ASSESSENT OF STRESS AND COPING STRATEGIES AMONG WOMEN WITH PROBLEM OF OBSTETRIC FISTULA IN ADDIS ABABA ETHIOPIA

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ACRONYMS

ANOVA: Analysis of variance
ANC: Antenatal care
BDS: Background data sheet
CSA: Central statistical agency
DHS: Demography and health survey
FCI: Family Care International
FGD: Focus group discussion
MCH: Maternal and child health
MOH: Ministry of health
PNC: Prenatal care
RVF: Rectovaginal fistula
SSI: Semi-structured interview
SC: Social comparison
SD: Standard Deviation
SPSS: Statistical Package for the Social Sciences software program
TPP: Time place person
UBOS: Uganda bureau of statistics
UNFPA: United Nations Population Fund
USA: United States of America
VVF: Vesicovaginal fistula
WCQ: Ways of coping questionnaire
WHO: World health organization

Abstract

Background: An obstetric fistula is a hole in the wall of the vagina connecting to the bladder or rectum that is caused by prolonged and obstructed labor. As a result the girl or woman is left with uncontrollable leaking of urine and/or feces from her vagina, and constant and humiliating odor and wetness. Compounding this catastrophic physical trauma, in almost all cases, the woman suffers the loss of her baby. Without treatment women are frequently ostracized from their communities out of shame. Some are rejected or abandoned by husbands and families. Many are unable to work or earn a living, driving them deeper into poverty [21]. Coping responses are a dynamic series of transactions between the individual and the environment, the purpose of which is to regulate internal states and/or alter the person-environment relations. The theory postulates that stressful emotions and coping are due to cognitions associated with the way a person appraises or perceives his/her relationship with the environment [22]. This study is conducted to determine the levels of stress and coping mechanisms used by women living with obstetric fistula admitted at Fistula hospital in Addis Ababa.

Objective: To determine the sources and levels of stress, and coping mechanisms of women living with obstetric fistula.

Methodology: Institution based retrospective cross sectional study was conducted at Addis Ababa fistula hospital from April 2009 to June 2009. Valid and reliable questionnaire administered to all eligible women admitted to the facility during the study period. Participants were surveyed with a demographic data sheet, stress, and ways of coping questionnaire and in-depth semi-structured interviews and then processed and analyzed using SPSS software version 17.

Results: Finding of this study showed that, the most frequently encountered sources of stress are internal stressors with highest mean and standard deviation 61.81(11.35) followed by external stressors 27.01 mean and 7.09 SD. The least

sources of stressors among these women were, situational stressors having Mean and SD 26.280(8.06). The coping strategy used most frequently among these study subjects was Planful problem solving, Mean and SD 20.341(3.856) and escape-avoidance 15.522 Mean and 3.841 SD. The less common utilized coping strategy among theses women was Confrontive coping having 3.806 Mean and 1.503 standard deviation.

Conclusions: Women with obstetric fistula are exposed to many stressful situations as a result of their problem, and these stressful situations are occurring with differing degree. Women utilize different coping mechanisms in order to avert their problem, identification of the type of stressor and it's level and coping strategy has a paramount importance.

Recommendation: The care that we provide to mothers must be an understanding and of holistic type which encompasses education, literacy training, the development of social networks, and the provision of skills with which to earn an adequate livelihood.

Chapter 1

1.1 Introduction

Obstetric fistula is a hole (or "false communication") that forms between the bladder and the vagina (known as a vesico-vaginal fistula, or VVF) or between the rectum and the vagina (a recto-vaginal fistula, or RVF) during prolonged and obstructed labor. The constant pressure of the fetal skull against the soft tissue around the vagina and the bladder and/or rectum cuts off the blood supply to the tissues, causing them to disintegrate (ischemic necrosis). A hole is then left, and urine and/or feces leak continuously and uncontrollably from the vagina [15]. In nearly all cases of obstetric fistula, the baby usually dies. [13, 20]

As many as 130,000 new cases of fistula are occurring annually worldwide, and up to 3.5 million women may be living with the condition [9]. In Uganda alone, an estimated 2.6% of women of reproductive age have experienced obstetric fistula. Based on population data from the most recent census, this equates to a national prevalence of over 142,000 women [37]. In Ethiopia, there are an estimated 100,000 women suffering with untreated fistula, and another 9,000 women who develop fistula each year [5]. A national DHS conducted during 2005 estimates the prevalence rate of fistula to be 1% [23].

The death or disability of a girl or woman due to complications during childbirth is avoidable and unjust. More than 2 million women living with obstetric fistula provide living testimony to this injustice. The existence of this condition reveals societal and institutional neglect of women [1]. Women living with fistula are the survivors, yet their lives are devastated and in most cases their voices have been silenced [1].

Caused by obstructed or prolonged labor without skilled medical care, obstetric fistula results in serious physical as well as psychological effects. The newborn usually does not survive the trauma. Despite its devastating medical and social impact, obstetric fistula is not a public health priority. Women continue to suffer in silence and isolation [1]. The last decade has seen some progress in reducing maternal mortality in Asia, Latin America, and Northern Africa. [36] However, there was little or no improvement in sub-Saharan

Africa, where risks were greatest for maternal death and illness and neonatal mortality [36].

The study of coping is fundamental to an understanding of how stress affects people, for better and for worse. Although it has proven difficult to document unequivocally, coping researchers argue that how people deal with stress can reduce or amplify the effects of adverse life events and conditions, not just on emotional distress and short-term functioning, but also long-term, on the development of physical and mental health or disorder. Researchers maintain that coping matters [(20)].

In the broadest sense, ways of coping are the basic categories used to classify how people cope. They capture the ways people actually respond to stress, such as through seeking help, rumination, problem solving, denial, or cognitive restructuring. Categories describe what is happening on the ground during coping episodes, that is, "specific coping responses: the behaviors, cognitions, and perceptions in which people engage when actually contending with their life-problems". They are the mechanisms through which coping have short-term effects on the resolution of the stressor as well as long-term effects on mental and physical well being [20].

Recently, researchers have determined that coping strategies used by persons with incurable diseases such as breast cancer, rheumatoid arthritis, and Osteoarthritis are vital component for adjustment to their disease [27-34]. Exploration of coping strategies used by women living with obstetric fistula, and the possibility of how certain sociodemographic variables might relate to coping strategies among these women is the focus of this study.

1.2 Statement of the problem

This year, over half a million women will die in pregnancy or childbirth, and a further 1.4 million will barely survive life-threatening complications [5]. Hemorrhage, sepsis, hypertensive disorders of pregnancy, unsafe abortion, and obstructed labor are the five main causes of maternal deaths. Obstructed labor is principally responsible for obstetric fistula, a devastating injury sustained by women during childbirth [12].

During prolonged obstructed labor, the presenting part of the fetus, usually the head, compresses the soft tissues of the mother's vagina, bladder, and rectum against the maternal pelvic bones. Without prompt intervention typically, a caesarean section to relieve the obstruction the fetus is asphyxiated and the impacted tissues of the mother's vaginal wall sustain pressure necrosis, slough off, and leave a hole (or abnormal communication) between the vagina and bladder (vesico-vaginal fistula) or between the vagina and rectum (recto-vaginal fistula) [12]. As a result the girl or woman is left with uncontrollable leaking of urine and/or feces from her vagina, and constant and humiliating odor and wetness. Compounding this catastrophic physical trauma, in almost all cases, the woman suffers the loss of her baby. Without treatment women are frequently ostracized from their communities out of shame. Some are rejected or abandoned by husbands and families. Many are unable to work or earn a living, driving them deeper into poverty [1,2,6,12,13]

As many as 130 000 new cases of fistula are occurring annually, and up to 3.5 million women maybe living with the condition [9]. The vast majority of these women live in resource-poor countries, and tragically, nearly all of these injuries could have been avoided if timely and competent obstetric care was available, accessible, and affordable [12].

According to the 2006 demographic and Health Survey in Uganda, an estimated 2.6% of women of reproductive age (15-49 years) had experienced obstetric fistula [37]. Based on the population of women of reproductive age from the most recent census, this equates to a national prevalence of over 142 000 women [(12)]. In Tanzania alone, approximately 2,500 – 3000 new cases of fistula are estimated to occur each year [36]. In Ethiopia, there are an estimated 100,000 women suffering with untreated fistula, and another 9,000 women who develop fistula each year [(5)].

A study done by Dr. Mulu, of Addis Ababa fistula hospital found a fistula prevalence rate of 0.22 percent among women of reproductive age (15-49) [40,41]. This is relatively low in comparison with the estimate of one percent (1%) of women living with fistula documented by a national DHS conducted during the same year [23]. According to Dr.Muleta, it is likely that the prevalence rate is underestimated for two reasons: first,

some women living with fistula may have migrated to monasteries and urban areas due to stigma, and second, cured women often seem to be unwilling to talk about their past history. Dr.Mulu further noted that during the research, 55 obstetric fistula patients were identified. Out of these only 12 were previously operated. She stated that out of the 33 non-operated women, only 20 reached the hospital (61%), despite the fact that all had received money for transportation [40].

Obstetric Fistula in Context

Obstetric fistula first presents as a medical condition, but the condition is deeply rooted in women's social, cultural, and economic vulnerability. Most women with fistula are young, poor, live in rural communities, and have low social status, little or no formal education and no political influence [9,41,42].

Social and Cultural Context

A country level need assessment done by UNFPA and FCI in 29 countries across the globe showed that Cultural beliefs and social values prevented adolescent girls and women from making decisions about their own bodies as well as their health [17]. Generally, women living with fistula had low literacy skills, low status in the family, and few years of schooling. Knowledge regarding family planning and safe motherhood was often limited and access to contraceptives restricted [17].

Across assessments, large proportions of women delivered at home with extremely low rates of Caesarean births in rural areas. Among the women who gave birth at home, many were assisted by female family members or traditional birth attendants with no formal training. When complications arose during pregnancy, access to necessary obstetric care was often avoided or delayed due to family pressures for home deliveries and misperceptions of the causes of complications.

In many assessments, child marriage and early childbearing were the norm and increased vulnerability by contributing to gender inequities in education, work, and decision-making. Girls were married at their first menstrual flow (10 to 15 years old) in

numerous countries, and as young as age 9 in Nigeria. These adolescent girls often had less access to reproductive health information and services, as well as contraceptives. Conversely, where cases of fistula were noted among older women with children, pregnancies were not well spaced and high fertility rates were prevalent. In some areas delivering the first baby is a norm which further contributes to the development of obstructed labor and obstetric fistula [17].

Political and Economic Situation

Poverty and gender inequality were evident throughout the assessments. The data illuminated grave disparities in the quality of life between poorer and wealthier women. Poverty and women's status had a negative impact on access to family planning and skilled care, as well as maternal health outcomes.

Research findings showed that most women who developed fistula tended to live in rural, low-resource areas with limited access to health facilities that might offer high-quality antenatal and delivery care [1,2,6,12,13,17]. Long distances to health facilities and a lack of resources added to delays in getting quality care in the case of complications during labor. For the same socio-economic reasons, once they have fistula, many women are unaware that surgical treatment is available, or cannot access or afford the treatment. As a result, they often live with the condition for years or decades. Lastly, even basic repair services are unavailable inmost developing countries where the capacity to treat fistula cannot meet the demand for services [9, 12, 13].

Chapter 2

Literature review

World wide each year more than half a million healthy young women die from complications of pregnancy and childbirth. Virtually all such deaths occur in developing countries [4]. The world health organization (WHO) estimates that, globally, over 300 million women currently suffer from short or long-term complications arising from pregnancy or childbirth, with around 20 million new cases arising each year [4] problems include infertility, severe anemia, uterine prolapse and vaginal fistula. Worldwide obstructed labor occurs in an estimated 5% of live births and accounts for 8% of maternal deaths [5]. Adolescent girls are particularly susceptible to obstructed labor, because their pelvis is not fully developed [14].

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 "safe mother hood" internationally, millions of girls and women still die in childbirth or live with maternal morbidities such as fistula.

The world health organization estimates that approximately two million girls and women live with fistula worldwide and that an additional 50,000 – 100,000 girls and women are affected each year [39]. Experts on fistula working in the field report that this is likely to be a serious underestimate of the problem, but this cannot be verified as very few studies of the condition exist [14]. Some in-depth studies serve to support the widely held belief that the true number of women living with untreated fistula and suffering the consequent pain and degradation may have been underestimated, suggesting that there may be between 100,000 and one million women living with fistula in Nigeria alone [21] and over 70,000 in Bangladesh [17].

Other studies in Ethiopia, Nigeria, and other parts of West Africa estimate the incidence of fistula to be 1-10 per 1000 births [21,23,40,41]. In Ethiopia it is estimated that 9,000 women annually develop a fistula, of which only 1200 are treated [8]. Not only has there been generally a lack of commitment in addressing and resolving this problem, but also

these young girls or women tend to live with their fear and stigmatization in silence and isolation, unknown to the health care system [14].

The root causes of fistula are grinding poverty and the low status of women and girls. In Ethiopia, the poverty and malnutrition in children contributes to the condition of stunting, where the girl skeleton, and therefore pelvis as well, do not fully mature. This stunted condition can contribute to obstructed labor, and therefore fistula. The other cause is marriage at an early age, combined with inadequate medical care during pregnancy and childbirth, and unavailability and inaccessibility of health institutions to women have led to high rates of obstructed labor and obstetric fistula among women in Ethiopia.

Less than 6 in 10 women in developing countries give birth with any trained professional, such as a midwife or a doctor. In Ethiopia only 1 in 10 women have a trained attendant. When complications arise, as they do in approximately 15% of all births, there is no one available to treat the women leading to disabling injuries like fistula and even death.

An obstetric fistula is a hole in the wall of the vagina connecting to the bladder or rectum. Because fistulas are not generally fatal, and because most of them are never repaired, the number of women with this condition goes up every year. However, although vesicovaginal fistula is the most common type of damage caused by prolonged obstructed labor, it is not the only one. Recent article in studies in family planning describes some of the other results of prolonged pressure against the pelvis. Author Lewis Wall of Louisiana State university medical center, New Orleans, USA, explains that prolonged pressure on the pelvis can result in other injures too. In at least one-fourth of cases of bladder fistula in northern Nigeria, the urethra is damaged as well; even if the fistula is repaired the woman may still leak urine.

Prolonged pressure on the pelvis can also damage the network of nerves to the bladder, and in some cases so much bladder tissue is destroyed that even after repair the woman's bladder capacity is very much reduced [11].

Obstructed labor also injures areas outside the urinary tract. Nearly two- thirds of women who develop obstetric fistula stop menstruating. The injury that causes the fistula also scars the vagina. There may be just a few isolated scars but in serious cases there is so much scarring that the vagina becomes narrow and rigid, making sexual intercourse impossible. Many patients also suffer severe damage to the cervix [11].

The WHO has called fistula "the single most dramatic aftermath of neglected childbirth." In addition to complete incontinence, a fistula victim may develop nerve damage to the lower extremities after a multi- day labor in a squatting position. Fistula victims also suffer profound psychological trauma resulting from their utter loss of status and dignity.

In a study done in Tanzania the majority of women who participated, who were married at the time they sustained fistula were subsequently divorced, and nearly all the women suffered isolation. The women stopped socializing or participating in public events for fear of wetting themselves, smelling bad, and/or due to their luck of confidence. In addition, the majority of women said that fistula affected their ability to work due to the health effects of the condition and the smell. In some cases women lost their jobs or could not get work because of the stigma associated with fistula. About half said they could not provide for themselves and/or their families as a result of not being able to work.

Families, too, were significantly affected by fistula, primarily due to the costs of treatment and for basic items such as clothing and soap. The majority of the women also indicated that their family members suffered from stress and worry about how the fistula affected the woman's life. A majority of women who develop fistulas are ostracized by their communities because of their inability to have children and their foul smell [1, 2, 3, 8, 20, 14].

Most women who develop an obstetric fistula do so in their first pregnancy and most will never become pregnant again. Where obstructed labor lasts long enough to cause a

fistula the baby usually dies; which means that most women with a fistula have no living children. Since in most African societies older people are cared for by their children, Dr Wall says, the growing number of childless women with fistula is a significant social problem [11].

A person who smells strongly of urine is not welcome in society. As long as they leak urine or feces, the women run a high risk of being abandoned by their husbands and will probably be ostracized by their neighbors. Studies in India and Pakistan show that as many as 80% or 90% of women with fistula are abandoned or divorced by their husbands. Women with fistula often become outcasts, not allowed to handle food or cook, not allowed to get on a bus [1,2,3,12.13,15,18].

Women with fistulae are almost always from poor families and communities. Typically she is very young, malnourished from birth, susceptible to disease, chronically anemic and often physically stunted. In addition, having a fistula impedes a woman's normal functioning and her ability to work. Naturally these women are embarrassed that they are constantly soiled and wet and that they smell. Their pain and shame may be further complicated by recurring infections, infertility, and damage to their vaginal tissue that makes sexual activity impossible and paralysis of the muscles in their lower legs which may require the use of crutches, if any are available [12,13,15].

The greater tragedy is that these obstetric fistulas can largely be avoided by delaying the age of first pregnancy, by the cessation of harmful traditional practices and by timely access to maternal and obstetric care. They can be repaired by surgery [14]. Unless they have access to a hospital that provides treatment and care, women may live with the fistula until they die, often at a very young age, from complications of their fistula. Such women often receive no support from their husband or family members [14].

In India and Pakistan, some 70% to 90% of women with fistula had been abandoned or divorced, according to limited hospital studies [10] At the Addis Ababa fistula hospital, 53% of the women had been abandoned by their husbands, and one woman in every five said

that she had to beg for food to survive [9]. It is not surprising, therefore, that some women can no longer cope with the pain and suffering, and resort to suicide [14].

Dr Saifuddin Ahmed of the Johns Hopkins Bloomberg School of public health showed that much research had been conducted on the effectiveness and success of surgical repair, but very few studies had examined the adverse social, economic and psychological consequences of fistula development. He noted that research gap exist in relation to the changes in quality of life before and after treatment, the definition of quality of life for fistula patients and the definition of resilience factors for fistula patients i.e. how women survive and overcome the odds and adverse life situations. There is also complete lack of knowledge about the links between fistula development and suicide, domestic violence murder or bride burning [19].

The fact that obstetric fistula has been virtually eliminated in the developed world is a clear reminder that the problem can be prevented through improved access to high-quality maternal services, including family planning, skilled delivery care, emergency obstetric care and postnatal care. Moreover, the fact that the majority of cases occur among young women and adolescent girls means that we need to help them to delay pregnancy and have greater access to maternal health care [1].

2.1 Obstetric fistula, coping and adaptation

Because of their physical and psychological impact, for many chronic illnesses coping strategies are essential for adaptation [29-35] various strategies exist to assist people with different chronic illnesses including cancer but little is existent for obstetric fistula due to lack of in-depth study done in this area.

In a study done by women's dignity project and engender health USA in Tanzania it was shown that women living with fistula dealt with the hardship of fistula through various coping mechanisms. The study revealed that nearly all of them said that they use planful problem solving, seeking social support. A minority of women mentioned that they coped by problem focused coping such as seeking treatment. The other minor group of

women mentioned that they isolate themselves by staying at home and or keeping their fistula a secret. Other coping mechanisms included: work, support by family, prayer and bible reading, and perseverance/self determination [13]. There is discrepancy in the coping strategies used by Ugandan women which requires further study to measure whether it is due to cultural difference or any other variable [12].

2.2 The Impact of Fistula

2.2.1 Years Living with Fistula

Studies show that there was a significant range in the length of time the girls and women had lived with fistula, spanning from one month to 50 years. The majority of women had lived with fistula for two years or more at the time of the study [1, 2, 20, 21, 22]. A minority of the women had lived with fistula for more than ten years [14]. For some women, the length of time before seeking treatment was long because they did not know treatment was available or they could not afford to get to the hospitals that provide repair and for a few of them poor health after fistula was the cause for not seeking treatment [1,2,20,21,22].

2.2.2. On Women's Physical Health

Women who have been involved in the study mentioned health related impacts of fistula. Mentioned health problems were; sores around their genitals as a result of fistula, foot drop, feeling a lack of energy, experiencing weakness, or tiring easily, inflammation, and dehydration. Other less frequently mentioned health problems include; chronic sickness, constant wetness, and pains in the uterus, back, head, or abdomen. A minority of the study subjects mentioned: Loss of appetite and weight, fever, irregular menstrual periods, and the inability to walk normally [1, 14, 20, 21]. One woman described: "*Presently, I am allergic to sanitary pads. I feel inflammation within my sore genitals. I am generally weak and dehydrated with occasional dizziness.*" *(Woman from Masaka, age 68)* [21].

For majority of women, access to health services after getting fistula was not a problem. However, a minority indicated that despite access to services, they could not use them

because of lack of income. In addition, few women did not use health services because they felt ashamed of their problem and did not want it to be revealed [14].

2.2.3. On Marital Status

In Ugandan case many women who were married at the time they sustained fistula were subsequently divorced. Of these separations, nearly all were for reasons related to their fistula. Moreover, nearly all of the women who were unmarried when they sustained fistula remained single [21]. In a study done in Tanzania, a minority of the married women got divorced as a result of the fistula [20]. This was a painful experience for them.

In one case, a woman said, "*My husband said, 'I can't live with a woman who rots my mattress with urine.' He left me and threw out all my belongings." (Woman from Songea, age 20)* [20]. Another woman similarly recalled, *"Currently I am divorced after my belongings had been thrown out one morning. I leave everything to God because I am suffering, and I am useless." (Patient at Bugando, age 30)* [20]. In a third case, a woman's partner left her after she sustained fistula and remarried. Her mother-in-law then said to her, *"What are you waiting for when you have this urine problem? Get out of here and go back to your parents." (Woman from Ukerewe, Age 23)* [20].

The same study showed that the majority of women with fistula were married before they sustained their fistula and stayed married after developing the problem. Women's partners continued to stay with them after the fistula despite pressure from others. In one instance, a 54-year-old woman from Singida explained that her brother in law told her husband to divorce her, but he stayed with her and they had 11 children together. Another husband related that when he married a woman with fistula, people used to say he was strange and asked him how he could live with a woman who leaked urine. However He would say that it was not her fault; its God's will, because she did not ask for it to happen [20].

However, in Uganda for only few women the marriage remained intact. In both studies despite intact marriage women have no sexual relationships with their husbands after

fistula [20, 21]. In one case, a woman reported that although she and her partner were happy, they did not share the same bed and did not have sex. Most husbands interviewed in Bangladesh indicated that their wives no longer had interest in sexual intercourse after the fistula occurred. In Bangladesh, Mozambique, and the Central African Republic, some husbands had remarried after the fistula occurred and the wives affected by fistula remained in the household as servants. Some women said that they had failed in their duties as sexual partners [1].

2.2.4. Stigma and Isolation: The Social and Psychological Impacts of Fistula

On Women with Fistula

The majority of the women with fistula isolated themselves from their communities [20, 21]. They remained in their homes as much as possible, stopped making social visits, and no longer attended public events such as funerals, celebrations, and meetings. Fewer than half of the women specifically mentioned not going to religious gatherings. The reason given was a strong sense of shame about their condition and did not want to soil themselves in public or to smell badly. As one woman explained, *"I got on well with the community, but did not want to visit them because I was ashamed of the urine."(Woman from Ukerewe, Age 70).*

Another woman expressed a similar sentiment, *"At mourning places, I stay isolated, and I also sleep in the corner so that people should not notice."(Woman from Singida, Age 45)* A third woman explained, *"I was also disturbed because I couldn't go anywhere. I just stayed inside and couldn't even go to church." (Woman from Ukerewe, Age 21).* Fewer than half of the women mentioned being ridiculed or being segregated by community members. A woman explained *"I feel shame. They laugh at me. They turn their lips up, and others leave the moment, I enter to take my tea with them." (Woman from Singida, Age 54)* [14]. *"Life is bad. When I go out in the streets, people yell at me that I was divorced because of wetting and rotting a mattress." (Woman from Singida, Age 20).*

Stigma also came from loved ones at times. This same young woman was treated badly by her grandmother, who told her, *"Get lost, I am fed up. I can't put up with your smell!" Nobody wants to stay with me due to the smell of urine. Even my husband sometimes blames me for my condition.22-year-old woman; Bangladesh* [1] woman from Masaka sadly related her separation from family life: *"I could no longer share meals with my family. They put cold food on a plate, and I had to collect it myself and eat alone. But when medics attended to me and I recovered a bit, we started sharing the room and meals." (Woman F from Masaka, age unknown).*

Women also reported being insulted and ridiculed by others in the community, which made these women isolate themselves. One woman recounted the ridicule she experienced and the abiding loneliness of her life totally secluded from others*:" I live alone because my father said that he cannot tolerate my smell and expelled me from his house. I stay in the kitchen. Since all my other sisters and brothers live far away, I stay there alone. My partner also never took me for marriage when I got this problem. So I am miserably lonely most of the time. I am unable to talk with community members because most of them abuse me. They curse me that I smell and even call me names like 'ever-wet', 'urinator', and 'ever-flowing'. I can't even go to social gatherings like parties, prayers, or meetings. I fear smelling in front of people and being wet, even at home. I am always indoors or hide in the banana plantation all day. I don't want people to see me."(Woman from Masaka, age 32)* [21].

In contrast, in select communities in Kenya and Cameroon, assessments showed higher levels of community support and sympathy for this condition. The study done in Tanzania showed that fewer than half of the women appeared to be treated well by the community, and did not isolate themselves. One woman reported that community members bring her fuel wood, water and various gifts. They also wished her well in seeking treatment. Another woman reported that her community cares for her and provides her with casual jobs so that she can get money for daily needs. A minority of the women interviewed said that the community did not know about their condition. One woman felt that this was the reason she got along well with her neighbors.

Another said that only two of her daughters knew of her fistula, despite the fact that she had lived with the condition for eight years. Other than shame, women also reported other social and emotional impacts resulting from fistula. Around 45% of the women reported feeling greater stress in their lives [14]. Additional stress was experienced due to their inability to attend church and/or mosque, and being unable to have a child or to marry again. Two girls were unable to return to school, and two other girls reported the need to eat separately from others. [14] *"Things are upside down because of the urine problem and I don't have a single child. What kind of life is this (Woman from Songea, Age 30).*

The majority of family members interviewed confirmed that women with fistula experienced isolation, mainly as a result of shame, but also due to the fear of harassment/ridicule or physical weakness that compromised a woman's ability to walk. A minority of family members explicitly mentioned the sadness of living with fistula. For example, one set of parents reported that their daughter experienced sadness and loneliness, and another set of parents said that their daughter was always unhappy because she could not walk properly and could not visit relatives or friends because of shame [14]. In some settings, women had experienced such severe stigma that they were reluctant to return home and were living in or near the hospital where they received treatment [1].

On Families

The majority of the women indicated that their family members suffered from stress and worry as a consequence of the fistula. A few family members reported being worried that the woman would be unable to get married, to finish school, or to fend for herself [1, 14, 20, 21]. They felt badly about the treatment of the women by the community, and felt powerless to help them. One woman explained that her family, especially her mother, had been crying constantly because she felt that her daughter's life was over as a result of the fistula. She reported that her mother felt that the fistula was a big punishment since people failed to enter her room due to the smell of urine. Her mother also worried that no man would marry her daughter so she would live a lonely life.

A few family members also mentioned being ridiculed because of their relative's fistula. One woman was accused of having gonorrhea because of the way she walked with fistula. Her children also were harassed by community members, who said to them, *"How can you eat with your mother?"(Woman from Singida, Age 29)*. This same woman also said that her husband was subjected to ridicule, and community members thought he was stupid, since they did not understand how he could live with a woman with fistula. Several other women also mentioned that their husbands had been ridiculed or pressured to divorce them, sometimes by close relatives. In one extreme case, a woman had to relocate the family due to insults from co-wives after getting the fistula. Some women also felt they were not able to provide for their children in the manner they wished.

One woman reported that her family was affected psychologically because she was at the hospital rather than at home, and the children asked for her everyday. She mentioned that her family experienced problems because she was not there to provide support or food for her children, or even take care of them when they were sick. In another case, a woman's children were looked after by a neighbor because the woman was at the hospital seeking care for the fistula. [14]

2.2.5. Economic Impacts of Fistula

The Impact on Women

Nearly all of the women with fistula said that the condition affected their ability to work. Of these women, the majority could not work at all, while fewer than half could work, but not as hard as they did before the fistula. A few of the women reported that they could not work, but had to in order to meet their basic needs.

Reasons cited by the women for not being able to work, or working less than before, included suffering poor health or feeling pain due to the fistula and/or needing to clean themselves constantly and change clothes [(14)]. In a few cases, women reported being unable to work as consequence of stigma. Overall, women experienced a reduction in

their sources of independent income, which increased their dependence on others. [14] *"...we cannot offer you a job, you smell like urine."(Woman from Songea, Age 20)*

Impact on Families

Families of women with fistula faced higher expenses in the daily management of the woman's condition, such as costs for extra clothes and soap, and in efforts to seek treatment to repair the fistula. Treatment expenses incurred by families included surgical repair and related expenses such as transport and lodging costs for the person accompanying the woman to the hospital, and food and other necessities while at the hospital, as well as payments to traditional healers.

One woman said that *"income has decreased because only my husband is working. There are times when we don't have food. Washing daily is costly, you must buy the soap. This money could be used for other things." (Woman from Singida, Age 29).* In addition to these direct expenses of care and treatment, families were also affected by the loss of the woman's contribution to work in the home, on the farm, or in earning income from other employment. One woman described her situation, *"My family has suffered economically because I could no longer engage in any income generating activities."(Woman from Ukerewe, Age 48).*

Another woman explained, *"I cannot work because of the sores around my private parts... my mother has no one to support the work in the farm. We harvest little." (Woman from Ukerewe, Age 28).* In a third situation, a woman related that *"after I got fistula, my husband struggled and in the end became sick himself." (Patient at Bugando, Age 32)* [14].

Families also had to forgo income when family members accompanied the woman to seek treatment. Moreover, in a few cases, children had to start working to help with their mother's care. One woman said that her children had to bear the burden of her fistula. She reported that her children had to perform activities that were beyond their ability because they were still young [14].

2.2.6 Impact of Water Scarcity

A minority of women reported difficulty accessing or collecting water, as illustrated by this respondent: *"Unfortunately, carrying a small amount of water can use up what little energy I have. There is no helper at home yet the water requirement is high for laundry, cooking and bathing. So at times I pay young men to fetch 2 jerry cans for us." (Woman from Masaka, age 38)* Moreover, in areas where water supplies were scarce, women with fistula and their families had to allocate what little water they collected between the consumption needs of the family (for drinking, cooking, etc.) and the needs of the woman for bathing and washing her clothes.

One woman described the situation poignantly: [14] *"Imagine you have fistula. You have to walk 6 hours to get one bucket of water. Now, you have to decide how you are going to use the water -for washing, drinking, bathing, cooking, or for yourself." (Woman from Singida, Age 39).* Another woman with fistula explained: "Water …we get it from very far away and, if the children don't go to fetch the water, it can be a problem since I can't go myself because of the sores on my private parts." (Woman from Singida, Age 29) [14].

2.3 Coping with Fistula

2.3.1 Women's coping Mechanisms

Various coping mechanisms were used by the women to manage their fistula. A study done by Women's Dignity Project Tanzania revealed that half of the women mentioned the importance of strict hygiene, cleanliness and padding. This is similar to the finding done in Uganda. One woman related:*" At first, I hesitated to join groups of people … until my husband encouraged me by asking:' for how long shall you keep back and not interact with other people? Be courageous, pad yourself and go to your friends'. However, I only became used to visiting people after seven years. And still, whenever I go, I have to return soon before wetting the pads." (Woman A from Masaka, age unknown)* (21).

One young woman described how keeping clean became a significant and time-consuming part of her life: *"It is a difficult life and don't know whether I will get over it.*

I have to bath from time to time and I have to wash the clothes daily. If I don't keep myself clean, I smell a lot." (Woman from Soroti, age 17) [21]. A few women also mentioned that they cope with fistula by being courageous, ignoring other people's comments, praying and going to church, doing exercises, and eating less. One woman said: *"My doctor told me to do exercise, and I think that is why I managed to visit some of my friends." (Woman from Masaka, age 21).* Fewer than half of the women also told the research teams that they coped with their fistula by seeking treatment [20, 21].

Other coping mechanisms cited by respondents included: isolating themselves by staying home, keeping their fistula a secret, working, being supported by the family, praying and reading the bible, and perseverance/self determination [14]as a woman from Ukerewe said*" I can take care of myself. I grow my own food, run a fish business and fetch water, fuel wood, and, at some times, look after my health." (Woman from Ukerewe, Age 39).*

2.3.2 Sources of Support for Women with Fistula

In studies done in Uganda and Tanzania [20, 21] nearly all of the women were supported by at least one person in their family or community. Only a few numbers of women did not receive any support or did not mention receiving support during their interviews. The types of support most frequently offered were food, soap, and money.

One woman recalled:*" In the first stages of my fistula problem, just after I had been discharged from hospital, I received assistance from the community in the form of money, foodstuffs, and fruit for a month."(Woman A from Masaka, age unknown)* Several women also received help to seek treatment from a traditional healer or at a facility, while others described the emotional support of family members and help with their chores and work, as the following quote illustrates: *"My father has so far sold his only cow and a goat taking me for repair and maintaining me in Soroti hospital." (Woman from Soroti, age 19).*

By far the most frequent sources cited were parents and other relatives, such as aunts and uncles. A woman from Masaka explained: *"My family gives me help, especially my mother. She buys me soap and clothes and food. She has stood with me from the time I got fistula up to this day. Even here at the hospital, she is the one who nurses me. I also got some support from the community members. They paid me for casual work like digging, which I used to buy soap. It is only a small amount of money but it is helpful to me." (Woman from Masaka, age 19).*

Family support appeared to reflect the woman's overall relationship with her family, and the majority of women reported positive relationships. One woman said: *"I live with my brothers and sisters who easily cope with me. I can prepare meals, which they partake. We share the house and they do not insult me. They know I am their relative whether healthy or sick." (Woman from Masaka, age 23).* Another woman demonstrated how her family did not blame or abandon her for sustaining fistula: *"Instead, they sympathized with me. They thought that the machine the doctor used accidentally cut my bladder." (Woman from Soroti, age 17).*

Of those women who stayed married after fistula, the majority received support from their husbands. In general, spouses helped their wives with chores, such as washing, cooking, fetching water, and taking care of the children. Others addressed basic needs, such as getting soap; and several women expressed how their husbands provided them with emotional support and encouragement. A woman from Soroti related: *"I do domestic work like digging and keeping children but I fear to go to the well. I think that urine may leak into the well accidentally while I draw water. So it is my husband who goes to the well. He understands my problem. He listens to me and avoids any nonsense."(Woman from Soroti, age 27).*

Community members were mentioned as additional sources of support. In Soroti, a woman described the moral support she received from her community: *"In most cases, they encourage me to be strong hearted. When I was in the hospital for repair, they used to pray for me to get well." (Woman from Soroti, age 19)* One woman told the research team how a neighbor informed her about where to go for fistula repair:" *Before*

you came, my neighbor had informed me of the announcement made by Kitovu Hospital about the imminent treatment of fistula patients. She pleaded for me not to lose this chance. However, I had not yet secured the means of reaching the hospital. Overall, community members do not treat me badly. Although, I fear to interact with them, they usually visit me."(Woman A from Masaka, age unknown).

Unfortunately, fewer than half of the women mentioned negative family relationships as typified by the experience of a young woman in Soroti: *"My uncles threw me out of their homes even before many of the people in the village learned of my condition. Instead of sympathizing and giving me support, they were the first to chase me out of their houses." (Woman D from Soroti, age 18)* A few married women also did not receive any support from their husbands. In some cases, husbands neglected their wives, were involved in other relationships, or treated the women badly because they blamed them for the fistula. One respondent sadly explained: *"My husband has lost his love for me. He has even neglected me. His temper is now very high. Whenever he talks to me, he is always backbiting." (Woman B from Soroti, age 18)*

Many researches done on obstetric fistula utilize qualitative methodologies to explore the experience of mothers with the problem. However, to my knowledge none of the published studies used quantitative methodology to explore relationships between demographic variables and coping strategies used by these women; additionally, there are inconsistencies in the literature regarding demographic variables that may predict coping strategies used by women with obstetric fistula. Therefore, the aims of this study are to specifically focus on coping strategies used by Ethiopian women with Obstetric fistula and to identify relationships among sociodemographic variables and coping strategies used by these women. Based on my literature review, we can hypothesize that the coping strategies of positive reappraisal, seeking social support, and planful problem solving would be related to sociodemographic variables.

2.4 Significance of the study

A recent review of more than 2250 published studies on maternal mortality revealed a lack of research on obstructed labor, unsafe abortion, and hemorrhage in view of their burden on maternal health. Further more, research on the cultural and political determinants of maternal mortality was limited highlighting the need to better understand critical underlying risk factors for maternal mortality and morbidity-including obstetric fistula- such as a girls or woman's low social status, limited access to health care, knowledge and perceptions about maternal health, social political context, cultural norms and poverty [43]. Even worse, very little research is done on the stress and coping mechanisms of women with obstetric fistula.

The research is conducted to understand women's sources of stress and the coping strategies they have used so far in order to avert physical, psychological, economic and social problems they face as a result of the birth injury. Based on the finding of the research recommendations is forwarded to the concerned bodies of the study area, which will help in formulating appropriate intervention. The study will also help the researcher as a learning process to be able to conduct similar and other studies in the future at the working place.

Chapter 3

Objectives

3.1 General Objective:

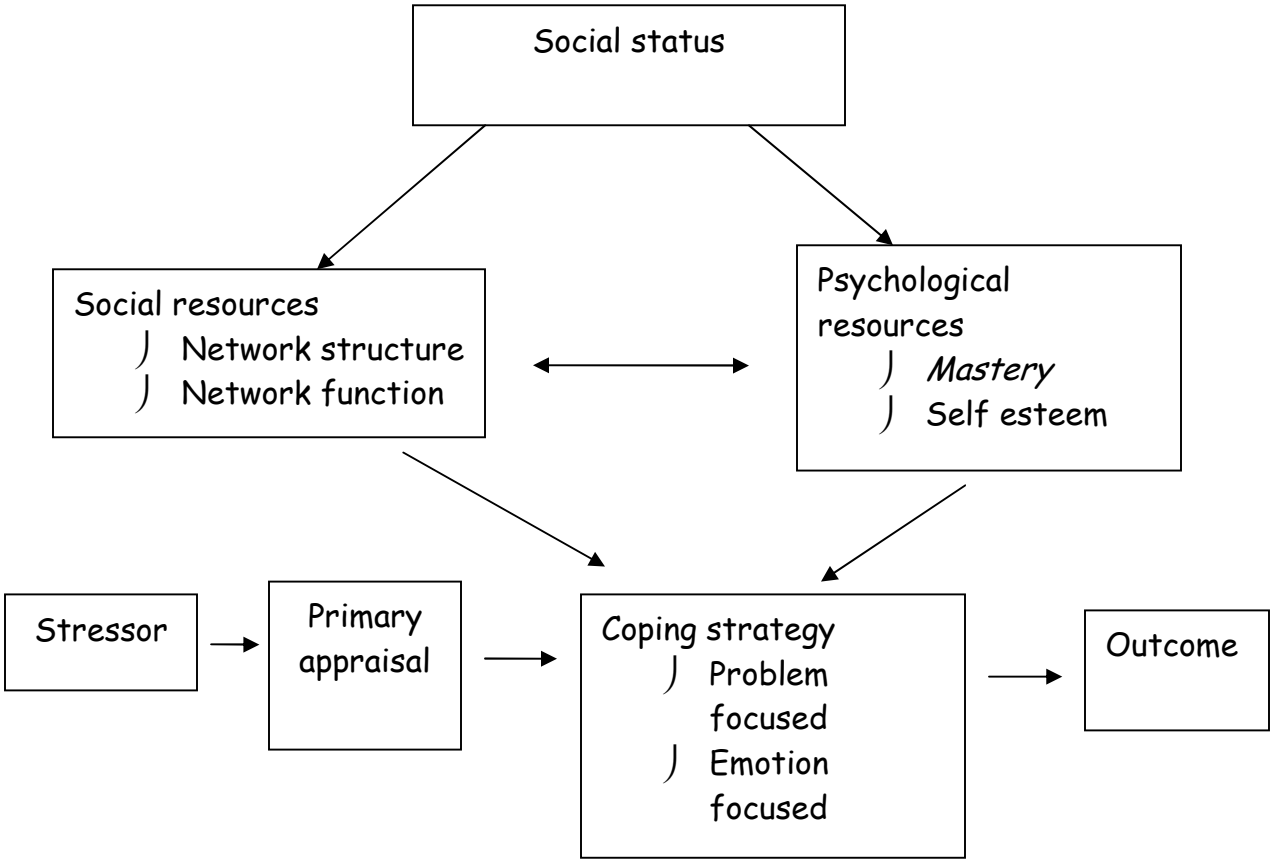
- To assess stress and coping strategies used by women living with Obstetric fistula

3.2 Specific objectives:

- To assess the sources of stress in women living with fistula
- To identify coping strategies used by these women to manage stressful situations they come across their life after the development of fistula.
- To explore women's experiences of living with fistula, including impact and coping mechanisms

3.3 Conceptual framework

Contextual model of coping



Chapter 4

Methods and materials

4.1 Study Area

The study was conducted at Addis Ababa Fistula Hospital about 7 kilo meters from the heart of the city. Drs. Reginald and Catherine Hamlin, both Gynecologist-Obstetricians, came to Ethiopia to set up a school for midwives at the princess Tsehai Memorial Hospital in 1959. They found that the plight of fistula patients so tragic that they immersed themselves in service to those suffering from Obstetric Fistula in Ethiopia. The need became so great that in 1974 they established Addis Ababa Fistula Hospital specifically for women with childbirth injuries. The hospital is located off the Jimma road section of the ring road in old Airport, Addis Ababa. The hospital has 127 bed capacities. The hospital is run by donations granted from different aiding agencies mainly from Australia and USA. The hospital has 3 Obstetrician Gynecologists, 25 clinical nurses, 1 stoma care nurse 1 psychiatry nurse 1 physiotherapy nurse, 2 anesthetist nurses 74 nurse aids, 2 physiotherapists, 2 pharmacists, 2 Laboratory technicians, and other supportive staff.

4.2 Study period:

The study was conducted between May 2009 and June2009.

4.3 Study design

A cross-sectional descriptive study design was used. Data was collected through background data sheet (BDS), stress questionnaire and the Ways of Coping Questionnaire (WCQ) developed by Folkman and Lazarus.[38]The BDS, used to obtain demographic data pertinent to the contextual stimuli such as age, marital status, income, and educational level. The stress questionnaire was used to assess the levels of stress and the WCQ served as a measure for cognator coping mechanisms utilized by women who are living with fistula.

4.4 Source population:

Women admitted to Addis Ababa Fistula hospital during the study period.

4.5 Study subjects

Study was inclusive of all women who were admitted to Addis Ababa Fistula Hospital during the study period and who fulfilled the inclusion criteria.

4.6 Sample size:

The following assumptions were made to determine the sample size: to obtain minimum sample size the expected prevalence of fistula among reproductive age group in the country was 1% (National DHS 2005) [39], with the margin of error (desired precision) 5%, 95% confidence interval. The actual sample size will be calculated using single proportion formula.

The formula to calculate the sample size

$$N = \frac{(Z\alpha/2)\, 2p\, (1-p)}{D^2}$$

$$= \frac{(1.96)2 \times .01(1-.01)}{(.05)^2}$$

$$= 155$$

Zα/2 =the confidence limits of the survey result (critical value at 95% confidence interval of certainty) = (1.96)

P= the proportion of study population experiencing fistula= 1%

D= the desired precision of the estimate [the margin of error between the sample and population (5%)]

N= the total sample size (155)

4.7 Study Variables:

4.7.1 Dependent Variable:

- Stress, coping mechanisms.

4.7.2 Independent Variables

- Maternal Age at interview, Age at fistula, Knowledge of pregnancy and labor, ANC attendance, the decision to attend ANC, health status during pregnancy, Educational status, Occupation, Ethnicity, Income Religion, Parity, Number of living children, Length of time with fistula, Accessibility of health care facility, Health impact, Economic impact, Impact on marital status.

4.8 Inclusion and exclusion criteria

Inclusion criteria

- Women who are willing to participate in the study
- Women with obstetric fistula
- Women who are oriented to time, place, and person (TPP)

Exclusion criteria

- Women who are not willing to participate in the study
- Women with other causes of fistula such as trauma, rape and so on
- Women who are not oriented to time, place, and person (TPP)

4.9 Data collection techniques and procedures

Data was collected utilizing a background data sheet; the Ways of Coping Questionnaire (WCQ) developed by Folkman and Lazarus, stress questionnaire and focus group discussions. The, background data sheet was useful to obtain demographic data that pertained to the contextual stimuli such as age, marital status, income, educational level, and length of time since diagnosis. The WCQ served as a measure for cognator coping mechanisms utilized by women who had been living with obstetric fistula. The stress

questionnaire was used to assess the stress levels of stressors .Two focus groups were formed with 8 women in each group. Purposive sampling was used to recruit women for FGD. Segmentation was done based on their characteristics such as age, social class, educational status, ethnicity etc…

The stress questionnaire is a 37 item, 5-point Likert-type instrument that assesses the level of stress with three subscales namely internal external and situational stressors. Participants were asked to respond to each item by indicating the degree of stress each stressor is causing with 0 indicating **"does not apply to me", 1 "only slight problem", 2 "moderate problem", 3 "a big problem", "4 a very big problem"**

The WCQ is a 31 item, 4-point Likert-type instrument that assesses cognitive and behavioral coping strategies with eight subscales. Participants were asked to respond to each item by indicating the frequency with which each strategy was used with 0 indicating **"not used," 1** indicating **"used somewhat," 2** indicating **"used quite a bit,"** and **3** indicating **"used a great deal."**The questionnaire was translated to Amharic to the interviewee by the translator who is available in the hospital.

The data was collected by five trained female nurses. The female nurses are preferred due to the sensitive nature of the study to make mothers feel comfortable to tell about their experiences more freely. Great care was taken during the training and supervision to avoid differences in interpreting the interview schedule.

4.10 Data Quality control Methods

The following measures were taken to maximize the quality of data: Five senior midwife nurse students collect the data after being provided with two days training; their recruitment was based on their academic performance and interest in working in data collection. The students had also been involved in data collection previously in another study. The Research advisor and an expert in the field of obstetric and gynecology from fistula hospital reviewed the interview schedule before the pilot study is conducted. The research advisor and the expert were asked to comment on the content, the

appropriateness and clarity of questions. Study participants were told that their responses are extremely confidential at any circumstance. No coercion to participate in the study.

4.11Data entry and analysis

Pre-coded data was entered and cleaned in SPSS soft ware version 17 and analyzed. Frequencies and proportion were used to describe the study population in relation to relevant variables. Raw scores and relative scores were calculated for the WCQ as described in the WCQ manual.[22] Raw scores represent the sum of the items divided by the number of items in that subscale. Multiple regression analyses was done with each coping subscale being regressed onto the sociodemographic variables of age, length of time since diagnosis, marital status, income, and educational level.

All categorical data were dummy coded. Relative scores were used to conduct multiple regression analyses where each coping subscale is separately regressed onto the sociodemographic variables. All of these data were analyzed utilizing the Statistical Package for the Social Sciences software program (SPSS, 2009) Version 17.0.

Taped interviews from the focus group discussion were transcribed verbatim. The transcribed text analyzed using grounded theory, an approach which is useful for identifying concepts, variables, and for generating hypotheses. Reading the transcripts and noting in the margins, the themes, patterns of attitudes, beliefs, and behaviors discussed by each woman. Themes, attitudes, beliefs, and behaviors were jointly reviewed, labeled, and assigned code numbers. The codes then compared and similar ones grouped into categories. After the codes were categorized, individual transcripts were compared with the categories to determine common patterns.

4.12 Ethical Consideration:

In order to conform to the ethical and legal standards of the scientific investigation, the proposal was reviewed by the Institutional Review Board of Medical Faculty of Addis Ababa University and permission was granted for the study to be conducted. In addition

the ethical committee of Addis Ababa fistula hospital has reviewed the proposal and granted permission for the study. The interview took place in an area where there is little traffic and when possible in a separate room in the ward, and the questionnaires were treated anonymously. Participation was voluntary. This was clearly stated in the informed consent which the informants were asked to sign before the interview. Each woman was told that the information obtained from her is treated with complete confidentiality.

4.13 Dissemination and utilization of results

The finding of this study will be communicated to governmental and non–governmental organizations, institution or individuals that have direct or indirect in put in the study and in the prevention of obstetric fistula in Ethiopia. This can be accomplished through submission of reports, presentation of finding at appropriate meetings and workshops and through publications on scientific Journals.

4.14 Operational definitions:

Stress: – is a condition in which a woman responds to changes in its normal balanced state.

Coping: Refers to what a woman thinks or does to try to manage an emotional encounter

Obstetric fistula: Obstetric fistula is a hole (or "false communication") that forms between the bladder and the vagina (known as a vesico-vaginal fistula, or VVF) or between the rectum and the vagina (a recto-vaginal fistula, or RVF) during prolonged and obstructed labor.

Coping strategies: which are a woman's active behavioral and/or cognitive efforts to deal with a particular demand

Chapter 5

Result

Table1. Socio-Demographic Characteristics of women with Obstetric fistula at Addis Ababa Fistula Hospital June 2009

Variables		Frequency	
		N	Percent
Age at interview			
	<20.	49	31.6
	20-24	39	25.2
	25-29	36	23.2
	30+	31	20.0
	Total	155	100
Age at marriage			
	<15	51	34.2
	15-19	87	58.4
	20-24	9	6.0
	25-29	2	1.3
	Total	149	96.1
Educational level			
	Unable to read and write	102	65.8
	Able to read and write	19	12.3
	Grade 1-4	21	13.5
	Grade 5-8	11	7.1
	Grade 9-10	2	1.3
	Grade 11-12	0	0
	Total	155	100
Occupation			
	Unemployed	107	69
	Self employed	40	25.8
	Government employee	1	0.6
	Other	7	4.5
	Total	155	100
Average monthly family income			
	No income	53	34.2
	< 100	45	29
	100-300	50	32.3
	> 300	7	4.5
	Total	155	100

Marital status			
	Unmarried	7	4.5
	Married	60	38.7
	Widowed	2	1.3
	Divorced	59	38.1
	Separated	26	16.8
	Living together	1	0.6
	Total	155	100
Para			
	1	104	67.1
	2	14	9
	3	20	12.9
	4+	17	11
	Total	155	100
Number of living children			
	0	110	71
	1	17	11
	2	11	7.1
	3	6	3.9
	4+	11	7.1
	Total	155	100

Table 1 depicts the summary of demographic characteristics of the participants in this study. Total number of respondents in this study was, 155 (100%). Majority of the participants, 88(56.8%) are below the age of 25. 138(89%) of the attendants had their first marriage below the age of 20. At the time of interview 60(38.7%) of the participants were married while 85(54.9%) divorced or separated, and 1(0.6%) mother is living in the same compound with her husband but not any more having contact with him. 86(58.9%) mothers divorced or separated after the development of fistula and from these 83(96.5%) believed that their divorce is caused by fistula. Educational levels ranged from not able to read and write to grade 10. Majority of the participants are not able to read and write 102 (65.8%). Most of them have no job 107(69%) that reflected on their income by showing a large figure on no income category 53(34.2%). Most of the mothers developed fistula in their first delivery 104(67.1%).

A little more than half of the attendants 82(52.9%) did not have any knowledge regarding pregnancy, labor, and delivery prior to the pregnancy that resulted in fistula. The other half that is 72(46.5%) had knowledge regarding pregnancy labor and delivery prior to the pregnancy that caused fistula. A few women learned about pregnancy from local health workers 5(6.8%), school teachers 5(6.8%), and mothers 11(15.1%) on the other hand past pregnancies 38(52.1%) and observing/learning from other women 14(19.2%) were the most common sources of knowledge.

62(40%) of the women in the study had gone for antenatal care (ANC) at least once. Of the women who mentioned how they made the decision to go for ANC, fewer than half 32(52.5%) said they had decided by themselves to go. For these women, their decision to attend ANC was largely because they had seen other women go or because their friends encouraged them to go. Of the remaining women, fewer than half went for ANC because a family member - parents, husbands, in-laws - had decided that they should go, while a few mentioned that the decision was made by a physician.

For the women who did not go for ANC, it was mostly because they have never heard about ante natal care service 35(37.6%) or distance to services was too large 33 (35.5%). Those who mentioned distance as a problem they had to travel from four hours to a day to reach to services.

The majority of the women interviewed 140(90.3%) indicated that they were planning to deliver at home, and the reason was because it is custom to deliver at home 79(56.8%). For women who did not decide for themselves on where to deliver, different individuals have been cited as decision maker. For 50(49%) of the women, decision has been made by husbands and for another 50(49%) attendants, families including mother in-laws made the decision.

Table2: Obstetric history of women at Addis Ababa fistula hospital June 2009

Variable	**Frequency**	
	N	Percent
Duration of labor *** 50 mothers delivered at home**		
24 hours and below	25	23.8
1-3 days	53	50.5
More than three days	27	25.7
Total	105*	100
Outcome of delivery		
Alive	16	10.3
Dead	139	89.7
Total	155	100
Mode of delivery		
Abdominal	29	18.7
Instrumental	63	40.6
Spontaneous	63	40.6
Total	155	100
Age at which fistula occurred		
<15	14	9
15-19	81	52.3
20-24	33	21.3
25-29	14	9
30-34	8	5.2
35-39	5	3.2
Total	155	100

Condition of marriage after fistula *9 mothers were single		
Intact	52	35.6
Separated	28	19.2
Divorced	58	39.7
Forced to leave the house	1	0.7
Married another man	7	4.8
Total	146*	100
Number of Times Women Sought Treatment Or Repair		
Once	65	41.9
Twice	46	29.6
Three times and more	19	12.3
Did not seek repair	25	16.1
Total	155	100
Reasons for Not Seeking Repair		
Did not have sufficient funds	13	48.1
Did not know where to go	10	37
Embarrassed to sit in taxi with other people when going for treatment	2	7.4
No one to look after house and children	1	3.7
Informed by community there was no cure for fistula	1	3.7
Total	27	100

Of the 155 participants whose age at the time of fistula was recorded, 95(61.3%) of the mothers developed fistula before the age of 20, while 14 (9%) mothers had fistula between the ages of 25-29. Participant's length of time since the diagnosis of fistula ranged from 1 month to 16 years. 29(18.7%) cases had fistula for seven or more years. As can be seen from table two, outcome of labor for majority of the mothers was painful. 110(71%) mothers were left childless following painful and prolonged labor.

For those mothers who delivered in health institutions, 27(17.4%) mothers had been in labor for more than three days before they move; 53(34.2%) mothers have been pushing at home for one to three days and the rest 25(16.1%) sought for help within 24 hours.

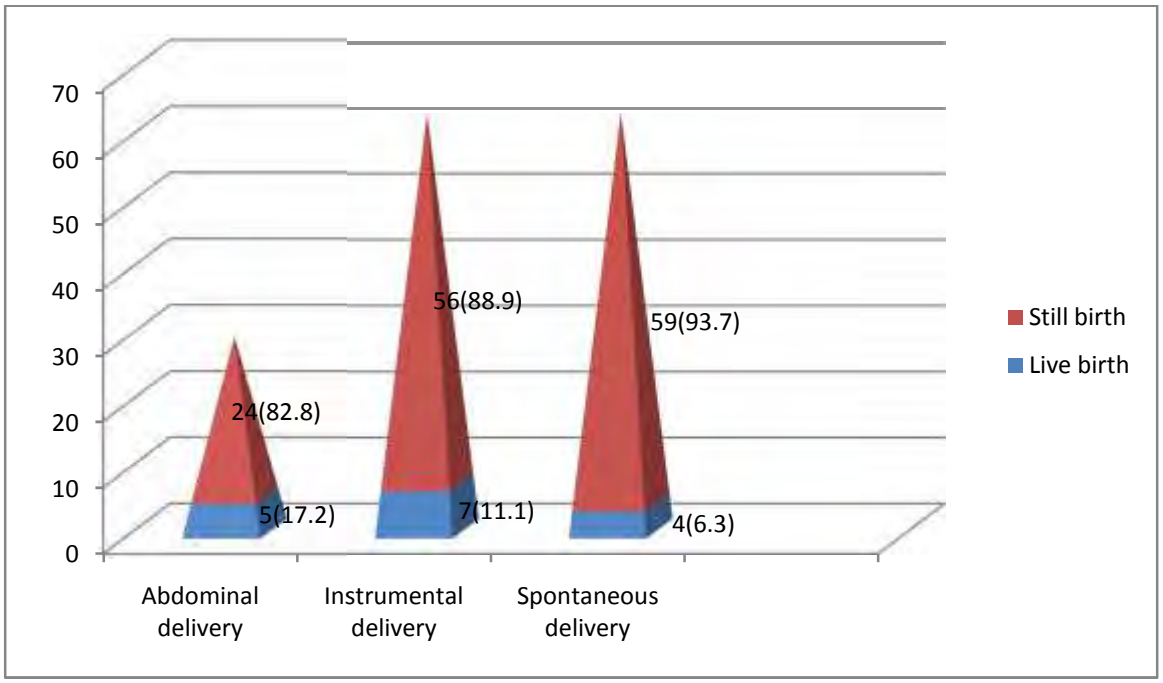


Figure 1: Delivery outcomes for mothers who reached at a health care facility at Addis Ababa Fistula Hospital Addis Ababa June 2009

As shown in figure 1 those who reached health settings for delivery, whether they have been delayed or not, 29(18.7%) of the mothers had an abdominal delivery, and 63(40.6%) had an instrumental delivery, and 63(40.6%) had spontaneous delivery. Of the abdominal deliveries, only 5(17.2%) deliveries ended up in live births; and from instrumental deliveries, only 7(11.1%) were born alive and only 4(6.3%) babies were born alive from spontaneous deliveries.

Table3. Relative Score Stress Subscales among Women with Obstetric Fistula in Addis Ababa Fistula Hospital June 2009

Stress Subscales	**Mean**	**SD**
Internal stressors	61.81	11.35
External stressors	27.01	7.09
Situational stressors	26.80	8.06

Based on relative scores of the standardized items, internal stressors are causing high level of stress by looking at the Mean and SD (Mean 61.81 and SD 11.35) followed by external stressors Mean 27.01 and SD 8.06. As shown in Table 15, situational stressors are with the least level of stress among women with obstetric fistula.

Table 4: Assessment of Level of stress based on age in women living with obstetric fistula in Addis Ababa Fistula Hospital June 2009

Stress subscales	**<20 M/SD**	**20-24 M/SD**	**25-29 M/SD**	**30+ M/SD**	**F**	**P**
Internal	63.34 (11.76)	60.51 (9.80)	61.47 (12.83)	61.45 (10.94)	.48	.69
External	26.79 (7.15)	26.94 (7.00)	27.27 (7.82)	27.12 (6.55)	.03	.99
Situational	26.24 (7.53)	25.94 (9.10)	26.76 (7.93)	29.51 (7.44)	1.48	.22

As can be seen from the above table the P value is larger than.05 which is indicating non significance of age in relation to women's stress level. Internal stressors are with the highest Mean and SD. Age group below 20 has Mean 53.346 and SD. 25-29 age group is the second highest Mean 61.472 and SD 12.836 From the stressors external stressors have the lowest Mean and SD.

Table 5: Assessment of Level of stress based on marital status in women living with obstetric fistula in Addis Ababa Fistula Hospital June 2009

Stress subscales	**Single M/SD**	**Married M/SD**	**Widowed M/SD**	**Divorced M/SD**	**Separated M/SD**	**F**	**P**
Internal	65.42 (11.01)	58.78 (11.55)	74.00 (8.48)	65.08 (10.10)	60.53 (10.793)	3.96	.002
External	28.28 (9.48)	25.06 (6.92)	27.00 (5.65)	28.55 (6.89)	28.34 (5.82)	3.19	.009
Situational	20.57 (9.41)	24.73 (7.07)	28.00 (8.48)	29.28 (8.05)	28.26 (7.48)	4.46	.001

The above table shows that the P value is less than.05 for all subscales of stress which is indicating significance association between marital status and subscales of stress namely internal stressors, external stressors and situational stressors. From the three subscales of stress internal stressors are with the highest Mean and SD. Widowed women are with the highest Mean 74.00 and SD 8.48 suggesting they have high level of stress in internal stressors than others followed by single mothers Mean 65.42 and SD 11.01. A level of internal stressors is very low in married mothers. Situational stressors do have higher level in women who are divorced Mean 29.28 and SD 8.05. Women who are single do score a low level of Mean and SD in situational stressors 20.57(9.41) indicating less level of situational stressors. Mothers who are divorced score the highest Mean in external stressors indicating that they have high level of external stressors than their counterparts Mean 28.55 and SD 6.89. In this subscale the least Mean is found in married women 25.06(6.92).

Table 6: Assessment of Level of stress based on income status in women living with obstetric fistula in Addis Ababa Fistula Hospital June 2009

Stress subscales	**<100 M/SD**	**100-300 M/SD**	**>300 M/SD**	**No income M/SD**	**F**	**P**
Internal	64.06 (10.54)	61.94 (12.65)	56.00 (14.67)	60.56 (10.06)	1.43	.23
External	27.95 (7.05)	28.92 (6.73)	23.42 (7.52)	24.88 (6.86)	3.85	.011
Situational	27.13 (7.40)	29.48 (8.13)	21.42 (8.44)	24.71 (2.47)	4.34	.006

The finding of P value less than 0.05 in the above table indicates the significance of income in two subscales of stress namely external and situational stressors. From the two subscales of stress situational stressors are with the highest Mean and SD. Women who have an income between 100 and 300 are with the highest Mean 29.48 and SD 8.13 suggesting they have high level of stress in situational stressors. Those who are earning monthly income below 100 are with the second highest level of stress in situational stressors with Mean 27.13 and SD 7.40. Mothers with an income above 300 birr per month are with low level of stress in situational stressors Mean 21.42 and SD 8.44. External stressors are causing high level of stress in mothers that are earning money between 100-300 birr per month Mean 28.92 and SD 6.73. Mothers who are earning an income 100-300 birr per month are with the second highest level of stress in external stressors Mean 27.95 and SD 7.40. External stressors cause low level of stress in those mothers that are earning monthly income above 300 birr. Income does not have statistical significance in relation to internal stressors according to our finding.

Those who are earning monthly income less than 100 birr per month are with the highest Mean while those earning a high income are with the lowest Mean.

Table 7: Assessment of Level of stress based on educational status in women living with obstetric fistula in Addis Ababa Fistula Hospital June 2009

Stress subscales	**Able to read and write M/SD**	**Unable to read and write M/SD**	**1-4 grade M/SD**	**5-8 grade M/SD**	**9-10 grade M/SD**	**F**	**P**
Internal	57.63 (11.00)	63.20 (11.66)	60.33 (8.19)	58.00 (13.05)	67.50 (9.19)	1.57	.18
External	29.10 (6.60)	26.67 (7.43)	26.57 (5.70)	26.72 (7.73)	30.50 (4.94)	.60	.65
Situational	26.31 (6.67)	27.10 (8.24)	25.66 (9.10)	27.18 (7.85)	26.00 (5.65)	.16	.95

The above table shows that P value for educational status is larger than.05 which is indicating non significance of educational status in relation to women's stress level. Internal stressors are with the highest Mean and SD. Age group below 20 has Mean 67.50 and SD 9.19. Those who are unable to read and write score Mean 63.20 and SD 11.66. From the stressors situational stressors have the lowest Mean and SD.

Table8. Relative Score Coping Subscales among Women with Obstetric Fistula in Addis Ababa Fistula Hospital June 2009

Coping subscale	**Mean**	**SD**
Confrontive Coping	3.80	1.50
Distancing	5.73	2.04
Self-controlling	9.10	2.26
Seeking social support	11.69	3.72
Accepting responsibility	4.73	1.84
Escape-avoidance	15.52	3.84
Planful problem solving	20.34	3.85
Positive reappraisal	5.60	1.30

Based on relative scores of the WCQ, the most frequently used coping strategies are planful problem solving Mean 20.34 and SD 3.85 escape avoidance Mean 15.522 and SD 3.84 and seeking social support Mean 11.69, SD 3.72 followed by self controlling and distancing. As shown in Table 11, the other coping strategies were not as common. Confrontive coping was the list used coping strategy among participants.

Table 9: Levels of women's coping ability based on age in Addis Ababa Fistula Hospital June 2009

Coping subscale	**< 20 M/SD**	**20-24 M/SD**	**25-29 M/SD**	**30+ M/SD**	**F**	**P**
Confrontive Coping	3.79 (1.55)	3.74 (1.44)	3.86 (1.69)	3.83 (1.31)	.04	.76
Distancing	5.73 (2.19)	5.17 (1.87)	5.75 (2.00)	6.41 (1.94)	2.15	.09
Self-controlling	8.9388 (2.27)	9.,46 (2.37)	9.11 (2.13)	8.90 (2.32)	.48	.69
Seeking social support	11.67 (3.86)	11.28 (3.16)	12.58 (4.08)	11.19 (3.69)	1.03	.38
Accepting responsibility	4.63 (1.94)	5.10 (1.65)	4.80 (1.73)	4.35 (2.02)	1.02	.38
Escape-avoidance	15.69 (3.74)	14.51 (3.34)	16.13 (3.78)	15.80 (4.52)	1.30	.27
Planful problem solving	20.28 (3.88)	19.76 (3.82)	20.91 (3.54)	20.48 (4.25)	.56	.63
Positive reappraisal	5.77 (1.04)	5.41 (1.42)	5.61 (1.49)	5.58 (1.31)	.56	.63

As can be seen from the above table the P value is larger than.05 which is indicating non significance of age in relation to women's coping ability. Planful problem solving is with the highest Mean and SD. Women at the age category 25-29 score the highest mean and

SD 20.91(3.54) followed by above 30 age group Mean and SD 20.48(4.25). Escape avoidance is the second coping subscale with high Mean and SD. Women in the age group of 25-29 have 16.13 Mean and 3.78 SD. The least Mean and SD is found in Confrontive coping

Table10: Levels of women's coping ability based on marital status among women at Addis Ababa Fistula Hospital June 2009

Coping subscale	**Single M/SD**	**Married M/SD**	**Widowed M/SD**	**Divorced M/SD**	**Living together M/SD**	**F**	**P**
Confrontive Coping	3.14 (1.86)	3.75 (1.51)	3.50 (.70)	4.01 (1.58)	3.57 (1.17)	1.08	.37
Distancing	5.00 (1.00)	5.81 (1.89)	7.00 (1.41)	5.83 (2.39)	5.53 (1.74)	.77	.56
Self-controlling	7.57 (2.69)	9.13 (2.50)	10.50 (2.12)	9.11 (2.12)	9.30 (1.91)	.83	.53
Seeking social support	10.85 (4.84)	11.63 (4.09)	10.00 (1.41)	12.11 (3.49)	11.30 (3.20)	.46	.80
Accepting responsibility	3.28 (1.25)	4.78 (1.83)	5.00 (.00)	4.69 (1.94)	5.07 (1.76)	1.07	.21
Escape-avoidance	13.64 (4.07)	15.31 (4.03)	13.00 (7.07)	16.11 (3.73)	15.76 (2.79)	2.24	.05
Planful problem solving	17.28 (2.92)	20.05 (3.77)	16.50 (7.77)	21.15 (3.78)	20.38 (3.82)	2.00	.08
Positive reappraisal	6.00 (.81)	5.65 (1.44)	5.50 (2.12)	5.62 (1.08)	5.42 (1.52)	.54	.74

The P value for marital status is larger than.05 which is indicating non significance of marital status in relation to women's coping ability. Planful problem solving is with the

highest Mean and SD. Women who are divorced are found to have the highest mean 21.15 and SD (3.78) followed by women who are living together with their husbands Mean 20.38 and SD 3.82. Escape avoidance is the second coping subscale with high Mean and SD. Women who are divorced have 16.11 Mean and 3.73 SD. The least Mean and SD is found in Confrontive coping 3.14(1.86).

Table11: Levels of women's coping ability based on income status in Addis Ababa Fistula Hospital June 2009

Coping subscale	**<100 M/SD**	**100-300 M/SD**	**>300 M/SD**	**No income M/SD**	**F**	**P**
Confrontive Coping	3.91 (1.50)	3.98 (1.49)	3.71 (2.13)	3.56 (1.43)	.75	.52
Distancing	6.08 (2.26)	6.52 (1.87)	4.71 (1.38)	4.83 (1.69)	7.84	.00
Self-controlling	9.90 (2.18)	9.60 (2.34)	7.58 (2.85)	8.86 (2.13)	1.73	.16
Seeking social support	11.75 (4.17)	12.20 (3.94)	13.00 (4.83)	10.98 (2.81)	1.25	.29
Accepting responsibility	4.80 (1.82)	5.32 (2.10)	3.85 (1.57)	4.24 (1.45)	3.64	.01
Escape-avoidance	16.64 (3.82)	15.98 (3.68)	15.14 (4.48)	14.18 (3.62)	3.87	.01
Planful problem solving	21.33 (4.47)	19.98 (3.08)	23.00 (3.00)	19.49 (3.80)	3.24	.02
Positive reappraisal	5.60 (1.40)	5.92 (1.38)	5.42 (1.27)	5.33 (1.10)	1.75	.15

The above table shows that there is association between a woman's income and coping strategies. From the eight subscales four of them do have P value below 0.05 Just like the previous two tables planful problem solving has a high Mean and SD with p-value .024 Women with an income level above 300 scored the highest Mean and SD 23.00(3.00)

which is indicating that this group highly utilize planful problem solving than the other group followed by those with an income below 100 Mean 21.33 and SD 4.47.

Mothers with no income category utilize planful problem solving less frequently than their counterparts. Escape avoidance is the second subscale with large mean. Women with an income below 100 are frequent utilizers Mean 16.64 and SD 3.82 followed by income category group 100-300 Mean 15.98 and standard deviation 3.68. Mothers who are categorized as no income are the least utilizers of distancing.

Distancing is the third subscale with significant p value (.00) Women in the income category of 100-300 have the highest Mean in the group that is 6.52 and SD 1.87 followed by income earners below 100 Mean 6.08 and SD 2.26. This subscale is less frequently utilized by mothers who have no income. Accepting responsibility is the last significant coping subscale with low Mean 5.32 and SD 2.10 mothers who are getting monthly income of 100-300 are the frequent utilizers followed by those who are getting below 100 Mean 4.80 and SD 1.82. Of this subscale mothers with the highest income are less utilizer.

Table12: Levels of women's coping ability based on educational status in Addis Ababa Fistula Hospital June 2009

Coping subscale	**Able to read and write M/SD**	**Unable to read and write M/SD**	**1-4 grade M/SD**	**5-8 grade M/SD**	**9-10 Grade M/SD**	**F**	**P**
Confrontive Coping	3.78 (1.65)	3.80 (1.51)	3.61 (1.20)	4.54 (1.57)	2.00 (.00)	1.48	.20
Distancing	5.68 (2.64)	5.78 (1.96)	5.09 (1.75)	6.54 (2.06)	6.00 (2.82)	.96	.42
Self-controlling	8.57 (2.11)	9.23 (2.31)	9.33 (1.93)	8.45 (2.65)	8.50 (3.53)	.64	.62
Seeking social support	11.84 (3.37)	11.64 (3.66)	10.66 (3.61)	14.27 (3.37)	9.00 (2.82)	2.05	.09
Accepting responsibility	4.73 (2.02)	4.74 (1.85)	4.80 (1.56)	4.81 (2.08)	3.00 (1.00)	.45	.77
Escape-avoidance	16.05 (4.04)	15.49 (4.13)	15.61 (2.78)	14.63 (2.76)	16.00 (1.41)	.24	.91
Planful problem solving	21.00 (3.63)	19.94 (3.85)	19.95 (3.21)	23.63 (3.72)	20.50 (7.77)	2.57	.04
Positive reappraisal	5.26 (1.62)	5.509 (1.216)	6.333 (1.278)	5.454 (1.213)	7.000 (.000)	.82	.02

The association between a woman's educational status and coping strategies is statistically significant. From the eight subscales two subscales have P value below 0.05 Planful problem solving is with the highest Mean from this group women who are 5-8 grade have 23.63 Mean and 3.72 SD showing that this category group utilize planful problem solving more than the other group. Women who are able to read and write have the second highest Mean 21.00 and SD 3.63 .From those who have shown statistical significance women who are unable to read and write are the least utilizers of this coping

subscale. The second subscale with statistical significance is positive reappraisal having p value 0.02 Mothers who are 9-10 grade are the highest utilizers of this subscale with Mean and SD 7.00(.00). Women who are 1-4 grades are the second most utilizers of positive reappraisal Mean 6.33 and SD (1.27). Positive reappraisal is less commonly utilized by who are able to read and write. The other coping subscales do not have statistical significance in relation to educational status of the mother.

Qualitative study

Two groups of women eight in each group were assigned for focus group discussion to see the impact of fistula on women's physical health, marital status, social relationships, economic status and to understand their coping mechanisms

Years living with fistula

There was a significant range in length of years with fistula, spanning from one year to sixteen years. The majority of women had lived with fistula for four years or more at the time of the study. Three women had lived with fistula for more than ten years, eleven, thirteen and sixteen years respectively. The reason given for not seeking treatment was did not know treatment was available or they could not afford to get to hospital or they are ashamed to go by transport while leaking

On women's physical health

Mentioned health problems were foot drop, feeling lack of energy, tiring easily, constant wetness and lack of control of stool, and back pain were common health problems mentioned by mothers. One woman described: *"I was unable to go to the toilet so I was dependent on my father when I feel to go to the toilet but most of the time the stool was leaking even before I knew it"* (Woman A aged 26). For majority of women access to a health facility was a problem either because of distance, lack of money or lack of assistance from family members to take them to health facilities. Woman D described *"I was begging my uncles to take me to hospital whenever I see them, even though they*

come rarely" Pain in the uterus; headache, abdominal pain, and dehydration are among the less frequently encountered problems.

On marital status

Almost all of the women who took part in focus group discussion had been married before the occurrence of fistula and all had been subsequently divorced following the occurrence of fistula and those who had been single they remained single. *"My husband said, now you have this problem because of your sin so I don't want to live with such kind of person and he throwed out my clothes, actually we had a lot of cattle and money"* (woman H). The finding is similar to that of Tanzania and Bangladesh [20,7] and different from Uganda [15]

Social and psychological impacts

Almost all women with fistula isolated themselves from their communities. They remained in their homes as much as possible, stopped making social visits, and no longer attended public events such as funerals, celebrations and meetings. Almost all stopped even going to church or mosque. The reason given was a strong sense of shame about their condition and did not want to soil themselves in public or to smell badly.

Woman C explained "*family members who do not know about my problem they want me to come to their house and stay few days there I always give them one or another reason now they have given up and no body is asking me no more"* Another woman described what she encountered in a public transport. *" I was going by bus not a long distance when I got out from home I was careful not to drink water and to put a lot of pad under my pants to prevent leakage but unfortunately I was leaking and the people around me noticed the smell and saw my soiled skirt and were looking at me, specially one young man he was saying loudly "hey lady you smell urine I cannot stand you" I jumped from the bus long way before I reach my stop and I was crying the whole way".*

Another woman expressed this *"I did not want people to visit me because of my condition once there was no one at home and a friend from neighborhood came to see if*

I need anything I told her that I am ok and tried to show her how strong I am but I fell down and sustained a laceration on my head. I did it not because I hated her but because I did not want anyone to know that I am leaking. Stigma also comes from significant others sometimes, woman M age 30 described how her own mother and father treated her badly *"I was living, eating, and playing with them before my problem but after it they made a shabby house which is leaking when it is raining and they throw me food through the door no one is talking to me"*.

Woman F sadly described how her grand parents returned her back to her mother after she sustained fistula *"I was brought up by my grand parents since when I was three at the age of 17 I sustained fistula and they sent me back to my mother, I did not know her much and she was married to another man and he was not welcoming and he was telling my mother to take me back to where I belong"*. Almost all the women who took part in focus group discussion are reluctant to return home this is due to the severe stigma they experience as a result of fistula.

Economic impact of fistula

Nearly all the women in the discussion said that the condition affected their ability to work some due to physical inability others due to demands made by the problem because they have to be near to places where they can get water for cleaning and they need sometime to care for themselves and others due to stigma associated with fistula. This has affected their means of income. Woman G expressed "*I was working in a café serving tea and coffee in between I had to go to the backroom to change pad once the owner notice my brief absence and asked me where I was I told her the reason the same day she sent me without my pay"*.

Women's coping mechanisms

Various coping mechanisms have been utilized by women to manage their problem. The most frequent coping mechanism cited by almost all women is prayer. Woman B expressed *"I get up early and go to church and pray to God to free me from my problem this I do everyday"*. All women mentioned that they keep their cleanliness by washing themselves washing their clothes and padding. Isolating themselves by staying home, keeping their fistula a secret, and being supported by family are less frequently cited

coping mechanisms by participants.”Woman K expressed *“my father reads me stories from bible he specially read for me Jobs book how job was struggling with his pain suffering and loss this has given me a lot of encouragement”.*

Source of support

This study revealed that women had at least one source of support from the family or community. Only a few numbers of attendants did not mention receiving any support or did not mention receiving support during their interviews. They were given different types of support such as food money assisting in washing clothes and fetching water. Woman D age 32 expressed *“My family had been a great asset to me when I was struggling with my problem, My father takes me out to sun my brothers wash my clothes and even my cousins come to help me so I had not been alone.* The most frequent sources of support cited were close family members such as mother, father brother, sisters sometimes uncles, aunts and cousins. For some neighbors were also mentioned as support system. Even in one case the mother has lost her husband because she decides to care for her daughter. *After my problem my husband divorced me so I had to go back to my mother there I did not get a good face from my step mother and he was nagging my mother to choose between him and me my other asked the elders to look through the matter and they had several meetings to settle it but with no good outcome. At last her marriage ended up in divorce because she did not want to throw me out”.*

Chapter 6

Discussion

This study showed similar findings like other studies, reporting a large number of women with fistula who are young and primigravida[15,18]. In fact, most of the women 133(85.8%) develop fistula before the age of 20. But, this finding is different from the findings in Uganda and Tanzania[12,13] where the participant's age at the time they sustained fistula was 20 years or more. Fewer women i.e. 5(3.2%) were 30 or more when the fistula occurred. In addition, about two thirds of the women, 104(67.1%) were in their first pregnancy, only 17(11%) developed fistula in their fourth or more pregnancy. The above finding indicates that fistula primarily affects young women in their first pregnancy; expanding the widely held assumption that fistula predominantly affects very young women on their first pregnancy

The majority of women 96(61.9%) had lived with fistula for one or more years this is also similar to a study done in Uganda.[15]At the time of the interview, the majority 130(83.9%) had already sought fistula repair or were seeking treatment. Of these women who sought repair, majority of them 117(75.4%) went only to one facility. Smaller number 13(8.4%) went to multiple places (including traditional healers) [12,13,15,18] Among all who did not sought treatment prior to interview stated that, 13(48.1%) I did not have money to seek treatment and 10(37%) mothers given the reason of not knowing where to go. Other reasons cited were embarrassed to sit in taxi/bus with other people when going for treatment, no one to look after house and children, and information gained from community members stating no cure for fistula. Similar reasons were cited in studies done by women's Dignity project and Engender health in Tanzania.[18]The finding shows that women face multiple barriers to get treatment for their problem, including economic, distance, and psychologic.

93(60%) of the women in the study had not gone for antenatal care which is larger than findings from Uganda and Tanzania.[12,13] For those women who did not go for ANC, it was mostly because they have never heard about ante natal care service 35(37.6%) or

distance to services was too large 33 (35.5%). Those who mentioned distance as a problem, they had to travel from four hours to a day to reach to services.

Our study analyzed levels of stress and coping strategies used by women with obstetric fistula. Many of our participants were divorced or separated, uneducated, and had relatively no personal incomes. Thus more insight is provided regarding the levels of stress and coping strategies used among women with obstetric fistula from this type of socioeconomic background.

In general women with obstetric fistula are exposed to stress in varying severity namely internal, external, and situational stressors. Based on relative scores of the standardized items, internal stressors are causing high level of stress followed by external stressors and situational stressors. From internal stressors, constant wetness is considered a very big problem by 81.9% of mothers, while 78.1% considered feeling ashamed to go to public places as a very big problem, and 57.4% of the respondents considered not having a hope to recover from fistula is a very big problem. Fear of not able to marry again is responded as no problem by 61.3% of the respondents followed by irregularity of menstruation 56.8%.

From external stressors staying at home because of fistula is considered a very big problem by 67.7% of the respondents while being insulted and ridiculed by others in the community is considered a very big problem by 58.7%. And 40.6 % of the respondents considered the amount of money their family spends on them for treatment are a very big problem. Unable to go to school is considered no problem by 68.4% of the respondents. Situational stressors are causing low level of stress in general. But from situational stressors, being unable to work at all, and being dependent on others as a result of fistula are considered a very big problem by 56.1% of the respondents.

The association of some demographic variables with stress level is verified statistically but it is associated inconsistently which requires further study.

There is statistical association between marital status and level of stress. Widowed women are with high level of stress in internal stressors than others while divorced women exhibit high level of stress in situational stressors and external stressors. Married women show low level of stress compared to the other group therefore marital status has a positive relationship with level of stress. Those women who are married show low levels of stress while those mothers who are single, divorced, or widowed show high level of stress

Coping strategies used among women in this study are similar to coping strategies reported by women with obstetric fistula who had lower incomes and were less educated.[12,13,15,18,25] this suggests that socioeconomic status may play a significant role in levels of stress and coping strategies in this population. Although research studies show that coping strategies are related to how people adapt to problem, it remains unclear how demographic variables may predict coping strategies used among women with obstetric fistula due to lack of quantitative research in this area.

Women's dignity project and Engender Health did a detailed qualitative research in three districts and one medical center in Tanzania and found that those who were married, had high income and education levels, used lower levels of avoidant coping had better adjustment, while length of problem was not related to adjustment. In a qualitative study of women coping with obstetric fistula, having an income and receiving social support from family members and friends helped them cope with the challenges of their fistula.[15,18] Using both quantitative methods and qualitative methods, we found similar results in that planful problem solving and seeking social support are the most frequently used coping strategies among women. This study showed that there was a significant relationship between sociodemographic variables and coping strategies.

There is lack of quantitative research in area of obstetric fistula to compare our mean subscale scores for the WCQ to other studies so we cannot say whether mean score for WCQ is higher or lower in this sample of women with obstetric fistula compared to another study of population. Women in this study use 4 out of 8 coping strategies namely planful problem solving, distancing, escape-avoidance positive reappraisal, and

seeking social support. From these coping subscales planful problem solving is used quite most, one of the reasons why planful problem solving may be used more among women with obstetric fistula is because of the nature of the problem which require frequent washing, cleaning and other means of problem solving.

Social support is important to women coping with obstetric fistula.[12,15,18] in this study, women used planful problem solving as a coping strategy more frequently than seeking social support. In the previous qualitative study of Ugandan and Tanzanian women, planful problem solving in the form of washing oneself, seeking treatment, padding and washing clothes frequently was used more frequently than positive reappraisal. In all three studies [12,15,18] there is no differences in the type of social support used Individuals who utilize planful problem solving as a coping strategy focus their efforts on planning and taking direct action to solve a problem which is related to better adjustment to their problem.[45] Participants in this study frequently used planful problem solving to cope with obstetric fistula.

Patients who utilize coping strategies such as distancing and escape-avoidance have more psychological distress related to their problem[35] Since a large number of women in this study used escape-avoidance and distancing as coping strategies, this suggests that women with obstetric fistula are susceptible to this negative coping approach. The qualitative study result shows no differences in the use of escape avoidance and distancing as a coping strategy in this sample or in studies done elsewhere.[12,15,18] People who are using these coping strategies are prone to blame themselves for the disease .

Accepting responsibility and Confrontive coping were the least frequently used coping strategies among women in this study which was similar to studies of obstetric fistula cases elsewhere.[12, 15, 18]

Chapter 7

Limitation of the study

- Studies based on interviewing patients in health care facilities are often biased because, girls and women who were already at a facility might not be a representative of all those living with fistula; they may represent women with greater proximity to health care facilities, family and social support, and/or economic resources.
- Those mothers who have been admitted to Fistula hospital, but who are not able to speak Amharic are excluded from the study this excludes the voices of mothers who should have had their say in this study.
- Women who are young do not have access to health care services or who are isolated are generally excluded.
- Findings on social vulnerability are regionally and culturally specific and therefore cannot be generalized.
- Retrospective methods require people to recall how they coped with an experience and thus are likely to be influenced by systematic and non- systematic sources of recall error. Coping efforts as well as psychological outcomes such as distress are best measured close to when they occur.
- Time was another limitation, permission from the IRB and ethical committee of Fistula hospital was so late that has seriously affected the time we should take to analyze the result and finding more literatures for comparison

Chapter 8

Conclusion and Recommendation

8.1 Conclusion

In this study we have assessed stress levels and coping strategies utilized by women with obstetric fistula in women admitted to Addis Ababa fistula hospital and came up with valuable scientific evidences. Based on the finding of this study it is possible to arrive at the following conclusions.

- Research findings show that obstetric fistula is excessively high where women lack education, economic autonomy, decision-making power, and access to appropriate reproductive health services, including emergency obstetric care.[1] The finding of this study is similar to the above finding. In this setting women who are young, living far from health settings, and with low income are the most frequently affected by fistula.
- In general women with obstetric fistula are exposed to high level of stress namely internal, external, and situational stressors.
- Internal stressors are causing high level of stress among women with obstetric fistula followed by external stressors.
- From internal stressors, constant wetness is considered a very big problem by 81.9% of mothers, while 78.1% considered feeling ashamed to go to public places as a very big problem, and 57.4% of the respondents considered not having a hope to recover from fistula is a very big problem.
- Fear of not able to marry again is responded as no problem by 61.3% of the respondents followed by irregularity of menstruation 56.8%.
- From external stressors staying at home because of fistula is considered a very big problem by 67.7% of the respondents while being insulted and ridiculed by others in the community is considered a very big problem by 58.7%. And 40.6 % of the respondents considered the amount of money their family spends on them for treatment are a very big problem.
- Unable to go to school is considered no problem by 68.4% of the respondents
- Situational stressors are causing low level of stress in general. But from situational stressors, being unable to work at all, and being dependent on others

as a result of fistula are considered a very big problem by 56.1% of the respondents.

- The association of some demographic variables such as marital status, income, and educational status, with stress level is verified statistically but their association is inconsistent.
- Women who were divorced, separated, or single were at risk of high level of stress
- Women who were married or living with their husbands were with low level of stress
- The most frequently used coping strategies are planful problem solving, escape avoidance, and seeking social support followed by self controlling and distancing. The other coping strategies are not as common. Confrontive coping was the list used coping strategy among participants.
- Socioeconomic status may play a significant role in levels of stress and coping strategies in this population.

8.2 Recommendation

- Demographic variables (income, education, marital status) were related to coping strategies used by women in this study; but without consistency therefore, further research is needed to explore contextual variables that may predict how women cope with obstetric fistula.
- It is vital for nurses to recognize the role that coping strategies may contribute in the adaptation to obstetric fistula among women and develop culturally sensitive interventions that may contribute to their survival of the problem.
- Planful problem solving, Positive reappraisal and seeking social support are common coping strategies used by women with obstetric fistula in this study and previous studies; therefore, nurses should consider utilizing these coping strategies to help women with obstetric fistula.
- Research is needed to explore how having a positive attitude and seeking social support can affect coping with obstetric fistula among women.
- Since coping strategies such as distancing, escape-avoidance, and accepting responsibility are reported to increase psychological distress for patients, [45] it is essential for nurses to teach women who utilize these strategies in more adaptive

ways of coping with obstetric fistula so they can have better health outcomes from their problem.

- Because of multifaceted problems of fistula there is a need for a holistic approach that pays as much attention to caring for the psycho-social as well as physical wounds inflicted on these women.
- Obstetric fistula caring places must encompass education, literacy training, the development of social networks, and the provision of skills with which to earn an adequate livelihood, in order to overcome the social problems that these women face.
- There is a great need for community-based studies of the sources of stress and coping strategy in women living with obstetric fistula.
- Healing from obstetric fistula is physical, psychological, social, economic, and spiritual in nature. Beside the surgical care to close the fistula, there is a need for social, economic, spiritual, and psychological rehabilitative care.
- There is a need for establishment of community-based organisations to create reintegration programmes for those who are returning to their home after fistula repair. It is important that women living with fistula are involved in the development of such programmes.
- Strengthen health system capacity to provide skilled maternity care that is accessible, affordable, and culturally acceptable
- Promote the empowerment and reintegration of women into communities' post-repair.
- Expanded access fistula services are required to reach those in need
- Although many fistula patients have been out casted by family members or communities, it is also common for them to have isolated themselves, for this reason counselling must often include key messages of acceptance to help women.
- Ensuring that mothers receive skilled maternity care throughout pregnancy, childbirth, and postnatal period
- Access to emergency obstetric care including caesarean section must be ensured.

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Annex

Annex-I-Information sheet

Addis Ababa University

Medical Faculty

Centralized School of Nursing

Survey Questionnaire

Subject Information Sheet

You are invited to participate in a research study to be conducted by a master's student at the Addis Ababa University, Faculty of Medicine, Centralized School of Nursing. Please read the following statements and ask any unclear questions before you agree to participate.

1. **Topic:** Assessment of the sources of stress and coping strategies in women with problem of obstetric fistula in Addis Ababa Ethiopia
2. **Objective of the study:** The purpose of this study is to assess the sources of stress and coping strategies used by women with obstetric fistula and to explore socio-demographic variables such as age, income, education, marital status, and length of time since the occurrence of obstetric fistula. The information you give will be used to improve the services that are provided to these women and to prevent the occurrence of such problems in the future. The survey asks questions about your experience in relation to fistula and your means of coping.
3. **Participation procedure and guidelines:**
    a. The information you provide will be kept completely anonymous. That is, your name will not be on any of the forms.
    b. It will take about 60 minutes to complete the survey. Nevertheless if you don't want to participate in the study please notify me
    c. Because the questionnaires are prepared in Amharic if you have problem in understanding the language properly please tell me so that I can arrange translator
4. **Participation benefits and risks:**
    a. Your participation in this study does involve risks that are greater than those you experience in your daily life. You might feel some discomfort from

responding some items on the questionnaire. But again, the risk of discomfort is not greater than you might have in other normal activities.

b. You also might experience some benefits from participating in this project. These benefits might be positive feelings from helping with an important research study and your responses will assist in developing appropriate preventive and promotive strategies, to equip mothers with resources to cope with stressful situations after the development of obstetric fistula. Participating in this study will also give you opportunity to learn about your coping behavior through introspection.

c. No incentives will be given for participating in this study

5. **Rights to refuse or withdraw:** Your participation is voluntary, and there is no penalty for you not wanting to participate. This means that you are free to stop at any point or to choose not to answer any particular question or all the questions.
6. **Rights as a participant:** You have a right to have any questions about this research project answered. Please direct any questions to Mesfin Mengesha: Centralized school of Nursing, Medical Faculty, Addis Ababa University. cell phone: +251-911-373996 E-Mail: nifsemmen@yahoo.com for additional information, please feel free to contact the Addis Ababa University, Faculty of Medicine Institutional review Board at +251-115-538734 or E-MAIL aaumf@yahoo.com
7. **Agree to Participate:**

Yes _____ No _____

Signature _____ Date _____

<u>አዲስ አበባ ዩኒቨርሲቲ የሕክምና ፋኩልቲ</u>
<u>አጠቃላይ ነርስ ት/ቤት ለተሳታፊዎች የቀረበ</u>
<u>የዳሰሳ ጥያቄ</u>

በአዲስ አበባ ዩኒቨርሲቲ የሕክምና ፋኩልቲ በአጠቃላይ ነርስ ት/ቤት በማስተርስ ተማሪዎች የሚካሄደውን ጥናት እንዲሳተፉ ተጋብዘዋል፡፡

እባክዎ በጥናቱ ከመሳተፍዎ በፊት ከዚህ በታች የተመለከቱትን መግለጫዎች ያንብቡና ግልፅ ያልሆኑ ጥያቄዎች ካሉ ይጠይቁ

1. **ርእስ፡- በአዲስ አበባ ፊስቱላ ሆስፒታል በወሊድ ምክንያት በተፈጠረ ፊስቱላ ተኝተው የሚታከሙ እናቶችን የጭንቀት መንስኤና ጭንቀቱንም የመቋቋሚያ መንገዶች ለማወቅ የተደረገ ጥናት፡፡**

2. **የጥናቱ አላማ፡- በወሊድ ምክንያት የፊስቱላ ችግር ያጋጠማቸውን እናቶች የገጠማቸውን ችግርና ችግሩን እንዴት እንደተቋቋሙት ለማወቅ ነው፡፡**

3. **የተሳትፎ አካሄድና መመሪያ፡-**

   ሀ. እርስዎ የሚሰጡት መረጃ ሙሉ በሙሉ ማንነትዎን አይገልፅም ስምዎም በማንኛውም ቅፅ ውስጥ አይሰፍርም

   ለ. ይህን መጠይቅ ለማጠናቀቅ 60 ያህል ደቃቂዎች ይፈጃል በጥናቱ ለመሳተፍ ፍቃደኛ ካልሆኑ ሊያሳውቁን ይችላሉ፡፡

   ሐ. መጠይቁ በአማርኛ የተዘጋጀ በመሆኑ መጠይቁን በትክክል መረዳት ወይም መመለስ ካስቸገረዎት አስተርጓሚ ላቀርብልዎ እችላለሁ፡፡

4. **በጥናቱ በመካፈል የሚያገኙቸው ጥቅሞችና ጉዳት፡-**

   ሀ. በዚህ ጥናት መሳተፍዎ እለት ከእለት ከሚያደርጉት እንቅስቃሴ ሊያጋጥምዎ ከሚችል ጉዳት የበለጠ አይደለም ምናልባት አንዳንድ ጥያቄዎችን ለመመለስ ምቾት ላይሰማዎት ይችላል ይህም ቢሆን እለት ለዕለት ከሚያደርጉት እንቅስቃሴ የባሰ ችግር የለውም

   ለ. በዚህ ጥናት መሳተፍዎም አንዳንድ ጥቅሞች ሊያስገኝልዎ ይችላል ይኸውም ምናልባት በዚህ አስፈላጊ ወይም ጠቃሚ ጥናት በመሳተፍዎ የሚሰማዎ ጥሩ ስሜት ሊሆን ይችላል ምላሽዎም በእናቶች ላይ ተመሳሳይ ችግር እንዳይከሰት ከተከሰተም ችግሩን እናቶች እንዴት መቋቋም እንዳለባቸው ለመረዳትና ለማገዝ ያስችለናል፡፡

5. **በጥናቱ ያለመሳተፍና የማቋረጥ መብት፡- ተሳትፎዎ በፈቃደኝነት ላይ የተመሠረተ ስለሆነ በጥናቱ ባለመሳተፍዎ የሚደርስብዎ ቅጣት የለም ይህም ማለት በማንኛውም ጊዜና ሰአት ተሳትፎዎን ማቆም ወይም ምንም አይነት ጥያቄ ያለመመለስ ይችላሉ፡፡**

6. **እንደተሳታፊ ያለዎት መብት፡- በዚህ ጥናት ላይ ያለዎትን ማንኛውንም ጥያቄ መጠየቅና ምላሽ ማግኘት ይችላሉ እባክዎ ጥያቄዎን ለመስፍን መንገሻ አጠቃላይ ነርስ ት/ቤት የሕክምና ፋኩልቲ አዲስ አበባ ዩኒቨርሲቲ ሞባይል ቁጥር 0**911-373996 **ኢ.ማይል**. nifsemmen @ yahoo.com **ለበለጠ መረጃ አዲስ አበባ ዩኒቨርሲቲ የሕክምና ፋኩልቲ የጥናትና ምርምር አጥኚ ኮሚቴ በ** +251-115-538734 **ኢ.ማይል**. aaumf@yahoo.com **ያለስጋት ሊያቀርቡ ይችላሉ፡፡**

7. **ለመሳተፍ ተስማምቻለሁ**

አዎን **የለም** _____
ፊርማ _____ **ቀን** _____

Annex-II- Consent form

CONSENT FOR PARTICIPATION IN RESEARCH STUDY

I, _____, agree to take part in a research study on Assessment of the sources of stress and coping strategies in women with problem of obstetric fistula in Addis Ababa Ethiopia" as a part of Mesfin Mengesha's masters dissertation, under the direction of Rajalakshmi Murugan MScN, Asst Professor, AAU.

The purpose of this study is to discover the sources of stress and coping strategies used by women with obstetric fistula and to explore socio-demographic variables such as age, income, education, marital status, and length of time since the occurrence of obstetric fistula. I understand that I am being asked to participate in this study because I am a victim of obstetric fistula. I understand that participation in this study is strictly voluntary. The study personnel may choose to stop my participation at any time. I understand that no guarantees or assurances can be made as to the results of the study.

This study will begin in April, 2009 and end no later than June, 2009. I consent to participate in one face-to-face interview which will last approximately one hour and will occur at an agreed location. I agree to have this interview tape recorded. Only the primary investigator, Mesfin Mengesha, his supervising professor, Rajalakshmi Murugan, or persons responsible for transcription will have access to this taped interview. I agree to complete a basic questionnaire about things such as my age, marital status, and employment. This questionnaire will be stored in a locked file when not in use by the research team and will be destroyed when the study ends. I understand that my name will be kept in confidence and that I will not be personally identifiable in the results of this study.

I understand that the procedures used in this study are without significant risk. However, I understand that I can withdraw from this study at any time without any consequences. Some people find answering questions about their disease stressful. I understand that I may be at risk of experiencing stress or emotional discomfort and that,

if I do, no form of compensation is available. If I seek any medical treatment, I will pay for it myself.

I understand that I should contact Rajalakshmi Murugan MScN, Asst Professor, AAU at the centralized school of nursing at Addis Ababa University at +251-911-721193 or Mesfin Mengesha at +251-911-373996 if I have further questions or any problems related to this study.

This research study has been reviewed and approved by the IRB of Medical faculty of Addis Ababa University Committee for the Protection of Human Subjects.

I voluntarily consent to participate in this study. I certify that I have had this research study explained to me and had ample opportunity to ask any questions. All questions on my mind have been answered to my satisfaction. I have read, understand, and have been told that I will receive a signed copy of this consent form.

Participant: _____Date:_____

I certify that I have explained the study and research procedures to the participant signing above. I have explained the known benefits and risks of the research. It is my opinion that the participant understood the explanation.

Investigator:_____Date: _____

በጥናቱ ለመሣተፍ የተሠጠ የፈቃድ ማረጋገጫ

በአዲስ አበባ ፊስቱላ ሆስፒታል በወሊድ ምክንያት በተፈጠረ ፊስቱላ ተኝተው የሚታከሙ እናቶች የጭንቀት መንስኤና ጭንቀትን የመቋቋሚያ መንገዶች ለማወቅ የተደረገ ጥናት

እኔ ----------ከላይ በርዕሱ በተገለጸውና በረዳት ኘሮፌሰር ራጂላክሽሚ ሙሩጋን መሪነት አቶ መስፍን መንገሻ ለማስተርስ ዲግሪ በሚያደርገው የምርምር ጥናት ውስጥ ለመሣተፍ ያለማስገደድ ሙሉ ፈቃደኛነቴን ሰጥቻለሁ፡፡

የዚህ ጥናት ዓላማ በወሊድ ምክንያት የፊስቱላ ችግር ያጋጠማቸውን እናቶች የገጠማቸውን ችግርና ችግሩን እንዴት እንደተቋቋሙት ለማወቅ ነው፡፡ በዚህ ጥናት እንድሣተፍ የተደረገው እኔም የችግሩ አንዷ ተጠቂ በመሆኔ ነው፡፡ በዚህ ጥናት እንድሣተፍ ምንም ዓይነት ጫና እንደማይደረግብኝ አውቃለሁ፡፡ የዚህ ጥናት አድራጊዎች በማንኛውም ሰዓት ከጥናቱ ተሳታፊነቴ ሊሰርዙኝ መብት እንዳላቸው እረዳለሁ፡፡ የዚህን ጥናት ውጤት በተመለከተ ምንም ቅድመ ማረጋገጫ እንደማላገኝ አውቃለሁ፡፡ ነገር ግን የዚህን ጥናት ውጤት በማንኛውም ሰዓት ከአቶ መስፍን መንገሻ ላገኝ እንደምችል አውቃለሁ፡፡

ይህ ጥናት በሚያዚያ ወር 2001 ዓ.ም ተጀምሮ በሠኔ 2001 ማለቅ ያለበት ነው፡፡ ፊት ለፊት በሚደረግ የቃለ ምልልስ ለመሳተፍ ስስማማ፡፡ ወደ አንድ ሠዓት ገደማ የሚፈጀው ይህ ቃለ ምልልስ በቴኘ እንዲቀረፅ ወድጄ ፈቅጃለሁ፡፡ ይህም ሲሆን ዋነኛ ተመራማሪ መስፍን መንገሻ የቅርብ ተመልካች ረ/ኘሮፌሰር ራጅላክሽሚ ሙሩጋን ወይም ይህን የተቀረጸ የቃለ ምልልስ ድምፅ ከሚተረጉሙ ሰዎች ውጭ በሌሎች ሰዎች እጅ እንደማይገባ አውቃለሁ፡፡ የተቀረጸው ድምፅ ለምርምር ስራው አስፈላጊ ባልሆነበት ወይንም ምርምሩ /ጥናቱ/ ከተጠናቀቀ በኋላ እንደሚቃጠል አውቃለሁ፡፡

መሠረታዊ የግል መረጃዎቼ እንደ ዕድሜ የጋብቻ ሁኔታ የሥራ ሁኔታ የመሳሰሉትን በሙሉ ፈቃደኛነት ሰጥቻለሁ ፡፡ ማንነቱ በሚስጥር እንደሚጠበቅ በመጠሪያ ስሜ በጥናቱ ሂደት እንደማልታወቅ እገነዘባለሁ፡፡
የጥናቱ ሂደት ምንም አይነት አደጋ እንደማያስከትልብኝ እረዳለሁ፡፡ በፊለኩም ጊዜ ያለምንም ተጨማሪ ችግር እራሴን ከጥናቱ ተሣትፎ ማግለል እችላለሁ፡፡ ምናልባት መጠነኛ የሆነ መጨነቅ ወይም የስሜት መረበሽ ይገጥመኛል ብዬ እገምታለሁ፡፡ ለዚህም ምንም አይነት ካሳ እንደማይኖር አውቃለሁ፡፡ ምንም አይነት የሕክምና እርዳታ ቢያስፈልገኝ እራሴ ወጭውን እችላለሁ፡፡ከጥናቱ ጋር የተያያዙ ተጨማሪ ጥያቄዎች ቢኖሩኝ በአዲስ አበባ ዩኒቨርስቲ ሜዲካል ፋካልቲ አጠቃላይ ነርስ ትምህርት ቤት ረዳት ኘሮፌሰር ራጂላክሽሚ ሙሩጋን በ+251-911-721193 ወይም አቶ መስፍን መንገሻን በ + 251-911-373996 መጠየቅ እንደምችል አውቃለሁ፡፡

ይህ የምርምር ስራ በአዲስ አበባ ዩኒቨርስቲ ሚዲካል ፋካልቲ የጥናትና ምርምር አጽዳቂ ኮሚቴ ማለፉንና ይሁንታ ማግኘቱን አውቃለሁ፡፡ ጥያቄዎች ወይም ጥርጣሬ ቢኖረኝ ይህንን ኮሚቴ በ +251-115-538734 ኢ.ማይል. aaumf@yahoo.com ማነጋገር እንደምችል አውቃለሁ፡፡

ይህ ጥናት በቂ ማብራሪያና ለመጠየቂያም በቂ ጊዜ ተሠጥቶኝ በአምሮዬ ይመላለሱ የነበሩ ጥያቄዎች በሙሉ በሚያረካ መልኩ ተመልሠውልኛል፡፡ ፊርማዬ ያረፈበት የዚህ የፈቃድ ማረጋገጫ ቅጅ እንደሚሰጠኝ ተነግሮኝ ተስማምቼ በዚህ ጥናት ውስጥ ለመሳተፍ በሙሉ ፈቃደኝነት ወስኛለሁ፡፡

ተሳታፊ ----------ቀን ----------

ከዚህ በላይ ስምና ፊርማቸው ለሰፈረው ተሳታፊ በበቂ ሁኔታ የምርምሩን ምንነት አላማውን ሂደቱን ጥቅሙንና ጉዳቱን እንዳስረዳኋቸው አረጋግጣለሁ፡፡ በእኔ እምነት ተሳታፊዋ ገለፃዬን ተረድተውታል ብዬ አምናለሁ፡፡

መርማሪ ---------- ቀን ----------

ANNEX-III-QUESTIONNAIRE

ADDIS ABABA UNIVERSITY

MEDICAL FACULTY CENTRALIZED SCHOOL OF NURSING

QUESTIONNAIRE PREPARED TO DETERMINE STRESS AND COPING IN WOMEN WITH PROBLEM OF OBSTETRIC FISTULA AT ADDIS ABABA FISTULA HOSPITAL (2001 E.C)

INSTRUCTION

1. You are kindly requested to fill in all blank spaces

2. Do not leave any item of information without answer

Date of interview

Day _____month _____ year_____

Name of interviewer_____ Code _____

Section I: Background data sheet

Ser.no.	Questions	Alternatives
Section I SOCIO - DEMOGRAPHIC QUESTIONS		
1.1	Age of the respondent	1. < 20 2. 20 – 24 3. 25 – 29 4. 30 +
1.2	Ethnicity	1. Amhara 2. Oromo

		3. Tigre 4. Gurage 5. Others (Specify) _____
1.3	Religion	1. Orthodox 2. Protestant 3. Muslim 4. Catholic 5. Others (Specify)
1.4	Marital status	1. Unmarried 2. Married 3. Widowed 4. Divorced 5. Separated 6. Living together
1.5	Educational status	1. Illiterate 2. Able to read and write 3. 1-4 grade 4. 5-8 grade 5. 9-10 grade 6. 11-12 7. College and above
1.6	Occupation	1. No work 2. Housewife 3. Self employed 4. Government employee 5. Student 6. Others (specify)
1.7	Monthly income	1. <100 birr 2. 100-300 birr

		3. >300 4. No Income
1.8	Number of living children	1. 0 2. 1 3. 2 4. 3 5. 4+
1.9	Parity at the time of fistula development	1. 1 2. 2 3. 3 4. 4+
1.10	Age at marriage	1. <15 2. 15-19 3. 20-24 4. 25-29 5. 30-34 6. 35-39 7. >39
1.11	Age at first pregnancy	1. <15 2. 15-19 3. 20-24 4. 25-29 5. 30-34 6. 35-39
1.12	Age at which fistula occurred	1. <15 2. 15-19 3. 20-24 4. 25-29 5. 30-34 6. 35-39 7. >39

1.13	Condition of marriage after the occurrence of fistula	1. Intact 2. Separated 3. Divorced 4. Forced to leave the house 5. Married another man
1.14	Do you believe that you are separated, divorced or forced to leave the house because of fistula?	1. Yes 2. No
SECTION II: PREGNANCY HISTORY		
2.1	Did you attend Ante Natal Care?	1. Yes 2. No
2.2	When did you start attending?	1. 1st three months 2. 2nd three months 3. 3rd three months
2.3	How many times did you have prenatal visits during pregnancy?	1. 1-2 2. 3-4 3. 5+
2.4	Why did you decide to go for Ante Natal Care? You may give more than one response.	1. Because I had seen other women going 2. Because my friends encouraged me to go 3. Because my family members asked me to go 4. Because a physician told me to attend 5. Others(specify)
2.5	Who made the decision for you to go for Ante Natal Care? You may give more than one response.	1. Myself 2. My husband 3. My mother- in -law 4. My husband and I 5. My family of origin 6. Others (specify)
2.6	If you did not go for ANC what was your reason? You may give more than one response.	1. No illness during this pregnancy 2. Never heard about ANC 3. Illness during pregnancy 4. Lack of time

		5. Bad experience with the service 6. Economic problem 7. Distance 8. Not having the decision making power 9. Others (specify)
2.7	If your reason for not going for Ante Natal Care is "distance" how far is the health institution from your home?	1. About 1 to 3 hours walk 2. About 4 to 6 hours walk 3. About 7 to 8 hours walk 4. It takes about a day
2.8	How long did you have the fistula?	1. Less than one year 2. 1-3 years 3. 4-6 years 4. 7-10 years 5. More than 10 years
2.9	Did you seek help for your problem?	1. Yes 2. No
2.10	If you had been seeking help for your problem where did you seek to get help?	1. Health care facility 2. Traditional healer 3. Both health care facility and traditional healer 4. Unclear where repair sought
2.11	Who told you that fistula can be repaired? You may give more than one response.	1. My husband 2. Teachers 3. My mother- in- law 4. A neighbor 5. A friend 6. Health workers 7. Others
2.12	How many times did you seek help?	1. One time 2. Two times 3. Three times and above
2.13	If you did not seek help for your	1. Did not have sufficient money for treatment

	problem, what was your reason?	2. Did not know where to go 3. Embarrassed to sit in a public transport with other people when going for treatment 4. No one to look after house and children 5. Fear of discrimination by Doctors and Nurses 6. Fear of leaking while waiting in long queues for attention 7. Informed by others that there was no cure for fistula 8. Others
SECTION III: KNOWLEDGE OF PREGNANCY AND LABOR		
3.1	Did you have any knowledge regarding pregnancy, labor and delivery before the pregnancy that caused fistula?	1. Yes 2. No
3.2	If your answer is "yes" who was your source of information?	1. Local health workers 2. From my mother 3. School teachers 4. Past pregnancy 5. Observing and learning from other women 6. Others (specify)
SECTION IV: BIRTH PREPARATION		
4.1	Where was your planned delivery site?	1. Home 2. Clinic 3. Health center 4. Hospital
4.2	If your plan of delivery site was outside of health institution, what was your reason?	1. Economic problem 2. Because of fear of bad outcome 3. Because it is custom to deliver babies at home 4. Because my mother- in -law said so 5. Others (specify)

4.3	Was there any one beside you that made the decision on where to deliver?	1. Yes 2. No
4.4	Who made the decision on where to deliver?	1. My husband 2. My mother- in- law 3. My neighbors 4. My family of origin 5. Others (specify)
SECTION V: LABOR AND DELIVERY		
5.1	Where did the labor start?	1. At home 2. At church/mosque 3. At work 4. Other place (specify)
5.2	At what time did the labor start?	1. In the morning 2. In the afternoon 3. At night
5.3	Where was your place of delivery	1. At home 2. Clinic 3. Health center 4. Hospital 5. Others
5.4	If your place of delivery is outside a health institution who assisted you?	1. My mother- in- law 2. My mother 3. Traditional birth attendant 4. A neighbor 5. Myself 6. Other (specify)
5.5	How long were you in labor before you go to the health facility?	1. 24 hours and below 2. 1-3 days

		3. More than 3 days
5.6	What was the mode of delivery?	1. Spontaneous 2. Instrumental 3. Abdominal
5.7	What was the outcome of delivery? The child is	1. Alive 2. Dead

አዲስ አበባ ዩኒቨርስቲ

የህክምና ፋኩልቲ አጠቃላይ ነርስ ት/ቤት

በአ/አ ፊስቱላ ሆስፒታል ለሚገኙ በፊስቱላ ችግር ምክንያት ለሚታከሙ ሕመ·ማን የቀረበ ቃለ መጠይቅ

መመሪያ

1. **ሁሉንም ባዶ ቦታዎች እንዲሞሉ በአክብሮት ይጠየቃሉ**
2. **የቀረቡት ጥያቄዎች በሙሉ መመለስ ይኖርባቸዋል**

ቃለ ምልልሱ የተካሄደበት

ቀን _____ወር _____ ዓመት _____

የጠያቂው ስም _____ መለያ ቁ. _____

ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች
ክፍል አንድ: መሠረታዊ የግል መረጃዎች		
1.1	**እድሜዎ ስንት ነው**α	1. ‹20 2. 20-24 3. 25-29 4. 30^{+}
1.2	**የየትኛው ብሔረሰብ አባል ነዎት**α	1. **አማራ**

		2. ኦሮሞ 3. ትግሬ 4. ጉራጌ 5. ሌላ.....
1.3	ሀይማኖትዎ ምንድን ነው	1. ኦርቶዶክስ 2. ፕሮቴስታንት 3. ሙስሊም 4. ካቶሊክ 5. ሌላ ይገለጥ
1.4	የጋብቻ ሁኔታ	1. ያላገባች 2. ያገባች 3. ባል የሞተባት 4. የፈታች 5. የተለያየች 6. አብራ የምትñር
1.5	የትምህርት ደረጃዎα	1. ማንበብና መፃፍ እችላለሁ 2. ማንበብና መፃፍ አልችልም 3. 1-4 ክፍል 4. 5-8 ክፍል 5. 9-10 ክፍል 6. 11-12 ክፍል 7. ኮሌጅና ከዚያም በላይ
1.6	ሥራዎ ምንድ ነውα	1. ሥራ የለኝም 2. የቤት እመቤት 3. የግል ድርጅት 4. የመንግስት ተቀጣሪ 5. ተማሪ

		6. ሌላ ይገለፅ _____
1.7	የእርስዎ የወር ገቢ ስንት ነውα	1. ‹100 ብር 2. 100-300 ብር 3. ›300 ብር 4. ገቢ የለኝም_____
1.8	በሕይወት ያሉ ልጆች ቁጥርα	1. 0 2. 1 3. 2 4. 3 5. 4+
1.9	ስንተኛ ልጆዎን ሲወልዱ ነው ፊስቱላ ያጋጠመዎα	1. 1 2. 2 3. 3 4. 4^{+}
1.10	ትዳር ሲመሰርቱ እድሜዎ ስንት ነበርα	1. ‹ 15 2. 15-19 3. 20-24 4. 25-29 5. 30-34 6. 35-39 7. ›39
1.11	የመጀመሪያ ልጆዎን ሲያረግዙ እድሜዎ ስንት ነበርα	1. ‹15 2. 15-19 3. 20-24 4. 25-29 5. 30-34 6. 35-39
1.12	የፊስቱላ ችግር ሲገጥምዎ ዕድሜዎ ስንት	1. ‹15

	ነበርα	2. 15-19 3. 20-24 4. 25-29 5. 30-34 6. 35-39 7. ›39
1.13	የፊስቱላ ችግር ካጋጠመዎ በኃላ ትዳርዎ እንዴት ነውα	1. አሁንም በትዳር ላይ ነኝ 2. ተለያይተናል 3. ተፋትተናል 4. ቤቱን ለቅቄ እንድሄድ ተገድጃለሁ 5. ፈትቼ ሌላ አግብቻለሁ
1.14	ትዳርዎ የፈረሰው የፊስቱላ ችግር ስላጋጠመኝ ነው ብለው ያስባሉα	1. አዎን 2. የለም
	ክፍል ሁለት: የእርግዝና ታሪክ	
2.1	ቅድመ ወሊድ ክትትል ነበረዎትα	1. አዎን 2. የለም
2.2	የቅድመ ወሊድ ክትትል ካደረጉ ስንተኛ ወርዎ ላይ ጀመሩα	1. የመጀመሪያዎቹ ሦስት ወር 2. ከ 4-6 ወር ባለው የእርግዝና ወቅት 3. ከ 7-9 ወር ባለው የእርግዝና ወቅት
2.3	ምን ያህል ጊዜ የቅድመ ወሊድ ክትትል አደረጉα	1. 1-2 2. 3-4 3. 5^{+}
2.4	ለምን የቅድመ ወሊድ ክትትል ማድረግ ፈለጉα ከአንድ በላይ መልስ መስጠት ይችላሉ፡፡	1. ሌሎች ሴቶች ሲያደርጉ ስላየሁ ነው 2. ጓደኞቼ እንዳደርግ ስላበረታቱኝ ነው 3. ከቤተሰቤ አባላት ክትትል እንዳደርግ ስለነገሩኝ ነው 4. ሐኪም ስለነገረኝ ነው 5. ሌላ ይገለፅ _____
2.5	የቅድመ ወሊድ ክትትል እንዲያደርጉ	1. እኔ እራሴ

	የወሰነልዎ ማነውα ከአንድ በላይ መልስ መስጠት ይችላሉ፡፡	2. ባለቤቱ 3. የባለቤቱ እናት 4. ከባለቤቱ ጋር ተማክሬ 5. ቤተሰቦቼ 6. ሌላ ይገለፅ _____
2.6	የቅድመ ወሊድ ክትትል ካላደረጉ ምክንያቱ ምን ነበርα ከአንድ በላይ መልስ መስጠት ይችላሉ፡፡	1. በእርግዝናዬ ወቅት ህመም ስላልነበረኝ ነው 2. ስለቅድመ ወሊድ እንክብካቤ ሰምቼ ስለማላውቅ ነው 3. በእርግዝና ወቅት ታምሜ ስለነበረ ነው 4. ጊዜ አልነበረኝም 5. ከዚህ በፊት በጤና ተቋም ችግር ስለገጠመኝ ነው 6. የገንዘብ ችግር ነው 7. የጤና ተቋሙ ሩቅ ስለነበረ ነው 8. የመወሰን አቅም ስላልነበረኝ ነው 9. ሌላ ይገለፅ _____
2.7	የቅድመ ወሊድ ክትትል ያለማድረግዎ ምክንያት ርቀት ከሆነ የጤና ተቋሙ ከቤትዎ ምን ያህል ይርቃልα	1. ከ 1-3 ሰዓት የእግር ጉዞ 2. ከ 4-6 ሰዓት የእግር ጉዞ 3. ከ 7-8 ሰዓት የእግር ጉዞ 4. ከ 8 ሰዓት በላይ የእግር ጉዞ
2.8	የፊስቱላ ችግር ካጋጠመዎ ምን ያህል ጊዜ ነውα	1. ‹1 አመት 2. ከ 1-3 አመት 3. ከ 4-6 አመት 4. ከ 7-10 አመት 5. ከ 10 አመት በላይ
2.9	ለችግርዎ መፍትሔ ለማግኘት ሞክረው ነበርα	1. አዎን 2. የለም

2.10	ለችግርዎ መፍትሔ ለማግኘት ሞክረው ከነበረ እርዳታ ለማግኘት ወዴት ሄዱα	1. ወደ ጤና ተቋም 2. ወደ ባህል ሕክምና አዋቂ 3. ወደ ባህል ሕክምና አዋቂና ወደ ጤና ተቋም 4. የት ሕክምና እንዳደረጉ ግልፅ አይደለም
2.11	ፊስቱላ በሕክምና እንደሚድን ማን ነገረዎትα ከአንድ በላይ መልስ መስጠት ይችላሉ፡፡	1. ባለቤቴ 2. መምህራን 3. የባለቤቴ እናት 4. ጎረቤቴ 5. ጓደኞቼ 6. የጤና ሰራተኞች 7. ሌላ ይገለፅ _____
2.12	ስንት ጊዜ ሕክምና አደረጉα	1. አንድ ጊዜ 2. ሁለት ጊዜ 3. ሦስት ጊዜና ከዚያ በላይ
2.13	ለችግርዎ መፍትሔ ሳይሹ ለምን ቆዩα ከአንድ በላይ መልስ መስጠት ይችላሉ፡፡	1. ለሕክምና በቂ ገንዘብ ስላልነበረኝ 2. ወዴት መሔድ እንዳለብኝ ስለማላውቅ 3. ሽንት እየፈሰሰኝ ከሌሎች ሰዎች ጋር በመኪና መሳፈር ስለፈራሁ 4. ልጆቼንና ቤቴን የሚጠብቅልኝ ሰው ስላልነበረኝ 5. ሐኪሞችና ነርሦች እንዳያገሉኝ ስለፈራሁ 6. ሽንት እየፈሰሰኝ ወረፋ መጠበቅ ስለፈራሁ 7. የአካባቢÂ ሰዎች የፊስቱላ ችግር እንዳማይድን ስለነገሩኝ 8. ሌላ ይገለፅ_____
ክፍል ሦስት: እርግዝና እና ምጥን በተመለከተ ግንዛቤ ወይም እውቀት		
3.1	ለፊስቱላ ከተጋለጡበት እርግዝና በፊት ስለ	1. አዎን

	እርግዝና፣ ምጥ እንዲሁም ወሊድ እውቀትነበርዎት ወይα	2. የለም
3.2	ለላይኛው ጥያቄ መልስዎ አዎን ከሆነ ዕውቀቱን ከማን አገኙትα	1. ከአካባቢው ጤና ሰራተኞች 2. ከእናቴ 2. ከመምህራን 3. ካለፈው እርግዝና ተሞክሮ 4. ከሌሎች ሴቶች በማየት በመማር 5. ሌላ ይገለፅ _____
ክፍል አራት: ለወሊድ ዝግጅት		
4.1	የት ለመውለድ አቅደው ነበርα	1. በቤቴ ውስጥ 2. ክሊኒክ 3. ጤና ጣቢያ 4. ሆስፒታል
4.2	ከጤና ተቋም ውጪ ለመውለድ አቅደው ከነበረ ምክንያትዎ ምን ነበርα	1. የገንዘብ ችግር 2. ችግር ያጋጥመኛል ብዬ ስላልሰጋሁ 3. በአካባቢያችን በቤት ውስጥ መውለድ ልማድ ስለሆነ 4. የባለቤቴ እናት እቤት ውስጥ መውለድ እንዳለብኝ ስለነገሩኝ 5. ሌላ ይገለፅ _____
4.3	ከእርስዎ ሌላ የት መውለድ እንዳለብዎት የወሰነ ሰው ነበርα	1. አዎን 2. የለም
4.4	ከእርስዎ ሌላ የት መውለድ እንዳለብዎት የወሰነው ማነውα ከአንድ በላይ መልስ መስጠት ይችላሉ።	1. ባለቤቴ 2. የባለቤቴ እናት 3. ጎረቤቴ 4. ቤተሰቦቼ

		5. ሌላ ይገለፅ _____
ክፍል አምስት: ምጥና ወሊድ		
5.1	ምጥ የት ሆነው ጀመረዎት·α	1. ቤቱ ውስጥ 2. ቤተክርስቲያን/መስጊድ 3. ሥራ ቦታ 4. ሌላ ይገለፅ _____
5.2	ምጥ በምን ሰዓት ጀመረዎት·α	1. ጠዋት· 2. ከሰዓት· 3. ለሊት·
5.3	ልጅዎን የት· ተገላገሉ·α	1. በቤቱ ውስጥ 2. ክሊኒክ 3. ጤና ጣቢያ 4. ሆስፒታል 5. ሌላ ይገለፅ _____
5.4	ልጅዎን ከጤና ተቋም ውጪ ከተገላገሉ· ማን አገላገለዎት·α	1. የባለቤቱ እናት· 2. እናቱ 3. የልምድ አዋላጅ 4. ጎረቤት· 5. እኔ እራሴ 6. ሌላ ይገለፅ _____
5.5	ልጅዎን በጤና ተቋም ውስጥ ከተገላገሉ· ወደጤና ተቋም ከመሄድዎ በፊት· ምን ያህል ሰዓት· አማጡ·α	1. 24 ሰዓት· 2. ከ 1-3 ቀናት· 3. ከሦስት· ቀናት· በላይ
5.6	ልጅዎን በምን መንገድ ተገላገሉ·α	1. በተፈጥሮ መንገድ 2. በመሣሪያ

		3. በኦፕራሲዮን
5.7	ሕፃኑ ሲወለድ	1. በሕይወት ነበር 2. ሞቶ ነበር

Section II Stress Related Questions

Here is a list of situations that you might encounter and that might cause your stress. For each situation, please decide whether the situation currently causes you any stress. If it does not, put an X under not application box of the issue described. If the issue described causes stress, then please indicate how much the situation is a problem for you by putting an "x" in the appropriate box scale. **0 does not apply to me, 1 only slight problem, 2 moderate problems, 3 a big problem, 4 a very big problem**

	List of situations	**0 Not applicable**	**1 Only slight**	**2 Moderate problem**	**3 A big problem**	**4 A very big problem**

			problem			
1	I feel lack of energy or experiencing weakness.					
2	I often suffer from sores around my genital					
3	I am unable to walk normally					
4	I get dehydrated					
5	I often fell chronically sick					
6	I have pain in the uterus					
7	My illness predisposed me to have poor appetite.					
8	I have occasional fever as a result of my illness.					
9	I have irregular menstrual periods.					
10	I suffered constant wetness.					
11	I suffered constant anxiety and depression.					
12	I have pain in the abdomen					
13	I have back pain as a result of my problem					
14	I suffered severe headache					
15	I lost my job as a result of my illness					
16	I am unable to work at all.					
17	I cannot dig enough food for my family like I used to do.					
18	I am unable to conduct					

	income-generating activities due to community stigma					
19	I am being insulted and ridiculed by others in the community					
20	I am not visited by people					
21	People who knew about the problem never wanted to eat with me.					
22	I am treated harshly by my family.					
23	Because of my illness I have poor relationship with my family					
24	My family spends a lot of money to care for me.					
25	Because of my illness I could not go to school					
26	As a result of my problem I am dependent on others					
27	I am isolated as a result of continuous leak					
28	I spend a lot of my time washing myself and clothes					
29	I stay at home because of my problem					
30	I have a fear that I will not be able to have more children.					
31	I have a fear that I will not be able to marry again.					
32	I did not have hope that I					

	would ever recover from my problem					
33	I lost my current partner as a result of fistula.					
34	I feel ashamed to go to public places because of my leak					
35	Travelling has become complicated and awkward because of my illness.					
36	I have had less sex since the onset of my chronic illness.					
37	Due to my illness, I can't sleep.					

ክፍል ሁለት፡- ጭንቀትን የተመለከቱ

ከዚህ በታች የዘረዘሩት ሁኔታዎች ምናልባት ጭንቀት ሊፈጥሩብዎ ይችሉ ይሆናል ብለን እናስባለን እባክዎ በቅድሚያ እያንዳንዱ ሁኔታ በአሁኑ ጊዜ ጭንቀት የሚፈጥርብዎ መሆኑንና ያለመሆኑን በሚከተለው ሁኔታ ያመልክቱ /ይግለጹ/ ሁኔታዎቹ ጭንቀትን የሚፈጥሩብዎ ከሆነ እንደ ጭንቀትዎ ክብደት እስከ አራት በተቀመጠው የጭንቀት ክብደት መለኪያ የ x ምልክት ያኑሩ ሁኔታው ጭንቀት የማይፈጥርብዎት ከሆነ እኔን አያስጨንቀኝም ከሚለው ስር የ x ምልክት ያድርጉ

0= እኔን አያስጨንቀኝም

1= በጥቂቱ ያስጨንቀኛል

2= በመጠኑ ያስጨንቀኛል

3= በኃይል ያስጨንቀኛል

4= በጣም በኃይል ያስጨንቀኛል

	ጭንቀትን የሚፈጥሩ ሁኔታዎች	**0 እኔን አያስጨንቀኝም**	**1 በጥቂቱ ያስጨንቀኛል**	**2 በመጠኑ ያስጨንቀኛል**	**3 በኃይል ያስጨንቀኛል**	**4 በጣም በኃይል ያስጨንቀኛል**
1	የአቅም ማጣት					
2	የብልት አካባቢ ቁስለት					
3	በትክክል መራመድ አለመቻል					
4	የሰውነት ድርቀት					
5	ብዙ ጊዜ አልጋ ላይ ማሳለፍ					
6	የማሕፀን አካባቢ ሕመም					
7	የምግብ ፍላጐት መቀነስ					
8	ትኩሳት					
9	የወር አበባ መዛባት					
10	ሽንት ያለማቋረጥ መፍሰስ					
11	ጭንቀትና ድብርት					
12	የሆድ ሕመም					
13	የጀርባ ሕመም					
14	ከፍተኛ የራስ ሕመም					
15	ከስራ መፈናቀል					
16	መስራት አለመቻል					
17	ለቤተሰብ የሚሆን በቂ ገንዘብ / ምርት ማሥገባት አለመቻል					
18	በተሰጠኝ መጥፎ ሥም የተነሳ በገቢ ማስገኛ ስራዎች ላይ መሳተፍ አለመቻል					
19	በሰዎች ዘንድ መሳቂያና መቀለጃ መሆን					
20	የጠያቂ መጥፋት፣እንደወትሮው እንግዶች ቤቱ መጥተው አለመጠየቃቸው					
21	ሥለሕመሜ የሚያውቁ ሰዎች ከእኔ ጋር መመገብ አለመፈለግ					
22	በቤተሰቤ የሚደርስብኝ ማዋከብ					
23	ከቤተሰቤ ጋር ያለኝ ግንኙነት					

	መልካም አለመሆን					
24	በእኔ ምክንያት ቤተሰቤ የሚያወጣው የሕክምና ወጭ ከፍተኛ መሆን					
25	ወደትምህርት ቤት መሄድ አለመቻሌ					
26	በሌሎች ሰዎች ላይ ጥገኛ መሆኔ					
27	በሕመሜ ምክንያት መገለሌ					
28	ረጅም ሰአት ልብሴን በማጠብና የራሴን ንፅሕና በመጠበቅ ማሳለፅ					
29	በሕመሜ ምክንያት ወደውጭ መውጣት ማqሜ					
30	ወደፊት መውለድ ያለመቻሌ ሥጋት					
31	ወደፊት ማግባት ያለመቻሌ ሥጋት					
32	ከሕመሜ እድናለሁ የሚል ተስፋ እጦት					
33	ከትዳር ጓደኛÂ/ ፍቅረኛÂ መለያየቴ					
34	ያለማቋረጥ ሽንት ሥለሚፈሰኝ ሰዎች ወደተሰበሰቡበት ቦታ መሄድ ያለመቻሌ					
35	ጉዞ ማድረግ አስቸጋሪ መሆኑ					
36	በህመሜ ምክንያት ወሲብ ማድረግ አለመቻሌ					
37	የእንቅልፍ እጦት ሰለባ መሆኔ					

Section III Coping Related Questions

WAYS OF COPING (Revised)

Please read each item below and indicate your answer, by putting an "X" in the appropriate box The following rating scale refers to what extent you have used the coping mechanism in the situation described: 0=Not used; 1=used somewhat; 2=used quite a bit; 3=used to a great deal.

	Coping Mechanisms	**Not Used 0**	**used somewhat 1**	**used quite a bit 2**	**used a great deal 3**
1.	I wash myself frequently.				
2	I often pad myself to control the leakage of urine.				
3	I wash my clothes daily.				
4	I ignore other people's comments				
5	I let my feelings out somehow.				
6	I coped with my problem by Seeking treatment.				
7	I use perfumes and lotions to manage the smell.				
8	I try to analyze the problem in order to understand it better.				
9	Went on as if nothing had happened.				
10	Went along with fate; sometimes I just have bad luck.				
11	I tried to keep my feelings to myself.				
12	Kept others from knowing how bad things were.				
13	Talk to someone to find out more				

	about the situation.				
14	Talked to someone who could do something concrete about the problem.				
15	I asked a relative or friend I respected for advice.				
16	Talked to someone about how I was feeling.				
17	Accepted sympathy and understanding from someone.				
18	I got professional help.				
19	Realized I brought the problem on myself.				
20	I made a promise to myself that things would be different next time.				
21	Wished that the situation would go away or somehow be over with.				
22	Hope a miracle will happen.				
23	Had fantasies or wishes about how things might turn out.				
24	Avoided being with people in general.				
25	Slept more than usual.				
26	Refused to believe that it had happened.				
27	Wished that I could change what had happened or how I felt.				
28	Came up with a couple of different solutions to the problem.				
29	I know what had to be done, so I doubled my efforts to make things work.				
30	I prayed.				
31	I jogged or exercised.				

ክፍል ሦስት ችግሮችን የመቋቋሚያ መንገዶች

እባክዎ ከዚህ በታች ያሉትን እያንዳንዱን ችግሮችን የመቋቋሚያ መንገዶች ጥያቄ ያንብቡና በሚከተሉት መለኪያ መጠን በመጠቀም በገለፁት ሁኔታ በምን ያህል ስፋት ወይም መጠን እንደተጠቀሙበት ያመልክቱ ከዚህ በፊት በገለፁልን ሁኔታዎች ላይ ምን ያህል ይጠቀሙበት እንደነበር ይንገሩን

0 = **አልጠቀምበትም** 2 = **በመጠኑ እጠቀምበታለሁ**

1 = **በትንሹ እጠቀምበታለሁ** 3 = **በብዛት እጠቀምበታለሁ**

	ችግሮችን የመቋቋሚያ መንገዶች	**አልጠቀምበትም** 0	**በትንሹ እጠቀምበታለሁ** 1	**በመጠኑ እጠቀምበታለሁ** 2	**በብዛት እጠቀምበታለሁ** 3
1	**ረጅም ሰአት የራሴን ንፅሕና በመጠበቅ**				
2	**የሽንቴን መፍሰስ ለመቋቋም ቶሎ ቶሎ ሽንት ጨርቅ በመቀየር**				
3	**ልብሴን በየቀኑ በማጠብ**				
4	**ለሌሎች ሰዎች አሥተያየት ቦታ አለመስጠት**				
5	**የተሰማኝን ስሜት በመግለፅ**				
6	**ችግሩን**				

	ለመቋቋም ወደጤና ተቋም በመሔድ				
7	የሽንቱን ጠረን ለመቋቋም ሽቶና ሎሽን በመጠቀም				
8	ችግሩን ከመሠረቱ ለመረዳት በመሞከር				
9	ምንም ነገር እንዳልተፈጠረ አድርጌ በመቁጠር				
10	ዕድለ ቢስ ስለሆንኩ እጣ ፈንታዬ የፈቀደልኝን ተቀበልኩ				
11	ስሜቴን ለራሴ አምቄ በመያዝ				
12	ነገሮች እንዴት አስከፊ እንደነበሩ ሌሎች ሰዎች እንዳያውቁብኝ በማድረግ				
13	ስለ ሁኔታው በበለጠ ለመረዳት ከሰው ጋር በመነጋገር				
14	ስለችግሩ ተጨባጭ ነገር				

	የሚያደርግልኝን ሰው በማነጋገር				
15	የቅርብ ጓደኛ ወይም ዘመድ ምክር በመጠየቅ				
16	ምን ያህል እደተሰማኝ ለሰው በማውራት				
17	ሀዘኔታንና እርዳታን ከሌሎች ሰዎች በመቀበል				
18	የባለሞያ ድጋፍ በመሻት				
19	ችግሩን በራሴ ላይ እንዳመጣሁ በማሰብ				
20	በሚቀጥለው ጊዜ ነገሮች የተለየ ይሆናሉ ብዬ ለራሴ ቃል በመግባት				
21	ሁኔታው እንዲጠፋ ወይም እንደምንም እንዲያበቃ በመመኘት				
22	ተዓምር እንዲፈጠር በመመኘት				
23	ነገሮች እንዴት በመልካም ሁኔታ ሊለወጡ እንደሚችሉ ቁጭ				

	ብዬ በማለም (በመቃዠት)				
24	ራሴን ከሰው በማግለል				
25	ከወትሮው በበለጠ በመተኛት				
26	እኔ ላይ መድረሱን በጭራሽ አላምንም				
27	የተፈጠረውን ነገር ወይም ስሜቴን ለመለወጥ በመመኘት				
28	ለችግሩ መፍትሔ ይሆናሉ ያልኳቸውን የተለያዩ ሃሳቦች በማፍለቅ				
29	ምን ማድረግ እንደነበረብኝ ስለማውቅ ጥረቴን አጠናክሬ በመታገል				
30	በመፀለይ				
31	የአካል እንቅስቃሴ በማድረግ				

Section IV

Obstetric fistula cases Semi-Structured Interview Guide

Instructions

Thank you for taking time to participate in this study. The information you give will help to understand how to serve the psychosocial needs of women with obstetric fistula. There is no right or wrong answer to the questions. We are only interested in your opinions. First, I would like to tell you about this study and what it involves. After I explain it, I will ask you to sign a consent form that states that I have told you about the study, that you understand the study and your part in it, and that you have agreed to participate.

The purpose of this study is to discover how women with obstetric fistula cope with this problem. We would like to hear from women. Your personal experiences with this problem will be very helpful. You are a part of the research.

I expect this interview will last at least one hour. You may choose not to answer any question and you may also terminate the interview at any point. With your permission, I would like to audio-record this interview. Your name will not be on this recording and your answers will remain confidential. After the recording is transcribed, it will be destroyed. Would you mind if I took notes? In order to keep your identity private, the consent form will be separated from the interview transcript and stored in a locked file. Do you have any questions? Would you like to look at a copy of the interview guide? Would you please sign the consent form? Before we talk about your experiences with fistula, it would be helpful to get some basic information from you. Would you mind helping me completing this questionnaire?

1. One of the most stressful experiences a person can have is to be diagnosed. When did you first learn about your illness?
    a. Probe: Tell what went through your mind when you were diagnosed.
    b. Probe: How did you know that something was wrong?
    c. Probe: How did you decide what to do?(e.g.,talk to afamily member, consult a friend)

2. Tell me about the kinds of treatment that you have received.
    a. Probe: Are you currently in treatment?
3. I would like to hear about the reactions from your family and friends since your problem was noticed.
    a. Probe: Do you have family living nearby?

b. Probe: Would you say you are close to your family?

c. Probe: Do you see or talk to them often?

4. Many people who have this problem come up with ideas about how they got it. Would you mind sharing your thoughts with me about this if you have any?

5. What has been the most stressful aspect of your problem? Has there been more than one thing?

6. Tell me how you have coped with that stress?

a. Probe: Which strategy have you used the most?

b. Probe: When do you tend to use [this strategy] the most?

c. Probe: Would you say this is the way your family tends to deal with stresses?

d. Probe: How does [this strategy] make you feel afterwards?

7. What is the most important advice you would give to a person who is dealing with this problem?

8. Tell me how your spiritual beliefs have helped you cope with your problem.

a. Probe: What about activities in your church? Are there any specific activities in your church that has helped you to cope with your problem?

b. Probe: Are you involved in organizations or social activities apart from the church (e.g., women associations, self help groups) that have helped you to cope with your problem? How have they helped you?

9. Some people think that fistula is a private matter and should not be discussed. Tell me your thoughts about that.

a. Probe: Who, if anyone, do talk to about your illness?

10. Could you describe the support you have received from family or friends in dealing with this problem?

a. Probe: Do you get as much support from your family and friends as you need?

b. Probe: What could they do to be more helpful?

c. Probe: What advice would you give to a family member or friend of someone suffering from this problem?

11. Who else helps you to deal with your problem outside of your family?

a. Probe: In what ways do you receive support from them?

b. Probe: Do you get as much support from this source as you need?

c. Probe: What could this source do to be more helpful?

12. How would you describe the support you have received from the doctors most responsible for treating your problem?
    a. Probe: Did you have a regular visit to a doctor before you were diagnosed?
    b. Probe: Do you get as much support from your doctors as you need?
    c. Probe: What advice would you give to a doctor who is treating a person with your problem?
13. What about the nurses? How would you describe the support you have received from them?
    a. Probe: Do you get as much support from these health care workers as you need?
    b. Probe: What could they do to be more helpful?
14. Some people find talking to a professional such as a minister, social worker or counselor when they are ill. What are your thoughts about that?
15. People receive information about their illness from different sources. Where have you gotten the most information about your illness?
    a. Probe: What has been the best source of information?
    b. Probe: Knowing what you know now, what kind of additional information would have been helpful?

We are just about finished with this interview.

17. Is there anything that I haven't asked you, but that you would like to tell me, about your experiences?
18. Is there anything that you think I need to ask in future interviews with obstetric fistula?
20. Is there anything you would like to ask me?

Thank you very much for your willingness to share your experiences. They have been very helpful and I know they will help others

በወሊድ ምክንያት ለሚመጣ የፊስቱላ ችግር ላጋጠማቸው እናቶች በከፊል የተዋቀረ የቃለ ምልልስ መመሪያ

በቅድሚያ ለዚህ ጥናት ጊዜ ሰጥተው በመሳተፍዎ አመሰግናለሁ።።

ከእርስዎ የምናገኘውን መረጃ በወሊድ ምክንያት በሚከሰት ፊስቱላ የተጎዱ እናቶችን ችግር ለመረዳትና ለችግራቸው መፍትሔ ለመስጠት ያስችለናል። በቃለምልልሱ ወቅት የተሳሳተ ወይም ትክክለኛ የሚባል መልስ የለም የኛ ፍላጎት የእርስዎን ሀሳብ ማወቅ ወይም መረዳት ብቻ ነው።። በመጀመሪያ ሰለ ጥናቱና ስለሚያካትታቸው ጉዳዮች ልነግርዎ እፈለጋለሁ ስለጥናቱ ከገለፅኩልዎ በኃላ ስለጥናቱም እንደገለፅኩልዎ የሚያስረዳ እንዲሁም በጥናቱ ውስጥ የእርስዎን ድርሻ መረዳትዎንና ለመሳተፍም ፈቃደኛ መሆንዎን የሚያስረዳ የፍቃደኝነት ፊርማ እንዲፈርሙልኝ እጠይቃለሁ።። የዚህ ጥናት አላማ በወሊድ ምክንያት የፊስቱላ ችግር የጋጠማቸውን እናቶች የገጠማቸውን አስቸጋሪ ሁኔታ እንዴት እንደተቋቋሙት ለማወቅ ነው።። ይህንንም ከእናቶች ለመስማት እንፈልጋለን እርስዎም የጥናቱ አንዱ አካል በመሆንዎ በችግሩ ዙሪያ ያለዎት ልምድ በጣም ጠቃሚ ነው።። ይህ ቃለ ምልልስ ቢያንስ አንድ ሰዓት ያህል ይወስዳል ብዬ አስባለሁ ምንም፣ አይነት ጥያቄ ያለመመለስ ይችላሉ ወይም ቃለምልልሱን ባሰኘዎት ሰዓት ሊያቋርጡ ይችላሉ።። ፍቃደኛ ከሆኑ ድምፅዎን በመቅረፀ ድምፅ ለመቅረፅ እፈልጋለሁ የእርስዎ ስም በድምፅ ቀረፃው ወቅት አይቀረፅም የሰጡትንም መልስ ከእኔ በስተቀር ማንም አይሰማውም ቅጅውም ከተገለበጠ በኃላ ይደመሰሳል ትንሽ ማስታወሻ ቢጤ ብፅፍ ቅር ይልዎታል? የእርስዎን ማንነት ምስጢር ለማድረግ የፈረሙት ፊርማ ከቃለ ምልልሱ ጽሑፍ ተለይቶ በቁልፍ ውስጥ ይቀመጣል።።

ጥያቄ አለዎት? የቃለምልልሱን መመሪያ ግልባጭ ማየት ይፈልጋሉ? የስምምነት ፎርሙን ይፈርሙልኛል? ስለፊስቱላ ያለዎትን ተሞክሮ ከመነጋገራችን በፊት አንዳንድ መሰረታዊ መረጃዎችን ከእርስዎ ማግኘት ጠቃሚ ነው ጥያቄዎችን በመመለስ ሊያግዙኝ ይችላሉ?

1. አንድ ሰው በህይወቱ ሊያጋጥመው ከሚችሉ አስጨናቂ ሁኔታዎች አንዱ ህመም እንዳለበት ማወቁ ነው የፊስቱላ ችግር እንዳለብዎት ያወቁት መቼ ነው?

    ሀ. ምርመራ፡-የፊስቱላ ችግር እንዳለብዎት ሲነገርዎት ምን ተሰማዎት?

    ለ. ምርመራ፡- የሆነ ችግር እንዳለ እንዴት አወቁ?

    ሐ. ምርመራ፡- ምን ማድረግ እንዳለብዎት እንዴት ወሰኑ? (ለቤተሰብዎ አባል መንገር? ጓደኛ ማማከር?)

2. እስቲ ምን አይነት ህክምና አደርገው እንደነበር ይንገሩኝ?

    ሀ. ምርመራ፡- አሁን በህክምና ላይ ነዎት?

3. ችግርዎ ከታወቀ በኃላ የቤተሰብዎ ምላሽ ምን እንደነበር መስማት እፈልጋለሁ

   ሀ. ምርመራ፡- በዚህ አካባቢ ቤተሰብ ወይም ዘመድ አለዎት?

   ለ. ምርመራ፡- ለቤተሰብዎ ቀረቤታ አለዎት?

   ሐ. ምርመራ፡- ቤተሰቦችዎን በተደጋጋሚ ያገኟቸዋል?

4. የዚህ አይነት ችግር ያላቸው ብዙ ሰዎች ችግሩ እንዴት እንደገጠማቸው የራሳቸው የሆነ አስተሳሰብ አላቸው ስለዚህ ጉዳይ የእርስዎን ሃሳብ ቢያጋሩኝ?

5. በጣም ያስጨነቀዎት የትኛው ችግርዎ ነበር? ከአንድ በላይ ችግር ነበረዎት?

6. ይህንን ችግር እንዴት ነበር የተቋቋሙት?

   ሀ. ምርመራ፡- በአብዛኛው የትኛውን ዘዴ ነበር የሚጠቀሙት?

   ለ. ምርመራ፡- ይህንን ዘዴ መቼ ነበር የሚጠቀሙት?

   ሐ. ምርመራ፡- ይህ ዘዴ ቤተሰብዎ ከጭንቀት የሚከላከሉበት ዘዴ ነበር ይላሉ?

   መ. ምርመራ፡- ይህንን ዘዴ ከተጠቀሙ በኃላ ምን ይሰማዎታል ወይም ምን አይነት ስሜት ይሰጥዎታል?

7. የዚህ ዓይነት ችግር ለገጠመው ሰው በጣም ይጠቅማል ብለው የሚመክሩት ካለ ምንድነው?

8. መንፈሳዊ እምነትዎ ይህንን ችግር እንዲቋቋሙ ምን ያህል ረዳዎት?

   ሀ. ምርመራ፡- በቤተክርስቲያን (መስጊድ) አካባቢ ያለው እንቅስቃሴስ? በእርሶ ቤተክርቲያን (መስጊድ) አካባቢ ችግርዎን እንዲቋቋሙ የረዳዎት የተለየ እንቅስቃሴ ነበር?

   ለ. ምርመራ፡- ከቤተክርስቲያን/መስጊድ ውጪ በተለያዩ ማህበራዊ እንቅስቃሴዎች ውስጥ ይሳተፋሉ? (ለምሳሌ የሴቶች ማህበር፤የመረዳጃ ማህበር) ችግርዎንስ እንዲቋቋሙ እረድቶዎታል? ይህንን እርዳታ ቢገልጹልኝ?

9. አንዳንድ ሰዎች ፊስቱላ የግል ችግር ስለሆነ ለውይይት መቅረብ የለበትም ብለው ያስባሉ እስቲ የእርስዎን ሃሳብ ያጋሩኝ?

ሀ. ምርመራ፡- ስለችግርዎ የሚያዋዩት ለማን ነው?

10. ለዚህ ችግርዎ ከቤተሰብዎ ወይም ከጓደኛዎ ያገኙት ድጋፍ ካለ ቢገልጹልኝ?

ሀ. ምርመራ፡- ከቤተሰብዎ ወይም ጓደኞችዎ ማግኘት አለብኝ ብለው የጠበቁትን ያህል ድጋፍ አግኝተዋል?

ለ. ምርመራ፡- ምን ቢያደርጉልዎ ነው በደንብ ሊረዱዎት የሚችሉት?

ሐ. ምርመራ፡- ከቤተሰቦችዎ ወይም ከጓደኞችዎ አንዱ የዚህ አይነት ችግር ቢያጋጥመው ምን አይነት ምክር ይለግሷቸዋል?

11. ከቤተሰብዎ አባላት ውጪ በችግርዎ ዙሪያ ያገዙዎት ሰዎች ነበሩ?

ሀ. ምርመራ፡- ምን አይነት እርዳታ አገኙ?

ለ. ምርመራ፡- ከነዚህ ምንጮች የሚፈልጉትን ድጋፍ አገኙ?

ሐ. ምርመራ፡- እነዚህ ምንጮች ምን ቢያደርጉልዎ ነው የበለጠ ሊደግፉዎት ወይም ሊረዱዎት የሚችሉት?

12. እርስዎን ለመርዳት በበለጠ ኃላፊነት ወስደው ከሚያክሙዎት ሐኪሞች የሚያገኙትን ድጋፍ እንዴት ይገልጹታል?

ሀ. ምርመራ፡- ሕመምዎ ከመታወቁ በፊት የሐኪም ክትትል ነበረዎት?

ለ. ምርመራ፡- ከሐኪሞች የሚያስፈልግዎን እርዳታ አግኝተዋል?

ሐ. ምርመራ፡ እንደርስዎ ያለ ችግር ያጋጠመውን ሕመምተኛ ለሚያክም ሐኪም ምን አይነት ምክር ይለግሳሉ?

13. ስለነርሶችስ? ከነርሶች የሚያገኙትን ድጋፍ እንዴት ይገልጹታል?

ሀ. ምርመራ- ከእነዚህ የጤና ባለሞያዎች አስፈላጊውን ድጋፍ እያገኙ ነው?

ለ. ምርመራ፡- ምን ቢያደርጉልዎ ነው የበለጠ ሊረዱዎት የሚችሉት?

14. አንዳንድ ሰዎች ሕመም ሲያጋጥማቸው ከሃይማኖት አባቶች ከማህበራዊ ሠራተኞች ወይም የምክር አገልግሎት ሠራተኞች ጋር ይወያያሉ እርስዎስ በዚህ ዙሪያ ያለዎት ተሞክሮ ምንድነው?

15. ሰዎች ስለሕመማቸው ከተለያዩ ምንጮች መረጃ ያገኛሉ እርስዎ ስለችግርዎ መረጃ ያገኙት ከየት ነው?

ሀ. ምርመራ፡- ከሁሉም የበለጠ መረጃ ያገኙት ከየት ነው?

ለ. ምርመራ፡- አሁን ያለዎት እውቀት እንዳለ ሆኖ የትኛው ተጨማሪ መረጃ ነው የጠቀመዎት?

ቃለ ምልልሳችንን እያጠናቀቅን ነው

16. እኔ ያልጠየቅኩዎት ነገር ግን ሊያካፍሉኝ የሚወዱት ተሞክሮ ካለዎት?
17. ወደፊት በወሊድ ምክንያት ለሚከሰት የፊስቱላ ችግር መጠየቅ የሚገባኝ ጥያቄዎች ያሉ ይመስልዎታል?
18. ሊጠይቁኝ የሚፈልጉት ጥያቄ አለዎት?

ተሞክሮዎን ሊያካፍሉኝ ፍቃደኛ በመሆንዎ እጅግ አድርጌ አመሰግናለሁ፡፡ ተሞክሮዎ በጣም ጠቃሚ በመሆኑ ሌሎችንም ሊጠቅማቸው እንደሚችል አምናለሁ፡፡

Annex 4

Declaration

1. Declaration of the principal investigator

I, the undersigned, declared that this thesis is my original work in partial fulfillment of the requirements for the degree of master of nursing science. All the resources of the material used for this thesis and all people and institutions who gave support for this work are fully acknowledged

Name; _____

Signature; _____

Place of submission: _____

Date of submission: _____

2. Approval of the primary advisor

This thesis work has been submitted for examination with my approval as a university advisor.

Advisor's name: _____

Signature: _____

Glossary

Description of Folkman and Lazarus ways of coping questionnaire subscales

Coping subscale	Description of coping subscale
Confrontive coping	Aggressive efforts used to alter a situation; describes the individual as using some degree of hostility and risk taking behavior
Distancing	Detachment or disengagement; a strategy to minimize the significance of the situation
Self controlling	Efforts that are used by individuals to regulate their feelings and actions
Seeking social support	Efforts used to obtain informational tangible, and/or emotional support
Accepting responsibility	Recognizes one's role in solving a problem
Escape avoidance	Wishful thinking and behavioral efforts to avoid confronting a

	problem or stressful situation
Planful problem solving	Problem focused efforts to alter the situation, including an analytic approach to problem solving
Positive reappraisal	A religious dimension includes giving positive meaning to a situation by focusing on one's personal growth