric fistula.

The results of the findings indicate that the counseling service did help the patients to decrease the level of depression they have before the treatment. This is evident by quantitative data, gathered during post treatment period. participants were asked about their opinion by conducting focus group discussions that examine the contribution of counseling in the process of their treatment. The qualitative data indicates that the counseling have significant contribution to decrease the level of depression among the participants. Also few participants indicated that they have encountered problem in getting successful surgery, they disclose that the counseling helped them to cope their situations.

Participants of focus group discussion indicated that the post-treatment counseling helped them to think in a better way about their future life in addition to their medical treatment which would change their thought in relation to social functioning.

The majority of counselors (83.3%) also agreed that the counseling did help the patients to cope form depression by enabling them to have better self-esteem.

4.2.3. Practice of counseling at AAFH

Assessing the practice of counseling is another objective of the study; gathering data with structured questionnaires from the counselors and by conducting focus group discussions with the counselees. The result of the finding indicates that all among six staffs who serves as a counselor four of them are nurses with one psychiatric nurse and one hospital Chaplin who is responsible for the spiritual counseling. Although half of them have master's degree in their respective field of study and half of the counselors also took the necessary training for basic counseling skills, and the rest three counselors among the total of six which is significant number, responded that they do not have proper training for counseling. This situation would compromise the quality of counseling service which is given at the hospital. It is possible to indicate this situation as one of major challenge in delivering counseling services for the patients.

Proper setting is another important input in standardizing counseling services but the study found out that there is a place but it is not conducive enough or proper to give counseling services. The researcher also observed that the places or rooms where the counseling is conducted were not organized as per the standard. This situation would lead to breach ethics of counseling, confidentiality and would in turn lead to conducting unsuccessful counseling sessions.

To assess the attitude towards their counseling practice, counselors were asked whether their counseling service is helping their clients to cope with their psychological situations. 33.3 %

of them are strongly agreed that counseling helped the patients to relieve from their depression while 50 % are agreed with the opinion.

Burnout which is defined by medical dictionary “emotional condition marked by tiredness, loss of interest, or frustration that interferes with job performance”(Wikipedia, 2015).

Burnout management is one of the indicators for the qualities of the counseling service. The finding indicates that there is high level of burnout among the counselors. All counselors experienced burnout in their practice of counseling. It is also found that there are no mechanisms in place to prevent burnout in their workplace or no burnout management system except their personal effort to minimize it.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATION

5.1 Conclusions

The study tried to assess the psychological problems of women with obstetric fistula and the role of counseling service by taking 40 patients receiving treatment at Addis Ababa Fistula Hospital. Practice of counseling also carefully analyzed by taking the standard obstetric fistula counseling manual in to account. The following conclusions are made from the overall findings of the study.

- Apart from the socio economic problems that patients face, they are also severely affected by psychological depression as 80% of the subjects have severe symptoms of depression during their pre-treatment period. The counseling was found to be important contributor to decrease the level of depression among the subjects. Counseling practice able to contribute to decrease the level of depression with minimum symptom to depression for 90% during post treatment period of the samples.
- The majorities of the women with obstetric fistula case are from remote rural areas and are characterized by low social status in relation to their educational and marital status. 87.5% are illiterate and 75% are divorced due to their health condition with 97.5% have experienced stillbirth. This situation affected their psychological functioning as they feel rejected and outcaste by the society.
- As this study uses the Biopsychosocial theoretical model in interpreting and conceptualizing the result of the findings, it is concluded that The Addis Ababa Fistula Hospital uses the Biopsychosocialmodel to treat the patients by providing the

holistic approach for the patient treatment at the hospital with certain limitations in relation to counseling.

- Lack of refreshment trainings and burnout management and lack of proper setting for counseling were identified as major challenges to provide the high level quality counseling services for the patients. Although there are rooms for counseling in some wards, they are not properly organized as observed by the researcher.

5.2 Recommendation

In order to increase the contribution of counseling service for the holistic care of the patients with obstetric fistula:

- The counselors needs to be capacitated with intensive counseling trainings so that they could provide enhanced counseling services
- The rooms should be organized in a way that they could be conducive for the counseling sessions
- It is recommended that establishing the counseling unit would help the hospital to promote holistic care services.
- Deploying the counseling psychologists to support the existing staffs to help the standardization of counseling service which is given in the hospital
- Implementing multicultural counseling approach is recommended for the patients who came from different regions with different socio cultural experiences.
- The rehabilitation and reintegration programs of the hospital should be more linked with the counselors starting from the pretreatment up to post treatment process of counseling so as to facilitate the patient reintegration to their families
- Finally, it is recommended that the hospital should continue its effort to provide holistic treatment for the obstetric fistula cases since their problems are all rounded and needs an integrated intervention.

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Posttraumatic Stress Symptom Scale (PSS)

Instruction: Below is a list of problems that children sometimes have after experiencing an upsetting event. Read each one carefully and circle the number (0-3) that best describes how often that problem has bothered you in the last 2 weeks. All the responses will be kept confidential. Thank you for your corporation!!!

Part-1					
SN	List of Problems	Responses			
		Not at all (0)	Once a week (1)	2 to 4 times a week (2)	5 or more times a week (3)
1	1 Having upsetting thoughts or images about the event that				
2	came into your head when you did not want them to				
3	Acting or feeling as the event was happening again (hearing something or seeing a picture about it and feeling as if I am there again)				
4	Feeling upset when you think about it or hear about the event (for example, feeling scared, angry, sad, guilty, etc)				
5	Having feelings in your body when you think about or hear about the event (for example, breaking out in to a sweat, heart beating fast)				
6	Trying not to think about, talk about, or have feelings about the event				
7	Trying to avoid activities, people, or places that remind you of the traumatic event				
8	Not being able to remember an important part of the upsetting event				

9	Having much less interest or doing things you used to do				
10	Not feeling close to people around you				
11	Not being able to have strong feelings(foe example, being unable to cry or unable to feel happy)				
12	Feeling as if your future plans or hopes will not come true (for example, you will not have a job or getting married or having kids)				
13	Having trouble falling or staying asleep				
14	Feeling irritable or having fits of anger				
15	Having trouble concentrating(for example, losing track of a story on the television, forgetting what you read, not paying attention in class)				
16	Being overly careful(for example, checking to see who is around you and what is around you)				
17	Being jumpy or easily startled(for example, when someone walks up behind you)				

Part 2

Indicate below if the problems you rated in Part-1 have gotten in the way with any of the following areas of your life DURING THE PAST 2 WEEKS

		Yes	No
18	Doing your prayers		
19	Chores and duties at home		
20	Relationship with friends		
21	Fun and hobby activities		

22	Schoolwork		
23	Relationships with your family		
24	General happiness with your life		