

Review Article

Self-efficacy for Re-acceptance in Communities Among Obstetric Fistula Patients in Africa: A Systematic Review of Qualitative Data

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Abstract: The physical and psychosocial problems associated with obstetric fistula affect the patients' efficacy to function within specific realms of life and affect their quality of life. This study documented the obstetric fistula patients' self-efficacy for reacceptance in the communities in Africa. The study used keywords and the year of publication (2000 to 2019) as a search strategy to obtain data for review. A Critical Appraisal Skills Programme checklist specifically for qualitative studies was used. The search resulted in 284 studies: Google Scholar; 37, PubMed; 12, Hinari; 3, African Journals Online; 36, Psych-INFO; 1 and other websites; 195. Subsequently, 258 studies were excluded due to duplication and failure to meet the study objective leaving 26 studies, which were thematically analyzed. Studies report loss of hope, dignity, confidence, and self-esteem among obstetric fistula patients. They feel unfit, and are often anxious, attributes that impede their employability, mobility, connections, conjugal affairs, childbearing, and enthusiasm to accomplish various tasks; an index of low self-efficacy. However, when repaired and empowered through skills training and counseling, their self-efficacy improves. Self-efficacy is generally low among obstetric fistula patients especially those that have not yet had fistula repair. Alongside repair of the fistula, activities intended for societal reintegration reduce levels of anxiety, increase confidence and overall self-efficacy, which enables reacceptance.

Keywords: Africa, Obstetric Fistula, Rehabilitation, Rectovaginal Fistula, Self-efficacy, Vesicovaginal Fistula, Social Reintegration, Women's Health

1. Introduction

In the year 2017, approximately 810 women died during child labor on a daily basis, 94% of whom were from developing countries with sub-Saharan Africa and Southern Asia alone contributing 86% [World Health Organization (WHO)] [1]. Usually, among the survivors of maternal mortality, 20 to 30% sustain morbidities such as post-partum

hemorrhage, severe anemia, and post-partum eclampsia and disabilities such as obstetric fistula. A woman who sustains obstetric fistula during labor is merely surviving but not living" [United Nations Population Fund (UNFPA) 2013] [2]. Whereas obstetric fistula and its sequels were long wiped out in developed countries, developing ones are till date saddled with the issue [3, 4]. The global prevalence of obstetric fistula is about 2 million women of reproductive age and these are

particularly from Asia and Africa [5-6]. Sub-Saharan Africa has an estimated obstetric fistula prevalence of 188 per 100,000 mothers of reproductive age [7] with an annual incidence rate of 60,000 to 90,000 women [6]. Its' persistence across the region has been attributed to traditional practices deeply associated with gender bias, including Female Genital Mutilation (FGM), [8-9] early marriage, socio-economic factors, early childbirth and homebirths [10-12]. These are closely linked to the three delays of access to care in case of emergency especially when labor is obstructed and or prolonged [10].

As labor gets prolonged and obstructed due to fetopelvic disproportion, the extensive and excessive pressure exerted on the vaginal, urinary, and gastrointestinal tracts by the fetal head against the pelvic walls eventually causes defects in the bladder, ureter, urethra and or rectum. This results in continual leakage of urine and or fecal matter through the defects in them connected with the vagina. It is often accompanied by infections, skin ulcers, and offensive odors. Patients sustain psychological trauma, shame, stigma, depression, and are unable to work [5, 8, 11]. These seriously affect their self-esteem and self-efficacy for a normal social lifestyle, and the ability to meet their goals. Generally, such a woman's social worth is compromised, as the community doubts her fertility potential, which hinders a smooth reintegration, and yet reacceptance has a significant influence on her overall well-being [8, 13].

Self-efficacy refers to personal beliefs that individuals hold about their capacity to accomplish certain tasks in specific domains of functioning, under specific conditions [14-16]. This means that beliefs precede outcomes and explains the judgment of one's capability to complete a given task successfully under certain situations [17]. The level of proficient performance is greatly influenced by higher-order self-regulatory competencies and skills. These among others may include diagnostic task demand skills, ability to construct and evaluate alternative courses of action, goal setting, engaging in tasking activities by creating and providing necessary incentives, stress management, and critical thinking for problem-solving [16, 17].

Therefore, determining the obstetric fistula patients' self-efficacy for reacceptance would bring new insights into appropriate approaches including assessment of their competencies aligned to specific domains mainly social interaction, community engagement, childbearing, meeting needs and being able to live a normal life in the context of each patient. Reacceptance is synonymously used with social reintegration [8] whereas reintegration is also used interchangeably with rehabilitation [3]. Reacceptance, therefore, is the assimilation of someone that once had no place in a given community. It encompasses any activities intended to advance the quality of lives of obstetric fistula patients before and after corrective surgery enabling them to normalize and navigate through all life's events [3]. Nonetheless, little is documented about self-efficacy for reacceptance among obstetric fistula patients in their communities in African settings, which warranted this study.

2. Methods

The keywords and year of publication (2000 - 2019) were used as a search strategy to identify relevant qualitative data on self-efficacy for reacceptance in communities among obstetric fistula patients in Africa published and archived with PubMed, Google Scholar, Hinari, Psych-INFO, African Journals Online and International Organizations' Websites. During the Google Scholar search, the phrase "self-efficacy for reintegration among obstetric fistula in Africa" was used which resulted in 37 papers. The search with PubMed resulted in 12 papers having used "social reintegration among obstetric fistula patients in Africa" to search. From Hinari, the search used the phrase "self-efficacy for social reintegration among obstetric fistula patients in Africa" which yielded only 3 results. From Psych-INFO, only 1 result was found when the search strategy used the phrase "obstetric fistula patients in Africa" since the use of "self-efficacy for social reintegration among obstetric fistula patients in Africa" had not yielded any results. The search on African Journals Online yielded 36 results when the search strategy was "obstetric fistula". The international organizations including United Nations Population Fund (UNFPA), EngenderHealth, and Fistula Care Plus yielded: 74, 39, and 82 results respectively when the phrase "self-efficacy for social reintegration among obstetric fistula patients in Africa" was used to search.

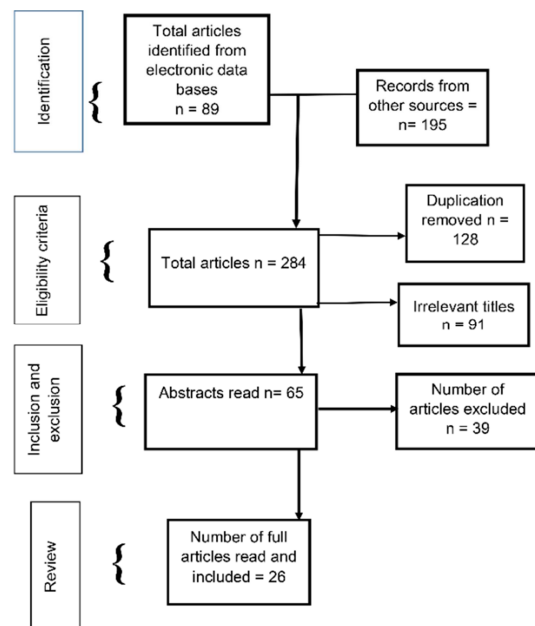


Figure 1. PRISMA flowchart indicating the selection and inclusion of reviewed studies. Guided by Moher D, et al. (2011) [18].

A total of 284 articles were gathered from the searched databases. Their titles were read but 128 studies were duplicates across various databases. Based on the Critical Appraisal Skills Programme (CASP) by Moher D, et al. (2011)[18], the author, year of publication, aim, type of study, sample size, study area, and the themes of interest were used for the inclusion and exclusion criteria. Thus, 91 studies were excluded due to failure to meet the study objective. Hence, 65

abstracts were read but 39 articles did not address self-efficacy for reintegration among obstetric fistula patients thus were excluded, leaving 26 full articles, which were read, analyzed and included as in Figure 1.

3. Results

Reacceptance of obstetric fistula patients in communities.

Findings from the 26 qualitative studies that were reviewed reveal that, across Africa, obstetric fistula patients endure relatively similar experiences including lack of social support, divorce, separation, severe depression, social stigma, isolation, and loss of esteem. Communities consider them unclean hence they are excluded from active participation in social events, preparation of food in their households and employment [3, 4, 8]. A report by UNFPA on the 10th anniversary of End Fistula Campaign identified a woman who stated that “...no one wanted to be around me. My in-laws abandoned me..... All I could do was stay home..... It was like a prison” [3]. Also, their social worth diminishes as the “potential suitors are not assured of her future fertility” [8]. Besides losing marriages, they are unemployable: either they are laid-off by employers or if they were self-employed, they close their business ventures due to lack of customers. A study done in Uganda in 2013, noted that “...her customers started reducing in number up to when...no one could come around....” [10].

Studies indicate that surgical repairs are possible, free of charge and improve the quality of life tremendously but women continue to face barriers to care [4, 19, 20]. Some of these barriers are deeply rooted in socioeconomic and cultural factors [10, 12]. Patients take a long period to access care and when they come, they present with higher levels of depression, suicidal ideation, sadness, shame and anxiety [19].

Some women try a lot to cope by wearing disguising attires, they carry extra clothing, frequently change clothes, limit physical activities, abstain from sexual intercourse, and limit

water intake. They also use recyclable pads, tissue paper, hand towels and or handkerchiefs as protective materials. Nonetheless, some communities continue to seclude them due to cultural norms [20]. An example is northern Nigeria communities, where wife seclusion is a norm. Hence in such a situation, there is total seclusion even from family members and neighbors. She is not as productive as she used to be besides failing to satisfy her husband sexually and meet overall marital roles such as childbearing [21].

Studies are done across the fistula belt: a geographical region from Mauritania in West Africa to Eritrea in East Africa with high incidence rates of obstetric fistula such as Uganda, Nigeria, Niger, Tanzania, Ghana, Guinea, Eritrea, and Ethiopia, state that the patients are considered cursed and infertile. Some communities perceive it as witchcraft, and others as a punishment from God [13, 22-25]. A study that was conducted in Malawi in 2016 highlighted several myths around witchcraft: “They say I was bewitched and I will remain like this forever” [22].

A study by Polan LM. et al (2015), reported that 85% to 92% of their births result in stillborn babies. This traumatizes them and affects their hope of ever remarrying and having a child [6]. Since they are considered cursed, the option of seeking treatment is unlikely unless mobilized and sensitized by the health care system and community-based organizations [2, 13, 26-27].

After the successful repair of a fistula, some patients do not want to return to their former communities. They think of relocating elsewhere to start all over again [26]. Partners are equally affected as they suffer an inferiority complex during this period. Men felt so small [28]. Some divorce or separate from their spouses because they cannot bear the shame. Others keep in marriage to care and maintain their social responsibilities. Their sexual and fertility life is dissatisfying as noted in a study that “women with fistula felt that their marital and sexual rights had been lost” [28]. These factors are summarized in Table 1.

Table 1. Self-efficacy for reacceptance and how it can be improved among obstetric fistula patients.

| Factors affecting patients' self-efficacy | Strategies to enhance the patients' self-efficacy for reacceptance |
|---|--|
| Inadequate reintegration efforts | Repair |
| Community perceptions of patients | Lobbying and advocacy around OF |
| Poverty | Health Promotion |
| Seclusion, and stigma | Engaging fistula ambassadors |
| Shame and disrespect | Installation and use of the hotline telephony |
| Offensive smell | Mass media |
| Marginalization of patients | Regular physiotherapy |
| Isolation | Involvement of civil society |
| Physical disability | Training in income generation |
| Low social support | Empowerment in autonomous decision making |
| Economic hardship | Equitable access to obstetric care |
| Divorce | Respect of women |
| Depression | Community-wide education |
| Low quality of life | Counseling |
| Suicidal tendencies | Individualization of women |
| A deep sense of loss | Political will and commitment |
| Loss of dignity and identity | Systematic postoperative care and follow-up |
| Social humiliation | Fistula campaigns |
| Consequences of loss of a child | Involvement of all surgeons trained in fistula repair |
| Interrupted socio-roles. | Psycho-education |

Self-efficacy for reacceptance among obstetric fistula patients.

Self-efficacy among obstetric fistula patients is generally low especially when they have not yet had a successful repair. They lose not only hope for achieving their preset goals and living their previous social life but also dignity. A study by Mselle TL, et al. (2012) in Tanzania identified patients whose self-efficacy to remarry, reunite with spouses and or accomplish several goals were hampered. However, the same study noted that 80% of the participants indicated that once they had a successful repair they could work and probably resume their previous work [25]. Work resumption and providing for themselves is viewed as a way of restoring dignity and value since a number of them have separated and have less family support [27, 29-30].

Successful repairs have been reported to improve self-efficacy among obstetric fistula patients. As their self-efficacy is revived, they engage more in self-initiated community activities. But still, a number of them retain the negative attitude against the communities that had banished and isolated them during the crucial moment they needed them. However, this cannot be generalized, depending on one's level of self-efficacy, and a supportive environment [19, 26]. Patients who receive community and family support and are also trained in skills, income generation activities, innovativeness, advocacy, awareness, and health education often reintegrate more easily [11-13, 29, 31]. On the other hand, though, one's level of self-efficacy is much more self-regulated and requires goal-setting, self-monitoring, evaluation, and appraisal, which eventually determines one's quality of life and is highest when success has been attained [32].

A study done in Northern Ghana found out that skills training was key to the social reintegration of obstetric fistula patients but needed to be tailored to the patients' physical efficacy and their geographical location [29]. Women's empowerment generally is desired. Whether they have a fistula or not, they "*should be supported to attain basic education as it is the first step towards their empowerment*" [8] and trained in income-generating activities and autonomy should be emphasized. Once this is realized, patients will be able to equitably access care, reintegrate easily and prevent the nightmare from occurring as "*prevention largely depend on women's empowerment*" [8]. These strategies are summarized in Table 1.

4. Discussion

Reacceptance of Obstetric Fistula Patients in the Communities

Reviewed studies indicate that obstetric fistula is a life-changing situation with deeper emotional wounds. Byamugisha J. et al. (2015) highlighted obstetric fistula as a condition past repair [27]. Patients in some communities are referred to as walking dead which portrays their state of despair. It is worse if deemed chronic because the entire socio-economic roles are curtailed due to low levels of self-efficacy [6]. Before repair, women suffer shameful and

humiliating experiences, which cause misery and hopelessness. They feel disempowered and disappointed with life [3-4, 8].

Women experience profound emotional distress and intense social exclusion even after repair. They develop a deep sense of loss of marital and sexual rights [28]. They report the worst experiences as childlessness and ex-communication as having profound psychological effects. To some patients, these effects are so unfathomable that they are carried forward even after a successful surgery. Some continue to lose appetite, spend sleepless nights; they still consider themselves cursed and being unfortunate [31].

A study done in Ethiopia indicated that obstetric fistula patients live in anguish, with low self-esteem, and anxiety believing that people dislike them [25]. Other studies pointing out similar issues were done in Kenya, Tanzania, Uganda, and Northern Ghana [8, 22, 26], but these studies do not highlight their impact on the patients' realm of functioning and social reintegration.

Nonetheless, repair improves the patients' quality of life tremendously hence they are easily assimilated. El Ayadi MA et al. (2019)'s study registered great improvements in physical and psychosocial life with time after successful repairs. Depression, social isolation, self-perception, and stigma declined while the patients' self-esteem improved [33]. Additionally, to repair, patients who get psycho-education that is competence-based, addressing coping mechanisms, and empowering, normally have their hope improved as well as the quality of their lives [34]. The major challenge remains that of the uncertainty of their fertility potential, which requires counseling, awareness creation, and follow-up [22]. Besides, spousal, family and community support quicken reintegration once the repair has been successful hence should be emphasized [35-40].

Incidences of divorce or separation are highlighted by several studies but also some partners are very supportive and persevered through the challenges [13, 22]. In some studies, women report having received immense and tangible emotional support from spouses and family. At the same time, they endorsed low divorce rates and strong relationships, which increased their assertiveness and resilience [40].

Self-efficacy for Reacceptance Among Obstetric Fistula Patients

A person with higher self-efficacy easily reintegrates and gains physical, emotional and social stability faster than the one with low self-efficacy. However, for one to have higher self-efficacy, self-awareness is necessary [32]. Therefore, life skills training that emphasizes self-awareness, and decision making is desired to propagate self-efficacy [8, 29].

The obstetric fistula patients whose fistula has not been repaired normally have low productivity, low self-confidence, are always moody and are anxious. Anxiety greatly affects self-efficacy; the lower the anxiety, the higher the level of self-confidence, and equally is the degree of self-efficacy [16].

To develop self-efficacy, self-esteem, and confidence should be cultivated among obstetric fistula patients. Also,

there should be community-level activities emphasizing reintegration to another society instead of the previous community. Efforts should encompass counseling, community-wide sensitization, and economic empowerment. They should be socially supported to enable them to resume their social and economic roles and responsibilities [30]. Follow up of patients at the community level would enable stakeholders to determine whether they have been wholly reintegrated [3, 5, 8]. Fistula Care also articulates the need for a community involvement approach to permit easy and quick reintegration or reacceptance [35].

A much broader social approach is also recommended for quicker and effective reintegration. Such an approach should consider individual patient's needs and context and should be aligned with the multi-sectoral and interdisciplinary approaches, aiming to build the patient's capacity to effectively reintegrate [3, 41]. Besides, the MSF Project recommends lobbying and advocacy, health promotion, actively engaging fistula ambassadors to mobilize patients for care and discuss its significance, counsel and address stigma. Also, fistula care centers ought to install a hotline for patients to use in case of need for information. They should work closely with mass media and include physiotherapy in their routine. For the patients deemed untreatable, regular home visits, facilitation of a source of livelihood and encouragement to join social groups are crucial for their reacceptance in the communities [41].

Like most systematic reviews, this study relied on a relatively limited number of databases for the identification of studies that would be eligible for inclusion. Many of the searched papers did not pass the criteria of inclusion since they did not address reacceptance. This led to a final selection of only 26 papers. However, the final review of the papers was conducted systematically leading to credible results.

5. Conclusion

Self-efficacy is generally low among obstetric fistula patients especially those that have not yet had fistula repair. Alongside repair of the fistula, activities intended for societal reintegration reduce levels of anxiety, increase confidence and overall self-efficacy, which enables reacceptance.

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