

# RESTORING WOMEN'S DIGNITY THROUGH FISTULA REPAIRS: EXPLORING THE CHALLENGES AND COPING STRATEGIES OF ZIMBABWEAN WOMEN

*Restaurant la dignitat de les dones mitjançant la reparació de fistules: Una exploració dels desafiaments i solucions de les dones de Zimbabwe*

*Restaurando la dignidad de las mujeres mediante la reparación de fístulas: Una exploración de los desafíos y soluciones de las mujeres de Zimbabwe*

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## ABSTRACT

**OBJECTIVE.** This study identifies and analyses the impact of fistula repair towards the restoration of women's dignity and their coping strategies or methods of adjustment to society. The study is critical given the negative effects of fistula on the identities of women and their loved ones.

**MATERIALS AND METHODS.** The study employed a qualitative case study which used purposive sampling to select participants for in-depth interviews with seven women (age range 17 to 42). Data were grouped into themes and analysed. Thematic analysis identified the main themes as; negative experience, stigma and positive coping strategies facilitating proper adjustment.

**DISCUSSION AND CONCLUSIONS.** Social stigma continues even after surgery and is the major challenge that participants have to deal with daily affecting the level of integration into the community. It also threatened the extent to which fistula survivors can be perceived and perceive themselves as 'dignified'. Participants faced mental health challenges like anger, sadness, depression, anxiety, stress and shame. However, participants acknowledged that through family support, empowerment programmes and community support, they were slowly getting back to their normal lives.

**Keywords:** Women's health; Vaginal Fistula; Maternal health; Psychosocial aspects

## RESUM

**OBJECTIU.** Aquest estudi identifica i analitza l'impacte de la reparació de la fistula en el restabliment de la dignitat de les dones i les seves estratègies d'afrontament o mètodes d'adaptació a la societat. L'estudi és fonamental donats els efectes negatius de la fistula en la identitat de les dones i els seus éssers estimats. **MATERIALS I MÈTODES.** L'estudi es va basar en un estudi de casos qualitatiu que va utilitzar un mostreig intencional per a seleccionar a les participants de les entrevistes en profunditat amb 7 dones (d'entre 17 i 42 anys). Les dades es van agrupar en temes i es van analitzar. L'anàlisi temàtica va identificar com a temes principals: l'experiència negativa, l'estigma i les estratègies d'afrontament positives que faciliten l'adaptació adequada. **DISCUSSIÓ I CONCLUSIONS.** L'estigma social continua fins i tot després de la intervenció quirúrgica i és el principal repte amb el qual els participants han de lidiar diàriament, afectant el nivell d'integració en la comunitat. També afecta el grau en què les supervivents de la fistula poden ser percebudes i es perceben a si mateixes com a «dignes». Les participants es van enfrontar a problemes de salut mental com la ira, la tristesa, la depressió, l'ansietat, l'estrès i la vergonya. No obstant això, les participants van reconèixer que, gràcies al suport de la família, els programes d'empoderament i el suport de la comunitat, estaven tornant a poc a poc a la seva vida normal.

**Paraules clau:** salut de la dona; fistula vaginal; salut materna; aspectes psicosocials

## RESUMEN

**OBJETIVO.** Este estudio identifica y analiza el impacto de la reparación de la fístula en el restablecimiento de la dignidad de las mujeres y sus estrategias para afrontar dicha patología o los métodos de adaptación a la sociedad. El estudio es fundamental dados los efectos negativos de la fístula en la identidad de las mujeres y sus seres queridos. **MATERIALES Y MÉTODOS.** La investigación se basó en un estudio de casos cualitativo que utilizó un muestreo intencional para seleccionar a las participantes de las entrevistas en profundidad con 7 mujeres (de entre 17 y 42 años). Los datos se agruparon en temas y se analizaron. El análisis temático identificó como temas principales: la experiencia negativa, el estigma y las estrategias de afrontamiento positivas que facilitan la adaptación adecuada. **DISCUSIÓN Y CONCLUSIONES.** El estigma social continúa incluso después de la intervención quirúrgica y es el principal reto con el que los participantes tienen que lidiar a diario, afectando al nivel de integración en la comunidad. También amenazó el grado en que las supervivientes de la fístula pueden ser percibidas y se perciben a sí mismas como «dignas». Las participantes se enfrentaron a problemas de salud mental como la ira, la tristeza, la depresión, la ansiedad, el estrés y la vergüenza. Sin embargo, los participantes reconocieron que, gracias al apoyo de la familia, los programas de empoderamiento y el apoyo de la comunidad, estaban volviendo poco a poco a su vida normal.

**Palabras clave:** Salud de la mujer; Fístula vaginal; Salud materna; Aspectos psicosociales

## INTRODUCTION AND BACKGROUND

Obstetric fistula is one of the sad injuries that can happen to women in childbirth when they experience prolonged obstructed labour in situations where there is inadequate medical care. Obstetric fistula is preventable and is mainly a problem of developing countries affecting about four women per thousand in Zimbabwe, having been eradicated in the developed world (Wall, 2006; Katsande, 2017; Bashah et al., 2018; Moyo-Ndlovu 2020). Cases of obstetric fistula contribute about 6 % of all maternal deaths worldwide and 50,000 to 100,000 injuries globally. It is assumed that more than 2 million women in Asia and Sub-Saharan Africa live with untreated obstetric fistula and yet about 80 % to 90 % of cases can be treated/repared (Yeakey et al., 2011; Katsande, 2017). In Southern Africa, about 100,000 women have gone through fistula repair (World Health Organisation, 2017).

In Zimbabwe the programme of fistula repair started in 2015 and has helped more than 700 women (Moyo-Ndlovu, 2020). This programme, which offers fistula surgery for free, is a result of partnerships between the United Nations Population Fund (UNFPA), government and some Non-Governmental Organisations and was first rolled out in two hospitals including the one attended by participants under study. However, in Zimbabwe there are poor follow ups for women who would have been successfully treated from fistula. The fact that the programme is new in the country indicates the need for the creation of knowledge on obstetric fistula repair as it relates to Zimbabwe. Studies on the challenges faced and how these women are coping are necessary.

Fistula repair is the surgical treatment of women who would have experienced prolonged labour which forces the unborn baby's head against a woman's pelvis (Coolican, 2007). According to De Ridder et al. (2010), the condition can risk the child's life and crush the tissues in the birth trench, the rectum and the urinary tract. The subsequent hole/gap created between the vagina and bladder (vesico-vaginal fistula) or between the rectum and vagina (recto-vaginal fistula) causes urinary or faecal incontinence (Ahmed and Holtz, 2007). A significant number of the women who experience such conditions lose their spouses and families, further driving them into neediness, while the seclusion they experience leaves them unnoticed by policy makers and little action is taken to address their condition (Bashar et al., 2018; Mutambara et al., 2013; Abrams et al., 2012; Ahmed and Holtz, 2007). Adjustment to society is necessary for all women with obstetric fistula and those who have undergone treatment.

Literature from the region indicates that there is stigmatisation of fistula survivors which is embedded in the cultural beliefs and sometimes bureaucratic processes within hospitals leading to negative experiences for women (Khisa and Nyamongo, 2012). In West Pokot-Ghana obstetric fistula survivors are labelled as having an illness that leaves them socially polluted (Ghana Health Service, 2015). They are seen as unclean and undeserving to participate in roles associated with women in the community such as cooking. While the success rate of fistula repair through surgery, is around 80-90 %, (Yeakey et al., 2011) some fistula survivors may not be fully accepted back by their community after surgery even though they may be healed (Kuo, 2011). The illness leaves a permanent stigmatising label on some survivors (Kabayambi et al., 2014; Ahmed and Holtz, 2007).

Generally, health education is given to women, and they learn how to take care of themselves during the postoperative period, how long to abstain from sexual activity after surgery and family planning. However, survivors of fistula repair may find it difficult to provide for their financial needs; as a result, they end up relying on their husbands and other family members (WHO, 2005). Many of these women may not be able to carry out heavy manual jobs (Lennon, 2014) and may fail to do jobs that they used to do before the repair.

Research in Sub-Saharan Africa in general and Zimbabwe in particular has mainly focused on women who have fistula (Bashah, Worku and Mengistu, 2018; Maunganidze, et al., 2015; Kabayambi et al., 2014; Mutambara, Maunganidze and Muchichwa, 2013) and not many studies have dealt with experiences after fistula repair (see Yeakey et al., 2011, who studied the experiences of Malawian women). This paper addresses the identified research gap outlining the challenges and coping strategies for fistula repair among Zimbabwean women.

This research highlights what fistula survivors think about their dignity and how they perceive societal response after the fistula treatment that is psychologically, socially, and economically. It sheds more light on what women intend to do with their lives after successful treatment of fistula. This study also highlights the struggles and coping strategies used by women as they integrate back into society. Key to this study is the concept of stigma and how survivors of fistula repair consider themselves stigmatised by society. The study also highlights how these women contest this stigmatisation by society.

Goffman's (1963) seminal work on stigma shows how society redefines certain members as different, bad and having undesirable qualities. He defined stigma as an attribute that is deeply discrediting. A stigma is an undesired differentness. It has the effect of reducing a person to being perceived and identified by that attribute. The attribute becomes the person's master status. Goffman argued that a stigmatised person «is thus reduced in our minds from a whole and usual person to a tainted, discounted one» (Goffman, 2006, p. 132). There are three types of stigma originally hypothesised by Goffman: various types of physical deformities, blemishes of individual character, and tribal stigma (where one is stigmatised on the basis of race, national origin, religion etc.). Once one is defined as such, their life is altered in a negative way because there is a tendency to associate other negative attributes to the original one. Over time, the concept of stigma has gone through further refining and redefinition. Link and Phelan (2001, p. 367) explain the elements of stigmatisation as involving the co-occurrence of «labelling, stereotyping, separation, status loss and discrimination in a power situation that allows the components of stigma to unfold». Stigmatisation always involves power to define normal from abnormal and to reject or accept a label.

But the process of stigmatisation is context-based and can be contested. Goffman (2006) outlined various responses to stigma ranging from shame to self-hate, self-derogation, self-consciousness, depression, bewilderment suspicion and hostility. The stigmatised may vacillate from a cowering response to that of a show of bravado. The stigmatised may also use the stigma as an explanation for failing in other areas of life, trying to correct the basis of stigma or trying to excel in other areas deemed to be inaccessible to persons with a particular kind of stigma and re-evaluating the limitations of those deemed normal. Goffman further argues that encounters of the «normal» and stigmatised are characterised by uneasiness where the response of the «normal» may range from over-sympathising with the stigmatised to acting as if the stigmatised is a non-person and not present at all.

This concept of stigma has been used to understand the experiences of various groups such as people with mental illness (Ahmedani, 2011), individuals with HIV (Surlis and Hyde, 2001), infertile women (Remennick, 2000) and even migrants (Schuster and Majidi, 2015). Link and Phelan (2001) highlight how the concept of stigma has been utilised as a frame of analysis to understand the lives of wheelchair users, mothers, the unemployed, those suffering from urinary incontinence and even stepparents. This shows

the growing edifice on the study of stigma in various situations. However, it is also important to understand how those that are stigmatised also participate in self-stigmatisation (Ahmedani, 2011).

This paper adds to this growing body of knowledge and deploys the same concept of stigma in order to understand the challenges and coping strategies of survivors of fistula. The paper further acknowledges that these women are not passive recipients of stigma but they actively recreate their images creating positive identities for themselves. This helps facilitate their reintegration and adjustment to society. The concept of stigma helps us appreciate the negative consequences of fistula repair such as divorce and isolation.

## **METHODS, PARTICIPANTS AND SETTING**

### **Research design**

The study applied a qualitative case study research method to explore the experiences of fistula survivors after repair and their adjustment to society. This method was adopted to provide more information on the impact of fistula repair in the restoration of women's dignity and their adjustment to society after the treatment, highlighting their challenges and coping strategies. This research is classified as an intrinsic case study. An intrinsic case study is defined by Stake (cited in Punch, 2005, p. 144) as a study undertaken to gain a better understanding of a particular case or a single case. A case study is defined by Yin (2009, p. 18) as «an empirical inquiry that investigates a contemporary phenomenon in depth and within its life context, especially when the boundaries between phenomenon and context are not clearly evident». This study sought a better understanding of the effects of fistula repair on the seven women participants, understanding in depth how they were adjusting to society. The aim of a case study is to provide rich details of the phenomenon under study. This is satisfied in the study through various quotations from the participants, providing «thick descriptions» of their experiences.

### **Participants and setting**

The study involved seven women, who had fistula surgery at a provincial hospital in Zimbabwe located in Chinhoyi, about 115 km North-West of the capital city Harare (Table 1).

**Table 1. Demographic characteristics of participants**

Participant	Age	Marital status	Level of education	Status of employ	Time with fistula	Period after repair	Number of children
A	31	Separated	Secondary	Self-employ	10 years	1 year, 2 months	2
B	24	Married	Primary	Self-employ	1 year	1 year	0**
C	29	Married	Primary	none	3 years	1 year	3
D	42	Divorced	None	Self-employ	8 years	1 year 2 months	4
E	17	Separated	Secondary	none	3 months	6 months	0**
F	38	Divorced	None	Self-employ	7 years	3 years 2 months	4
G	21	Separated	Primary	Self-employ	2 years	6 months	1

\*The self-employed mainly engage in vegetable vending.

\*\*Women whose first child died at childbirth

As mentioned earlier in the background, this hospital is one of the two where fistula repair was first introduced in Zimbabwe. This research does not claim to provide a representative sample of women who have undergone fistula repair in Zimbabwe but



provides an in-depth analysis of the few that participated in the study. Qualitative research designs generally aim to provide in-depth analyses with smaller sample sizes (Sandelowski, 1995). Moreover, the sensitive nature of the research meant that it was not easy to get a bigger number of participants as some of the identified women refused to participate. While this might be a shortcoming, the research still provides rich data in an area where there is a clear gap in knowledge regarding survivors of obstetric fistula repair in the country. The study is among the few that have tackled this important subject matter.

The ages of participants ranged from 17 to 42. The women were interviewed at least 6 months after the surgery. Study participants had low literacy levels and formal education. Two out of seven never went to school, three attained primary education only and two went up to secondary school. Six out of seven came from a rural and poor background.

### **Data collection and ethical Procedure**

Between February and May 2019 participants were engaged in in-depth interviews on the impact of fistula repair towards their dignity and their adjustment to society. Three face-to-face interviews were done as well as four telephone interviews. The interviews lasted between 30 and 60 minutes and were tape recorded. During the interviews notes were written down in a notebook. Sample size was determined by data saturation, that is to say, interviews were stopped when there were no new information emerging from the participants.

Permission for study was sought from the hospital after getting ethical clearance from the Midlands State University through the Faculty Ethics Committee. The ethical clearance was done by first and second authors. Having been given approval for research the researchers sought profiles of women who had gone through fistula repair at the hospital. In order to obtain rich data, the researchers of this study purposively selected women of all the age ranges within the childbearing age (from teenage to the forties). They also targeted those who had a longer duration with fistula (e.g., 8-10 years) and those among the very first patients to undergo fistula repair (about 3-4 years) since the service was introduced in the country in 2015.

The authors collected contacts and home addresses of the women and then contacted them, first via the telephone and for those who agreed, home visits were done. Only those

whose phone numbers could not go through and lived in remote areas during the data collection phase were left out.

At every point voluntary informed consent was maintained stating clearly that this was an academic research which was not part of the hospital procedures. Participants signed consent forms and agreed to have the findings published as an academic study. Before the interview, participants were given detailed information about the research including procedures, purpose of the research, risks and benefits as well as contact details of the researchers. The participants were interviewed on the days and times convenient to them. In order to protect the privacy of research participants, in the data presentation and analysis, their responses are anonymised, they are only identified by alphabetical letters A-F.

A semi structured interview guide was used to collect data. The guide had a section on demographic data and another section with questions of the women's experiences. Some of the questions were: May you please describe your negative experiences after Fistula repair? What were the economic challenges that you faced after the repair? Explain your process of engaging back into the community after repair; Describe the coping strategies that helped you to integrate into society after repair.

### **Data analysis method**

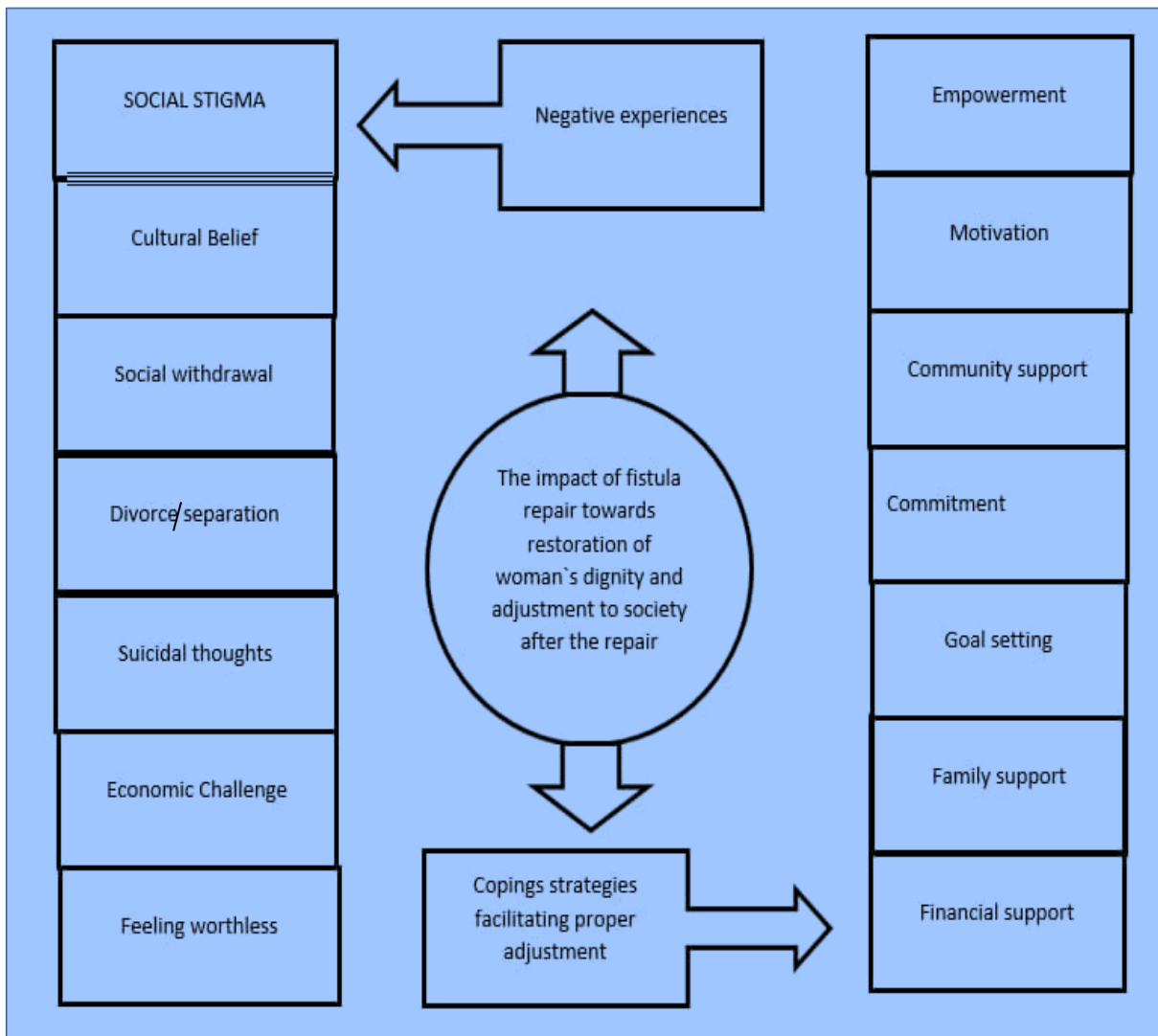
Thematic data analysis was used to analyse and present data using major themes and subthemes. Braun and Clarke (2006, p. 79) define thematic analysis as a method for identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes a data set in (rich) detail and frequently goes further to interpret various aspects of the research topic. The specific form of thematic analysis used in this study is both inductive (data driven) and realist. The stages of thematic analysis identified by Braun and Clarke (2006, p. 87) and utilised in this research for coming up with themes and categories for data classification and analysis are:

1. Familiarisation: transcribing, reading and rereading of work.
2. Generating initial codes: coding interesting features of the data.
3. Searching for themes: gathering all data relevant to a potential theme.
4. Reviewing themes: checking if generated themes work in relation to coded extracts.

5. Defining and naming themes: generating clear definitions and names for each theme.
6. Producing the final report: final opportunity for analysis and crafting a scholarly report.

The resultant themes and their relationships are illustrated diagrammatically in Figure 1 below.

**Figure 1.** Major themes from the study



## FINDINGS

The research consisted of 7 participants who went through a life changing experience of fistula repair at Chinhoyi provincial hospital. The obstetric fistula survivors interviewed were aged between 17 and 42 years. The average age was 25. Out of seven women

interviewed five were divorced and or separated from their partners and two were married.

### **Negative experiences faced by women after fistula repair**

Obstetric fistula survivors mentioned several factors that prevented their reintegration after surgery and affected their perceptions of dignity. These factors included social stigma, cultural beliefs, social withdrawal, divorce or separation, suicidal thoughts, feeling worthless, shame, blame, and economic challenges.

### **Social stigma, cultural beliefs and social isolation**

All the interviewed women complained that they suffered continuous stigma and isolation. Stigma was directed at the women both by their families and the community, who isolated them and did not allow them to participate fully in household chores or social activities.

*I felt worthless when other women isolated me after repair. Continuation of stigma after repair led to feelings of hopelessness. People in my community did not believe that I was healed when I returned home after the operation. People used to laugh at me because after the operation I was not able to play my roles as a woman and as a mother. (Participant C)*

*My fellow women were gossiping even after I was healed. They could not buy the vegetables I was selling. Some of them did not want to talk to me and some were not responding when I greeted them. Even now some women do not feel comfortable sitting next to me at community meetings and it's still hard to attend all the community meetings. (Participant B)*

On cultural beliefs, six participants argued that the community did not believe that Fistula was a medical condition but rather they believed the victim was cursed or bewitched.

*It affected my identity in the community because my husband's relatives said this had never happened to anyone in their family before and I was the first so this means I am cursed and I will bring bad luck into their family. (Participant B)*

*It affected me because before I went for the operation I went to consult a local healer in our community and he told me that my life was surrounded by evil spirits so even after the operation when I was healed people were saying that I am surrounded by evil spirits and some people*

*said I do not deserve to mingle with other women because I am spoilt.*  
(Participant A)

All members explained that they secluded themselves from their networks as a result of the stigmatisation. For instance:

*I used to isolate myself avoiding being called with different names. I was neglected by my fellow women, and I was abandoned by my husband, so I tried to live in the house all the time until I was able to walk and do my chores.* (Participant F)

*I isolated myself from the society because my fellow women were laughing at me because my husband separated with me after the operation... I had to abstain from sex for six months. They were laughing at me saying that I failed to satisfy the sexual needs of my husband, so I used to stay in the house most of the time.* (Participant G)

### **Divorce and separation**

Five women of the survivors reported that fistula repair affected their marriages, since they had to abstain from sex for half a year in order to heal properly. The husbands deserted them for other wives or partners (3) while 2 of these women were completely divorced.

*At first when I went for the first operation my husband was supportive but after the first operation failed, he abandoned me with my four children and went on to marry another woman.* (Participant D)

*When I was healed my husband was very happy, but everything changed when I told him that we must abstain for six months after the operation. He said that he could not do it. We separated and he sent me back to my father's house and married another wife.* (Participant G)

### **Suicidal thoughts, erosion of self-worth and blame**

Three (42 %) of the participants felt the segregation, stigma and the societal shame was too huge a burden for them to carry and contemplated suicide.

*I experienced anger, sadness, and shame because I had no support from my friends. My father threw me out after I got pregnant, so I was very scared after the treatment because my boyfriend had also abandoned me when the baby died, so I thought about suicide as a better solution.*  
(Participant E)

*I could not socialise with other women, go anywhere with them or associate with them in any way. Once you join, they would leave. I*

*prayed for death to come and release me from this agony, because it was even harder after the repair. (Participant A)*

The lack of support and social stigma from the community reinforced women's feelings of worthlessness and isolation. This affected the extent to which they were perceived and perceived themselves as dignified.

*I lost my dignity and self-worth since I was not able to provide and offer help to my family. I was not able to play role as woman in my family or in the community. People could not believe that I was healed, and I was just like any other normal woman. (Participant F)*

*I had low self-esteem and I looked down upon myself because I felt that chances of getting married again were very slim because of my blemished record and my social worth had decreased. I was depressed and I did not see myself achieving something good in life. (Participant G)*

The loss of a child during birth was reported to be traumatising and produced intense feelings and self-blame. Blame came from two main sources: the community members and the self. In such cases self-blame was largely a result of internalisation of the negative label attached to the self by the community members. Participants felt cursed by the Spirits.

*I felt like it was double punishment and I wanted to take my life because I had start to believed that I was cursed when my boyfriend abandoned me after the death of child. People were blaming me saying I caused everything. (Participant E)*

*People blamed that I had caused the death of my child because they believed that I was lazy to push the baby during birth. I started to believe that I was cursed, and I blamed myself when my husband left me. (Participant G)*

## **Economic challenges**

The lack of economic empowerment was a big challenge after surgery as the women found themselves too dependent on their spouses and other relatives.

*For me it was a big challenge because I used to depend on my husband. I had no capital to start a small business and I was afraid to start because of the bad image and I believed that no one will support me in our community. (Participant A)*

*I was humiliated because I lost my job as a domestic worker, and no one was willing to hire me even after I was healed and it was very hard for my family and because I used to help with financial support. (Participant F)*

*I lost dignity and self-worth since I was not able to provide and help my family. When I started my business fellow women did not buy my vegetables because of my condition in the past. (Participant B)*

## **Coping strategies and facilitators to women's adjustment after fistula repair**

### ***Income generation projects***

Most survivors who had received some form of help or business capital felt that this was very important and had helped in their integration:

*Empowerment played a crucial role in my life because I am now financially independent. After I was healed, I started my small business of buying clothes from South Africa and Zambia and sell them in my community. I can provide for my family and myself and because I am always busy with my business I can move on with my life without stress or thinking about my separation. (Participant G)*

*Empowerment helped me a lot because I used to help my husband at the farm so when he abandoned me I was able to move on with my life because I started my own farming projects and I am able to take care of my children and all my financial needs. I am no longer stressed or depressed because I am capable of providing all my needs and my family can depend on me. (Participant D)*

### ***Community support, personal commitment and motivation***

From the community, the survivors needed acceptance and involvement in the normal activities like any other women:

*The community started to support me after the second operation was successful. Fellow women were inviting me to their houses, and I was involved in societal activities especially farming programmes. (Participant D)*

*Changing environment helped me a lot because I moved to another community where no one knew about my past life, so they are treating me like any other in the society. I am able to move on with my life without any stigmatization or bad image. (Participant E)*

Asked on why and how she was committed being physically well again, one fistula survivor indicated having a different perception of the fistula treatment which she reinterpreted as a once-in-a-lifetime opportunity to lead a normal life and thus a new lease of life which offered a second chance and an opportunity to possibly right the wrongs of the past.

*When my operation was successful, I felt like I was given a second chance in life to make things right with my parents whom I had*

*disappointed by getting pregnant whilst I was still in school. I wanted to correct my mistakes, so I was focused on my future because being healed was a miracle in my life. (Participant E)*

*I wanted to work very hard so that I could provide for my children, and I want them to have a better life because they suffered for a long time (7 years) when I had fistula so I was focused on recovering so that I would be the best mother. (Participant F)*

The inspiration to be better by fistula survivors was connected to variables related with their encounters of living with fistula and enduring the physical and social outcomes of the condition after medical procedure, their regenerative history and their capacity to work and be financially independent.

*I was tired of living by myself most of the times because my children were taken from me because of my condition so I was not happy with the fact that someone was taking care of my children whilst I'm still alive. This motivated to be strong and focused on my life because I wanted to be good mother to my children and good wife to my husband so as to fulfil all my duties. (Participant A)*

*I was motivated after I was healed, and I wanted to prove to the community that I was not a prostitute like what they used to tell their children. I wanted also to prove to my partner, who abandoned me, that I can move on with my life without his support, and my parents motivated me to focus on my future, so I believed it was my turn to make them proud. (Participant E)*

### **Social and economic support from family**

The family has a big role to play in supporting a fistula survivor. Acceptance and taking care of nutritional and hygiene needs is important. They provided the necessary social interaction that the survivors felt accepted.

*My sister was very supportive, and my husband showed his love and commitment though his relatives were against him. My sister used to come and cook, clean and wash my clothes. I lost both my parents when I was young. I only had my sister sympathising with me. Other relatives did not care about my condition. My husband was there for me. Though it was very hard, he stood by me. (Participant C)*

*My family sympathised with me, showed emotional support. My siblings sided with me against my unsupportive husband. They invited me to stay with them. They loved me, they would help me and advise that I should not think about him anymore. I can say that I am proud of having them because they were concerned about my life. (Participant E)*

Financial support has enabled fistula survivors to cater for their material needs and improve their reintegration and adjustment to the society. Financial support and income



generating activities afford the survivors food and other material needs, as well as an opportunity to self-fulfilment through financial independence. Financial independence assists in redefining the self.

*My family used to take care of my financial needs when my husband abandoned me but now, I can cater for myself and I am able to help my family as well. (Participant G)*

*After surgery it was very hard for my family to provide for my financial needs and my children, but my parents and siblings helped me until I was strong enough to go to the farm, now I can rely on myself and I can take care of my children. (Participant D).*

## DISCUSSION

The research findings confirm that survivors of obstetric fistula in Zimbabwe experience various challenges which include social stigma, reduced sense of self-worth, low perceptions of dignity, physical illness, and financial loss due to fistula. This study has established that social stigma continued even after surgery and highlighted the forms of stigma that obstetric fistula survivors face. In all cases, however, the survivors were stereotypically labelled as abnormal and undignified. These observations confirm literature which highlights those survivors of fistula are often discredited as women, their social status being questioned and devalued (Mutambara et al., 2013; Donnay and Ramsey, 2006), and they may also be separated from mainstream society either by total isolation or being partially accepted at social events (Kaplan, et al., 2014). In this research the isolation of women was both imposed by society and also self-inflicted as a form of coping strategy. Self-isolation causes self-stigma. Ahmedani (2011) notes how stigma can be conceptualised from three different levels of social stigma (by community members), professional stigma (by health or other professionals dealing with individuals who are labelled negatively), and self-stigma (stemming from the individual herself after internalising the label). This study clearly highlights the consequences of both social and self-stigma.

In a patriarchal society such as the one under study, the dignity of Zimbabwean women is closely tied with definitions of wifhood, motherhood and womanhood which themselves hinge on the ability to enact sexual and reproductive roles (Mugwini, 2008; Mutambara et al., 2013). These roles are difficult to fulfil for women with fistula and those that have undergone treatment. Perceptions of indignity affected the women under study, and they were laughed at by fellow women and community members. The actions

of their unsupportive husbands were not only condoned by the community, but they created further room for discrimination of fistula survivors. Victims of one form of stigma often face other forms of discrimination (Stangl et al., 2019; Yeakey et al., 2011). Goffman (2006, p. 133) elaborates this by noting that «we tend to impute a wide range of imperfections on the basis of the original one». Some women in this study were now viewed as prostitutes, bad mothers and wives and cursed or surrounded by evil spirits.

This study demonstrates that after surgery the survivors experience psychological trauma as though they still have a fistula even though they may be physically healed. Often, physical healing is not sufficient for fistula survivors and there is need to address social stigmatisation that continues after surgery. Therefore, there is need for long-term counselling for survivors and community sensitisation to counteract the effects of stigma. This is necessary because stigmatisation is a process that takes place at community level and involves a common definition of what is «normal», what is socially expected and the reality on the ground (Schuster and Majidi, 2015; Link and Phelan, 2001), which when identified properly can be tackled at community level. The community needs to accept and involve fistula survivors in the «normal» activities of women.

Successful outcomes after surgery, family and community support, having a form of income generation activity and undergoing a form of skill training were all noted as having a positive effect on the survivors' psychological well-being as well as providing them with material needs. The study corroborates findings by Yeakey et al. (2011), who argue that there needs to be interventions at various levels of the community for the full integration of fistula survivors.

It is important to note that survivors of fistula repair attempt to manage stigmatisation and reconstruct their spoilt identities through various ways; some engage in income generating activities, trying to be financially independent and be the «best mother» who is «the provider for the family». Others try to buffer negative perceptions of society through social isolation which is a negative coping strategy that could lead to further discrimination and even poverty. A different strategy is relocation. The one case presented above indicates how a woman relocated to a place where her past and condition were unknown. Downplaying feelings of love for the uncaring partner and not stressing about the man was another strategy that some women engaged in, sometimes with the encouragement of their family members.

Positive efforts such as keeping busy and earning some income, economically empowered obstetric fistula survivors and provided access to material needs, and psychological satisfaction. A sense of agency came from intervening in their own situations and productive activities engaged in with other people. As noted by other researchers, women who reintegrate into their communities after fistula repair demonstrate a positive connection between being able to work again on the farm and their integration process (World Health Organisation, 2017). But despite full recovery, some women may be unable to sustain themselves after they reintegrate because they would have been left out of economic activities for some time. Economic difficulties compromise their quality of life and the degree to which they integrate.

In reconstructing a spoilt identity and refocusing energy in different directions, survivors felt there is need for fistula survivors to support each other. This is in line with findings by Schuster and Majidi (2015), which indicated that supporting each other as a group helped the stigmatised to somehow engage in a process of reversing the stigma and offsetting the negative label by talking about how they are characterised. Support from people experiencing similar stigma can be calming, especially for those who may be new in the particular predicament (Goffman, 1963; Surlis and Hyde, 2001).

While most of the strategies and facilitators point towards the positive reintegration to society, a disturbing strategy that some women engaged in was self-isolation which came as a result of the reactions of society to the fistula survivors. Challenges of blame, especially after the death of a child, rejection by spouse and other family members and discrimination by society, especially other women, fuelled thoughts of suicide further reinforcing the need to self-isolate. The preference for self-segregation seems to be common among individuals experiencing stigma (Goffman, 1963; 2006; Surlis and Hyde, 2001).

This study has some limitations: the small number of participants may not allow for generalisations of findings to the rest of the women in Zimbabwe that is the findings may not be a true reflection of all the women who had fistula repairs in the country. Since the interviews were done after integration into society some phone numbers were unreachable and place of residence could not be verified, these women could not be included in the study.

## CONCLUSION

The presence of some factors was seen as slowing down the integration process or preventing it altogether. They included social stigma, unsuccessful repair, negative cultural beliefs, poverty and general economic challenges. The negative factors interplayed in many cases and thus must be eliminated if integration is to be successful. The survivors who were stigmatised found it hard to interact with other community members and responded by self-isolation. This further jeopardised their chances of participating in social and economic activities, leading to poverty, helplessness, and psychological trauma.

It is suggested that, in order to facilitate reintegration, surgical repair needs to be accompanied by psychological and social rehabilitation. As shown in this study, there is need to involve different community members at different levels and also consider women's sexual and reproductive needs as well as strategies for their economic empowerment after fistula repair. Health practitioners need to find ways of shortening the period of abstaining from sex since this directly determines the chances of remaining in marriage. Family members faced higher expenses in the daily management of women's conditions, including taking care of costs on food and soap. Successful reintegration requires that families make great sacrifices in helping the women after fistula repairs.

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