Abstract

Genitourinary fistula is a stigmatizing injury primarily affecting women with poor access to quality emergency obstetric care. Western Kenya is a region which has consistently had high rates of fistula. In an effort to better understand the surgical and non-surgical support required to address fistula cases, we aim to contribute to the global understanding of fistula patients living in Western Kenya to better understand how patient mobilization can be modified to improve access to quality fistula treatment in the region. We seek to delineate the value of different types of obstetric and fistula care. We will explore who undergoes fistula surgery through in-depth interview among approximately 30 women who underwent reconstructive fistula surgery at the Gynocare Fistula Centre in Eldoret, Kenya. Study participants will be asked to describe patient decision-making processes and eventual care access, including the role of various facilities and barriers at each step, attitudes and experiences with healthcare before and after developing fistula, and patient recommendations for overcoming the identified barriers to improve access to fistula care. This study will contribute to the evidence base on the challenges patients face in accessing fistula care in Western Kenya. We hope to find insightful findings to local and international programs, such as the Fistula Foundation, to assist in the work currently underway that aims to access care for fistula patients for Kenya women. Furthermore, the project hopes to contribute to the narratives of a urogynecologic issue underrepresented in scientific research.

Introduction

Since the early 2000s, access to surgery has tripled; however, many women still face challenges obtaining the care they need. In spite of gaining improvements in maternal health, women in many low- and middle-income countries worldwide remain at risk.

Eliminating obstetric fistula will require a dual focus on increasing the quality of maternal care in conjunction with the sociocultural norms of early marriage, early childhood, and low literacy rates which contribute to disparities in access to quality care and greater compliances at childbirth, thus resulting in higher incidence of obstetric fistulas. Therefore, given the high prevalence of fistulas, we need to consider the sociocultural, psychological, and trauma factors whose causes are also rooted into sociocultural dynamics.

Methods

STUDY SETTING

This study is conducted at the Gynocare Women’s and Fistulas Hospital established in 2009 and began providing genital fistula surgery in 2011. It has a 100-bed capacity, and 49 clinical and administrative staff members. The hospital is a referral center to offer fistula care to patients originating from 16 counties in Kenya, as well as patients living near the hospital and waiting for treatment. The fistula center provides primary reproductive care, consultation, obstetric, gynecologic, and general medical services. Doctors, nurses, and other medical staff come from霁c all Kenyan provinces. Gynocare Women’s and Fistulas Hospital is a referral facility for a population of approximately 30,000 people, providing a broad array of services to women’s health and community with a focus on minimizing the need for surgical interventions.

STUDY PARTICIPANTS

The study participants were women and girls who experienced genital fistula surgery at Gynocare Women’s and Fistulas Hospital (n=30 qualitative interview participants). Given this particular patient population, we expected that our study participants would be low socioeconomic status and come from different parts of the country. We did not implement restrictions based on participant age; we expected that the majority of participants would have obstetric-related stigmatic fistulas, and thus potential participants under the age of 18 might meet the criteria for emancipation under Kenyan law.

RECRUITMENT AND ENROLLMENT

Recruitment occurred for study participation at Gynocare after diagnosis of fistula. Prior to approaching potential participants, the research assistant commenced the primary care discussion with potential participants’ next of kin to ensure that ending participation in this study at the current time will not cause distress. During the time of women’s willing to participate at least one day in between the time of their scheduled surgery date, the primary investigator visited them at their homes, in the hospital, and in the community. In the study, explaining the purpose, the time investments and data to be collected. The women had been provided with information about the study and their participation, and if they were interested in participating, they provided written/telephone informed consent from their next of kin.

STUDY PROCEDURES

We conducted the semi-structured interview with the research team. The interviews took place in a private location at Gynocare hospital. Women were first asked to complete a brief interview on sociodemographic characteristics and prior health experiences, particularly through the use of a questionnaire. The qualitative Care questionnaire developed by Afolabi et al. Subsequently, in-depth interviews were conducted within the participant’s preferred language and were anticipated to take approximately one hour. Participants were asked for their permission to audio-record the interviews, and interviews were then transcribed and translated into English (as necessary) for analysis.

Results

The coded interviews of study participants highlighted their individual healthcare experiences as it relates to patient seeking behavior for fistula repair. The majority of participants expressed preference for hospitals and dispensaries over traditional medicine, such as herbal medicine and community healers. Some of the main reasons provided were the availability of medication when going to large community hospitals; as well as its overall efficacy. Despite acknowledging that there are flaws to the medical system, participants generally mentioned that they “trust hospitals because they help.”

Future Prospects

As the study’s analysis remains ongoing, a potential direction for the project could be to conduct a linear regression analysis of a possible correlation between the study respondents’ PCC scores and the “time to care-seeking” variable, in which are measured by the amount of time a patient decided to seek fistula care since the time of fistula onset. Additional options could be an analysis of PCC scores against other demographic factors, such as level of education obtained, domestic status (urban, rural, etc.), and income-level (as determined by types of assets currently owned).

Discussion

The PCC questionnaire is a series of 30 questions pertaining to participants’ previous healthcare experiences and how they factor into the healthcare seeking practices that have led them to Gynocare Fistula Centre—the anticipated final destination for fistula repair. While an overall summary of all participants’ descriptions of individual health experiences has been summarized, this study aims to conduct a deeper analysis relying each participant’s PCC responses with their individual recollections of the healthcare experience. Within our in-depth interviews we seek to understand participants’ previous experiences with the healthcare system and how this experience may have facilitated or hindered their healthcare-seeking trajectories. We will seek to understand subjective norms through querying the healthcare perspectives of influential individuals (e.g. family members, neighbors) for their input.

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An Intersectional Analysis of Quantitative Patient-Centered Care Metrics and Qualitative Themes in the Healthcare-Seeking Practices Among Fistula Surgery Candidates in Kenya

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