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Information Professionals’ Role in Enhancing Awareness Creation towards Obstetric Fistula Treatment in Rural Areas of Tanzania

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Information Professionals’ Role in Enhancing Awareness Creation towards Obstetric Fistula Treatment in Rural Areas of Tanzania

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Abstract
This paper focuses on sensitisation of information professionals to create awareness on the treatment of Obstetric Fistula in rural areas of Tanzania. The rural women in Tanzania lack access to information on treatment of Obstetric Fistula, as a result, they face many problems such as social isolation, stigmatization, humiliation, rejection by their husbands and relatives. Due to these problems, Obstetric Fistula survivors feel guilty and loneliness, they lose hope for living and become disappointed. There is, therefore, a need for information professionals to disseminate Obstetric Fistula information in rural areas to create awareness of the treatment of this problem. Non-probability purposive sampling technique was used to identify 64 respondents in the four surveyed villages from Mpwapwa District, Dodoma Region, Tanzania. The same sampling design used to identify twelve health professionals (medical doctors and midwives). Data were collected through documentary reviews, in-depth interviews, questionnaires, Focus Group Discussions and observation. The study revealed that the problem could be cured, but the problem is that most of the rural community members lack information on the possibilities of obstetric fistula treatment. The study, therefore, concluded that information professionals have to play their role in creating awareness on the treatment of Obstetric Fistula in rural areas of Tanzania.

Key Words: Obstetric Fistula, Information, Information Professionals, Awareness Creation, Rural Areas, Tanzania
1. Introduction

Obstetric Fistula is a hole or false communication that forms between the bladder and vagina known as Vesical Vaginal Fistula (VVF) or between the rectum and vagina Recto Vaginal Fistula (RVF) during prolonged labor and obstructed labor. The constant pressure of the fatal skull (the baby’s head) 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. Obstetric Fistula has an immediate health impact for women and her child and left untreated can have devastating medical and social consequences (Kimani, 2014).

In most developing countries Tanzania included, most of the women in the rural communities always have heavy responsibilities in production and reproduction roles. It is estimated that about 60% to 80% of the women population in the rural communities are occupied with agriculture which is the primary economic activity (Ogunlela and Mukhtar, 2009). In addition, women are the ones who mostly have the role of childbearing, child rearing, and the responsibility of feeding their families. Njau and Mruma (2004) stated that “the poorest and the most need in most rural societies are women. They carry heavy responsibilities for farming, for feeding their families and often take the role of head of the household”. International Fund for Agricultural Development (IFAD, 2012) added that rural women have many roles, and they have responsibilities and knowledge that differ from those of men. As farmers, they plant, weed and harvest food crops and tend livestock. As caretakers, they prepare meals and manage the home. In developing countries such as in Africa, Asia, and the Pacific, women typically work 12 more hours than men. Also, UN-Women (2014) asserted that women have a critical role in advancing agricultural and rural development and ensure food security. Giving women the same access as men to agricultural resources and inputs could increase production on women’s farms by 20-30 percent. This could reduce the number of hungry and poverty in the world. IFAD (2012) confirmed that in more than 30 years of working in rural development, it has revealed that, women can be a powerful force in fighting poverty.

Despite these multiple and heavy responsibilities performed by women in the countryside, they are the ones who are the disadvantaged group and marginalized in decision making, even that pertaining to their health problems. For example, health decisions of many married women in rural areas are made by their husbands or their mother- in- laws. As a result, the majority of
women are facing different health complications such as body disabilities, deaths, and Obstetric Fistula. Women Dignity Project (WDP) (2006) stated the following:

*every quarter of a second somewhere in the world a child is born, every second two women suffer from long-lasting complications of pregnancy or childbirth, including Obstetric Fistula, infertility and depression, every nine seconds somewhere in the world a woman delivers a stillborn baby, every minute one woman dies in pregnancy or childbirth, leaving behind more than one million orphaned children each year, every four minutes somewhere in the world a woman gets Obstetric Fistula.*

Most of these problems are influenced by intangible social, cultural factors such as women marginalization in decision-making, men dominance of the household, harmful female genital mutilation, malnutrition, early marriages, poverty, poor transport infrastructures and illiteracy. In addition, Obstetric Fistula survivors face many social problems such as social isolation, stigmatization, humiliation, abandoned by their husbands and their relatives; they feel guilty and loneliness, they lose living hope and become disappointed. Most of these health and social problems which affect most of these rural women are contributed by lack of information provision in the rural context.

Mazie and Ghelfi (1995) describe information as a critical resource for people and communities in both rural and urban areas. Information is paramount for community development. Information creates awareness, increases broad participation in decision making and taking actions, provides an opportunity to support policy change, institutional change, and audience behavioral change. Mchombu (1992) pointed out that “studies over the past three decades have revealed that in many parts of Africa, most development programs do not succeed because of ineffective communication strategies which are used”. According to Mtega (2008) as cited by Mbangala and Samzugi (2014) argued that an information gap exists within and between nations because of unequal access to information. Information brings about positive change, moving the targeted group or individual from a disadvantaged position to an improved one, it reduces uncertainty and enhances awareness of possible actions to solve problems. Wakelin and Simelane (1995) pointed the importance of information provision in ‘capacity building’ and in ‘empowering communities’ and argued that a lack of information acts as a barrier to development.
Currently, many health problems including Obstetric Fistula can be cured, but many rural community members are not aware of treatment. Wakelin and Simelane (1995) pointed out that “while information is becoming increasingly available to urban-based organizations through the media, modern linkups, workshops, and literature, the historical marginalization of rural-based people continues.” For Obstetric Fistula survivors to regain their dignity, information professionals should play the role of disseminating information concerning the treatment of Obstetric Fistula.

2. Materials and Methods

The study was conducted at Mpwapwa District, Dodoma Region. The population of Mpwapwa district is 305056 whereby male were 147,306 and female were 157,750 (Tanzania National Bureau of Statistics, 2012). Administratively, Mpwapwa District is made up of three divisions: Mpwapwa, Kibakwe, and Rudi. The district has eighteen wards and eighty-four (84) villages. This study was conducted by using quota and purposive sampling techniques. Quota sampling design used to select two divisions which are Mpwapwa Town and Kibakwe. After that, two wards were selected from each division. That means, Mpwapwa Town and Matomondo wards selected from Mpwapwa Town division while Wotta and Luhundwa wards selected from Kibakwe division. Then, one village was selected from each ward. Therefore, this study conducted into four villages which are Mwanakianga village from Mpwapwa Town ward, Tambi village from Matomondo ward, Ikuyu village from Luhundwa ward and Mlunga village from Wotta ward. Below is a figure which summarizes sampling procedures.

Figure 1: Divisions, Wards and Villages Sampled in Mpwapwa District

![Diagram showing the divisions, wards, and villages sampled in Mpwapwa District](source: Field data, 2011)
In selecting respondents from each village purposive and snowball sampling techniques were used. This technique helped to choose only respondents who were able to provide the required data. For snowball sampling technique, this begins with few people or cases and then gradually increases the sample size as new contacts are mentioned by the people you started with (Kombo and Tromp, 2006). At this stage, village leader/s such as Hamlet Leaders and Village Chairpersons helped to identify other respondents who were likely to have the required data. The following instruments were used to collect field data: Self-administered Questionnaire, an interview, focus group discussion, two focus group discussions (men and women) which comprised of 6 members in each group within each village and observation.

The population included women living with Obstetric Fistula, men, women who have not been affected, health workers (nurses and doctors), and traditional birth attendants, people who take care of Obstetric Fistula Victims and fistula information generators such as Women Dignity Project, AFNET, and AMREF. A total of 64 respondents were selected as follow: 14 respondents from Mwanakianga; among them, 2 were traditional birth attendants, five men, five women who have not been affected, one village leader and 1 Obstetric Fistula survivor. Tambi village constituted of 15 respondents: 2 were traditional birth attendants, five men, five women who have not been affected, one community leader and 2 Obstetric Fistula Survivors. There were 18 respondents from Ikuyu: 2 were traditional birth attendants, five men, five women who have not been affected, one village leader, 3 Obstetric Fistula Survivors and two family members who take care of Obstetric Fistula patients. Mlunga village constituted of 17 respondents: 2 were traditional birth attendants, five men, five women who have not been affected, one community leader and 3 Obstetric Fistula Survivors and one family member who take care of an Obstetric Fistula Patients.

Data of this study was analyzed quantitatively and qualitatively. Quantitative data was collected from self-administered questionnaires, organized; coded and analyzed using the Statistical Package for Social Science (SPSS) to derive frequencies and percentages. Qualitative data was
analyzed during the research process. For example, at the end of each interview, field notes, recordings, and comments were reviewed. Other qualitative data from interviews and observations were analyzed using content analysis.

4. Conceptual Framework
For the sake of awareness creation towards the treatment of obstetric Fistula in rural areas, informational professionals should act as a bridge. In telecommunication, a bridge is a device that connects two Local Areas Networking (LANs). Information professionals should act as a bridge in the sense that they should access treatment of obstetric fistula from different channels such as radios, televisons, newspapers and social media. In order to get reliable information, sometimes they should visit different hospitals which provide free treatment of obstetric fistula. Apart from that, they should communicate with different Nongovernmental organizations which are used to help rural women such as Women Dignity Project, Tanzania Gender Networking Programme, and African Medical and Research Foundation (AMREF). After getting full information on where to get treatment and how it will be done, information professionals should repackage the acquired information into channels which are affordable and accessible by rural community members such as village meetings, outreach and establishment of information centers from division level. Berlo (1960) in his communication model suggested that the information generators and disseminators should consider the level of education, attitudes, culture, communication skills, knowledge, geographical location and social systems of the intended audience (information receiver). For the sake of awareness creation, there must be a high consideration and diagnosis of those factors before the information is generated and disseminated. Shramm (1955) argued that communication should be interactive. Both the sender and the receiver should be active during the communication process. The sender sends a message and receives feedback from the receiver. In an interactive
model of human communication, there is continuity of responses between the sender and the receiver.

Figure 2: A Modified Shramm (1955), Berlo’s (1960) and Lasswell (1948) Models of Information Communication

3. LITERATURE REVIEW

Kimani (2014) defined Obstetric Fistula as an abnormal communication created between the vagina and the bladder and or the rectum. Khisa et al. (2011) explain that Obstetric Fistula occurs mainly due to prolonged and obstructed labor. Donnay (2005) and Women Dignity Project (2006) which is the primary Non-Governmental Organization dealing with Obstetric Fistula in Tanzania in collaboration with the Ministry of Health, defined Obstetric Fistula as:

A hole or false communication that forms between the bladder and vagina known as a Vesical Vaginal Fistula (VVF) or between the rectum and vagina Recto Vaginal Fistula (RVF) during prolonged labor and obstructed labor. The constant pressure of the fetal skull (the baby’s head) 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. In nearly all cases of Obstetric Fistula, the baby dies.

Most of these problems are influenced by intangible social, cultural factors such as women marginalization in decision-making, men dominance of the household, harmful female genital mutilation, malnutrition, early marriages, poverty, poor transport infrastructures and illiteracy.
Obstetric Fistula survivors face many social problems such as social isolation, stigmatization, humiliation, abandoned by their husbands and their relatives; they feel guilty and loneliness, they lose living hope and become disappointed. According to United Nations General Assembly Report (2014) reported that “with research indicating the majority of women from 78 percent up to 95 percent who develop obstetric fistula also deliver a stillborn baby.” The report also indicates that those obstetric fistula survivors feel guilty, loneliness and this isolation affect their mental health which resulting in depression, low self-esteem, and even suicide. Treatment of this problem is available, but the problem is a lack of information. Raassen (2006) reported that “currently in Tanzania, there are about 15 trained specialists carrying out approximately 845 repairs a year, which is more than in neighboring countries of Kenya and Uganda.” Chong (2004) stated that “there are medical institutions such as Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) which provide free treatment and an individual expert.”

Jerome and Theresa (2009) describe information as a critical component in decision making. The authors pointed out that availability of information enables individuals, groups or organizations to make rational decisions and reduce the level of uncertainty. Mazie and Ghelfi (1995) describe information as a critical resource for people and communities in both rural and urban areas. Information is imperative for community development. Information creates awareness, increases broad participation in decision making and taking actions, provides an opportunity to support policy change, institutional change, and audience behavioral change. Mchombu (1992) pointed out that “studies over the past three decades have revealed that in many parts of Africa, most development programmes do not succeed because ineffective communication strategies are used”. Information brings about positive change, moving the targeted group or individual from a disadvantaged position to an improved one, it reduces uncertainty and enhances awareness of possible actions to solve problems. Wakelin and Simelane (1995) pointed the importance of information provision in ‘capacity building’ and in ‘empowering communities’ and argued that a lack of information acts as a barrier to development. Musoke (2005) illustrated that “access to information is an essential component of development; it is a human right and it does bring about sustained development and social-economic progress”.
5. FINDINGS AND DISCUSSION

5.1 Composition of Respondents

Table 1: Respondents’ Categories Involved in the Study  (N=64)

<table>
<thead>
<tr>
<th>Category</th>
<th>WHNOAF</th>
<th>OFS</th>
<th>WTC</th>
<th>VL</th>
<th>TBAs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>%</td>
<td>F</td>
<td>%</td>
<td>F</td>
<td>%</td>
</tr>
<tr>
<td>Mwanakianga</td>
<td>10</td>
<td>15.6</td>
<td>1</td>
<td>1.6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tambi</td>
<td>10</td>
<td>15.6</td>
<td>2</td>
<td>3.1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ikuyu</td>
<td>10</td>
<td>15.6</td>
<td>3</td>
<td>4.7</td>
<td>2</td>
<td>3.1</td>
</tr>
<tr>
<td>Mlunga</td>
<td>10</td>
<td>15.6</td>
<td>3</td>
<td>4.7</td>
<td>1</td>
<td>1.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>40</td>
<td>62.4</td>
<td>9</td>
<td>14.1</td>
<td>3</td>
<td>4.7</td>
</tr>
</tbody>
</table>

|                   | F      | %   | F   | %  | F    | %    |
|                   |        |     |     |    |      |      |
|                    | 8      | 12.5|     |    |      |      |

Source: Field Data, 2011.

F = Frequencies

% = Percentages

WHNAOF = Women Who Have Not Been Affected with Obstetric Fistula

OFS = Obstetric Fistula Survivors

WTC = Women who take Care (relatives

VL = Village leader

TBAs = Traditional Birth Attendants

Table 1 above shows different categories of respondents who provided views on how Obstetric Fistula victims get information on how to prevent the disease and where to be cured. These includes Obstetric Fistula Survivors 9 (14.1%), people who use to take care of them 3 (4.7%), those who have never been affected with Obstetric Fistula Problem 40 (62.4%), Village Leaders 4 (6.3%) and Traditional Birth Attendants 8 (12.5%). The aim of involving different categories of respondents was to get different views, ideas, suggestions and opinions to facilitate the retrieval of reliable and valid information on the topic.
This study aimed at getting views, opinions, and suggestions from both male and female respondents.

According to Table 2, there were 23 (35.9%) men, whereby 41 (64.1%) were women. There were a large number of female respondents compared to male respondents. The reason behind is that Obstetric Fistula Survivors (OFS) were women. Among 41 (64.1%). Male respondents were only six from each village except Mwanakianga village which had only five male respondents and one female community leader. This was different from other villages where all community leaders were male.

5.2 Level of Education

Table 3: Respondents’ Level of Education by Village and Gender    (N=64)

<table>
<thead>
<tr>
<th>Category</th>
<th>Never Attended Formal Education</th>
<th>Attended Adult Education</th>
<th>Attended Primary Education</th>
<th>Attended Secondary Education</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male F % Female F %</td>
<td>Male F % Female F %</td>
<td>Male F % Female F %</td>
<td>Male F % Female F %</td>
<td></td>
</tr>
<tr>
<td>Mwanakianga</td>
<td>0 0.0 1 1.6</td>
<td>0 0.0 2 3.1</td>
<td>3 4.7 6 9.4</td>
<td>2 3.1 0 0</td>
<td>14 22</td>
</tr>
<tr>
<td>Tambi</td>
<td>2 3.1 3 4.7</td>
<td>0 0.0 0 0</td>
<td>4 6.3 6 9.4</td>
<td>0 0.0 0 0</td>
<td>15 23</td>
</tr>
<tr>
<td>Ikuyu</td>
<td>1 1.6 5 7.8</td>
<td>1 1.6 1 1.6</td>
<td>3 4.7 6 9.4</td>
<td>1 1.6 0 0</td>
<td>18 28</td>
</tr>
<tr>
<td>Mlunga</td>
<td>3 4.7 4 6.3</td>
<td>0 0.0 0 0</td>
<td>3 4.7 7 10.9</td>
<td>0 0.0 0 0</td>
<td>17 27</td>
</tr>
<tr>
<td>Total</td>
<td>6 9.4 13 20.3</td>
<td>1 1.6 3 4.7</td>
<td>13 20.3 25 39.1</td>
<td>3 4.7 0 0</td>
<td>64 100</td>
</tr>
</tbody>
</table>

Source: Field Data, 2011.
According to UNFPA (2003), “Education attainment is an important determinant of peoples’ opportunities and behavior. Studies have consistently shown that education attainment has strong effects on reproductive behavior especially on issues related to maternal health”. Thus to obtain information about education as a socio-economic variable, all respondents were asked about their educational level. Results for this question were as follows: The total number of respondents was 64. Among them, there were 23 (36%) male respondents and 41 (64%) female respondents. Respondents who never attended formal education included 6 (9.4%) male and 13 (20.3%) female. There were 1 (1.6%) male respondent and 3 (4.7%) female respondents who attended adult education. 13(20.3%) of the male respondents and 25 (39.1%) of the female respondents attained primary school. Only three male (4.7%) had secondary education. No female had secondary education. In all the four villages, no respondent had post-secondary education. Results from Table 5 revealed that there were more female respondents 25 (39.1%) who had a primary education than male respondents 13(20.3%). This was because the number of women respondents was larger than that of male respondents 23 (36%) and 41(64%) respectively. In addition, more female respondents did not complete their primary education. For example, among the 9 Obstetric Fistula Survivors who were interviewed, only one female completed her primary education, others ended up with standard two, three and most of them studied up to standard five. Primary school was attained by most of the respondents from all the four villages. This was followed by respondents who never attended formal education, then adult education, and lastly, secondary school. The figure below also summarize the above findings.

**Figure 3: Respondents’ Levels of Education by Village.**

![Figure 3: Respondents’ Levels of Education by Village.](source)

**Source:** Field Data, 2011.
5:3 Table 4 Respondents’ Sources of Income (N=64)

<table>
<thead>
<tr>
<th>Category</th>
<th>Small Scale Farmer</th>
<th></th>
<th>Self Employed</th>
<th></th>
<th>Employed</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
</tr>
<tr>
<td>F %</td>
<td>F %</td>
<td>F %</td>
<td>%</td>
<td>F %</td>
<td>F %</td>
<td>F %</td>
</tr>
<tr>
<td>Mwanakianga</td>
<td>5</td>
<td>7.8</td>
<td>9</td>
<td>14.1</td>
<td>14</td>
<td>21.9</td>
</tr>
<tr>
<td>Tambi</td>
<td>6</td>
<td>9.4</td>
<td>9</td>
<td>14.1</td>
<td>15</td>
<td>23.4</td>
</tr>
<tr>
<td>Ikuyu</td>
<td>6</td>
<td>9.4</td>
<td>12</td>
<td>18.8</td>
<td>18</td>
<td>28.1</td>
</tr>
<tr>
<td>Mlunga</td>
<td>6</td>
<td>9.4</td>
<td>11</td>
<td>17.1</td>
<td>17</td>
<td>26.6</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>35.9</td>
<td>41</td>
<td>64.1</td>
<td>64</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Field Data, 2011.

According to Wagala (2008) and WHO (2006), in most of the researches which have been done nationally and internationally on the problem of Obstetric Fistula, results have revealed that most of the women and girls who are living with this devastating problem come from low-income families. For this reason, respondents were asked a question about their source of income. They were asked if they were employed or self-employed. For those who were self-employed questions were geared towards small scale business such as small-scale farming, cattle keeping and poultry farming. Answers to this question revealed that all 64 (100%) of the respondents from all villages depended on small-scale farming, 20 (31.2%) were self-employed and 4 (6.3%) were employed. Respondents who were employed were community leaders.

Most of the respondents who were self-employed were women. For example, results from Table 4 reveal that 5 (7.8%) were men whereby 20 (31.2%) were women. The reason behind is that most of Traditional Birth Attendants were widowed; therefore, they used their skills to earn some money. Moreover, the women who were separated or divorced by their husbands depended on their efforts to run their lives. This was different with women who were living with their husbands because their lives depended much on their husbands’ efforts. Also, from these findings, it can be revealed that the urban environment is more conducive than the rural one. People have different opportunities for self-employment in urban areas than in the countryside. Apart from that, in the countryside, most of the residents have no education on entrepreneurship. Most of the rural residents depend on small scale farming which depends on unreliable rainfall. These factors are among the factors which contribute to reasons which necessitate rural people live in poverty. Due to poverty, most of the rural populations fail to pay for their health services. According to the study done by WDP (2003) in Tanzania, it was revealed that some women could not even afford the 1,000 Tanzanian shillings’ fee, “they stay at home and wait for anything to happen to them including death.”
5.4 Age of Obstetric Fistula Survivors by Villages

Figure 4: Age of Obstetric Fistula Survivors by Villages

Source: Field Data, 2011

According to Figure 4, it is revealed that Obstetric Fistula Survivors below 20 years old were found in Ikuyu village, those from 21 to 30 were found in Tambi village, and those from 31 to 40 were found in all the four villages. In this study, respondents from one village (Ikuyu) reported that, apart from poverty, early childbearing was the principal cause of Obstetric Fistula. In other villages, for example, Mwanakianga, the leading reason apart from poverty was corruption and abusive language whereby in Tambi the major cause apart from poverty was poor transport infrastructure. In Mlunga the primary causes were poor transport infrastructure and circumcision. Findings from this study are similar to the survey conducted by Mamdani and Bangser (2004); WDP (2003, 2006 and 2008). These studies revealed that Tanzania Obstetric Fistula affects girls and women of all ages, and factors which contribute to Obstetric Fistula vary from one area to another.
5.5 Community Perception towards Obstetric Fistula Survivors

Table 5: Respondents’ Perception towards Obstetric Fistula Survivors (N=64)

<table>
<thead>
<tr>
<th>Category</th>
<th>Curse/Misfortune</th>
<th>Innocent Woman</th>
<th>Patient</th>
<th>Crippled/Disabled Person</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>%</td>
<td>F</td>
<td>%</td>
<td>F</td>
</tr>
<tr>
<td>Mwanakianga</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Tambi</td>
<td>8</td>
<td>12.5</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ikuvu</td>
<td>3</td>
<td>4.7</td>
<td>2</td>
<td>3.1</td>
<td>8</td>
</tr>
<tr>
<td>Mlunga</td>
<td>7</td>
<td>10.9</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>28.1</td>
<td>2</td>
<td>3.1</td>
<td>15</td>
</tr>
</tbody>
</table>

Source: Field Data, 2011

Rural community members (women, men, traditional birth attendants, village leaders and Obstetric Fistula Survivors asked a question on how they perceive a woman living with this problem. Answers to this question varied from village to village. In Mwanakianga Village 10 (15.6%) of the respondents perceived an Obstetric Fistula Survivor as a physically challenged person in the sense that she cannot be remarried and have children. In the same village 4 (6.3%) of the respondents perceived her as a patient. They believed that a woman with Obstetric Fistula could be cured but she cannot be active in sexual intercourse with her husband. Therefore she cannot get children even after being repaired. In Mwanakianga village no respondent perceived Obstetric Fistula Survivors as a cursed or misfortune person. A community leader from Mwanakianga reported that when she was a community leader at a neighboring- village Kisokwe, one woman appeared to have this problem. Her husband wanted to leave his wife due to this problem. This community leader decided to assist in solving this issue, and finally, the husband decided to send his wife to CCBRT Hospital for treatment. She was repaired and returned to her husband. For the case of Tambi village, 8 (12.5%) of the respondents perceived Obstetric Fistula Survivor as a cursed person, a woman who has a misfortune. Respondents believed that if someone continues to live with a woman with Obstetric Fistula, the problem will be inherited in the family. During the interview, one woman from Tambi village reported that when she told her husband that she has that problem, her husband replied that “I can’t live with a woman who rots
my mattress with urine.” Later on, the woman said that her husband left her and threw out all her belongings.

Another woman in the same village recalled by saying that “Currently I am divorced after my belongings had been thrown out one morning. I leave everything to the God because I am suffering, and I am useless”. Another woman in Mlunga village was left with her husband after having Obstetric Fistula. Her mother-in-law said to her “what are you waiting for when you have this urine problem? Get out of here and go back to your parents”.

In Mlunga Village, 7 (10.9%) of the respondents perceived an Obstetric Fistula Survivor as a cursed and disabled woman. All of the above descriptions made most of the women disappointed, they felt guilty and lived in loneliness. Results in this study concur with the reviews by Ejembi (1994), Hinrichen (2004), Miller (2005) and WDP (2006).

5.6 Table 6: Community Perception on Obstetric Fistula Treatment (N=64)

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
<th>I don’t Know</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>%</td>
<td>F</td>
<td>%</td>
</tr>
<tr>
<td>Mwanakianga</td>
<td>14</td>
<td>21.9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tambi</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>9.4</td>
</tr>
<tr>
<td>Ikuyu</td>
<td>13</td>
<td>20.3</td>
<td>3</td>
<td>4.7</td>
</tr>
<tr>
<td>Mlunga</td>
<td>5</td>
<td>7.8</td>
<td>3</td>
<td>4.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32</strong></td>
<td><strong>50.0</strong></td>
<td><strong>12</strong></td>
<td><strong>18.8</strong></td>
</tr>
</tbody>
</table>

Source: Field Data, 2011

Community members were asked if Obstetric Fistula can be cured. The aim for asking this question was to investigate the level of awareness on Obstetric Fistula treatment. Answers to this question were as follows; respondents from Mwanakianga village, 14 (21.4%) stated that Obstetric Fistula could be cured. Most of the respondents stated that they were familiar with women who were living with Obstetric Fistula for a long time, but they had already been repaired. To get verification on the above details, the researchers interviewed two women who were living with this problem and already received treatment. According to their explanations, they perceive the cure of their problem as a miracle. These women stated that after getting treatment, they could
attend meetings; perform their domestic chores such as fetching water, and wood, farming, and cooking. One woman from Mwanakianga village stated, “I didn’t know that one day I would be like other women because the problem was big.” Another woman from the same village stated: “Now I can stay with people and eat with them with no problem. The community now views me as a human being.” Almost all women who received treatment respondents elaborated that, their relationships with community members had improved. They reported that they were no longer isolated, and they were, therefore, able to visit other community members and friends and go to church.

Respondents from Ikuyu 13 (20.3%) stated that Obstetric Fistula can be cured if Obstetric Fistula victims will have accurate and timely information on its treatment and if the treatment will be free of charge. During the Focus Group Discussion, most of the respondents from Ikuyu village stated that they heard on the radio that Obstetric Fistula can be cured at CCBRT Hospital in Dar es Salaam; the problem was how they could reach to CCBRT. One woman living with Obstetric Fistula stated that “I have no money to travel up to CCBRT Hospital; on the other hand I didn’t know how I can reach to CCBRT; worst of all I don’t have any relative in Dar es Salaam, who could support me during the treatment at CCBRT Hospital. This was because they lacked information about the availability of therapy. Another woman from Mlunga village said “my family experienced difficulties trying to get me treatment. They took me to traditional healers. They spent a lot of money, yet the leaking did not stop”. Another woman from the same village expressed her desire to receive treatment but was unable to find services. She stated: “I wanted to get treatment for the urine problem, but I didn’t know where to go. I even went to the district hospital but was not treated. I wasted my fare, and I was tired”.

5.7 Doctors and Midwives’ Perception on Obstetric Fistula Treatment

Doctors and midwives from Mpwapwa District Hospital and CCBRT Hospital stated that “Obstetric Fistula treatment is much costly. It ranges between Tanzanian shillings 3,000, 000 to 8,000,000. A person living under 1,000 Tanzanian shillings per day cannot afford the treatment, and that is why in 2005 CCBRT opened Obstetric Fistula ward to ensure the vulnerable social group receives this treatment free of charge. CCBRT is the only hospital in Tanzania which provides Obstetric Fistula treatment free of charge”. One Midwife from CCBRT reported that “for
women, who have been affected with Obstetric Fistula, everything is free of charge, which means treatment, food, accommodation and transport from their villages up to CCBRT Hospital are free. Below is the sample of information from CCBRT on Obstetric Fistula treatment.

**Figure 6: Information from CCBRT Hospital on Obstetric Fistula Treatment**

![Information from CCBRT Hospital on Obstetric Fistula Treatment](image)

**Source:** Field Data, 2011

These health specialists from CCBRT Hospital added by explaining that, “in every district, we have community members (villagers) who act as our ambassadors. After identifying that in their village there are women living with Obstetric Fistula, we send transport credit for those women through mobile phones money transfer (Vodafone M-PESA), we send 5,000 Tanzanian shillings for each ambassador who helps in identifying that woman. This is used as motivation; one ambassador is paid 5,000 Tanzanian shillings for identification of one Obstetric Fistula patient.”
Despite these explanations and good commitment, this information was not available for the majority of the people in Mpwapwa District.

According to the questionnaires distributed to doctors and midwives in CCBRT, it revealed that Obstetric Fistula is cured. The problem is many women living with obstetric Fistula hide their condition. UNFPA (2014) reported that “it is probable these figures are underestimates since has not only there been generally a lack of commitment to addressing and resolving this problem but also young girls or women tend to live with their fear and stigmatization in silence and isolation, unknown to the health care system.”

5.8 Channel Which They Use to Get Information on Obstetric Fistula

Table 7: Showing Usage of Communication Channels in Four Villages

<table>
<thead>
<tr>
<th>Source</th>
<th>Radio</th>
<th>Television</th>
<th>Relatives</th>
<th>Newspapers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mwanakanga</td>
<td>Aa</td>
<td>A F O Ra Ne</td>
<td>Aa A F O Ra Ne</td>
<td>Aa A F O Ra Ne</td>
</tr>
<tr>
<td></td>
<td>0 0 3 2 5 4</td>
<td>0 0 0 1 3 10</td>
<td>0 2 5 7 0 0</td>
<td>0 0 0 1 2 11</td>
</tr>
<tr>
<td>Tambi</td>
<td>0 0 0 2 13</td>
<td>0 0 0 0 15</td>
<td>0 6 9 0 0 0</td>
<td>0 0 0 0 0 15</td>
</tr>
<tr>
<td>Kayu</td>
<td>0 0 0 7 11</td>
<td>0 0 0 0 18</td>
<td>2 8 2 5 1 0</td>
<td>0 0 0 0 0 18</td>
</tr>
<tr>
<td>Mlunga</td>
<td>0 0 0 2 15</td>
<td>0 0 0 0 17</td>
<td>1 5 8 2 1 0</td>
<td>0 0 0 0 0 17</td>
</tr>
<tr>
<td>Total</td>
<td>0 0 3 2 16 43</td>
<td>0 0 0 1 3 60</td>
<td>3 21 24 14 2 0</td>
<td>0 0 0 1 2 61</td>
</tr>
</tbody>
</table>

Source: Field Data, 2011.

Note: Aa = Almost Always, O = Occasionally, Ra = Rarely, A = Always, F = Frequently
Researchers of this study asked respondents on the channels they used to get Obstetric Fistula information, results were as follows: With regard to usage of radios, 3 respondents used the channel frequently, 2 respondents occasionally, 16 respondents rarely and 43 respondents never received information through the radio. Results on the use of a Television were as follows: 3 respondents used it rarely, 1 respondent occasionally and 60 respondents never heard Obstetric Fistula information through the television. 3 respondents received Obstetric Fistula information through relatives almost always, 2 always, 24 frequently, 14 occasionally and 2 rarely. There was no respondent who never heard Obstetric Fistula information through relatives. Results also revealed that 1 respondent received Obstetric Fistula information through the newspaper occasionally, 2 rarely and 61 never received Obstetric Fistula information through the newspapers.

Generally, findings from this study revealed that the major communication channel which was very common was the face-to-face communication channel. That means 64 respondents got Obstetric Fistula information through relatives, friends, and neighbors. This communication channel was followed by radio in which 19 respondents received Obstetric Fistula information through the radio. 4 respondents received Obstetric Fistula information through the television and 3 through the newspapers. Most of the respondents who were reported that they received Obstetric Fistula information through the radio, television and newspaper were from Mwanakianga village which is situated at Mpwapwa urban (Mpwapwa center). Below are channels and levels of accessibility of Obstetric Fistula information.
Figure 7: Channels Used for Communication at Mwanakianga Village

Source: Field Data, 2011

Figure 8: Channels Used for Communication at Tambi Village

Source: Field Data, 2011

Figure 9: Channels used for Communication at Ikuyu village

Source: Field Data, 2011
According to Figure 11, the majority of the respondents (37.5%) from all surveyed villages accessed Obstetric Fistula information frequently through relatives (face-to-face) communication channel. This was followed by (32.8%) respondents who always accessed Obstetric Fistula information through the same channel. 21.9% of the respondents’ accessed Obstetric Fistula information though relatives occasionally. Those who accessed Obstetric Fistula Information rarely and almost always were very few 4.7% and 3.1% respectively.
Figure 12: Accessibility of Obstetric Fistula Information through Radios in Four Villages [Mwanakianga, Tambi, Ikuyu and Mlunga].

Source: Field Data, 2011

Figure 12 above showed the majority of the respondents (67.2%) never received Obstetric Fistula information through the radio. Very few respondents (25.0%), (4.7%) and (3.1%) heard Obstetric Fistula information through the radio rarely, frequently and occasionally respectively.

For more verification, the researchers decided to distribute questionnaires to the institutions such as WDP and AFNET who are used to generate and disseminate information on Obstetric Fistula. They stated that they disseminate Obstetric Fistula information through radios, newspapers, leaflets, theater performances, seminars, and workshops. Medical doctors and midwives were asked the same question. According to them, they stated that Obstetric Fistula information was disseminated through posters, leaflets, and antenatal care clinic but the radio was the major communication channel which they used to disseminate Obstetric Fistula information.
Through observation, the researchers did not see posters or leaflets on the walls of dispensaries. At Mpwapwa District Hospital, there were no leaflets or posters containing information on Obstetric Fistula. Many posters which were found at Mpwapwa District Hospital carried information on HIV-AIDS such as ‘Ukimpenda utamlinda’ meaning ‘If you love her you will protect her’; ‘Tanzania bila ukimwi inawezekana nenda kapime’ meaning (Tanzania without AIDS is possible, go for the blood test). There were also posters which consisted of information on Malaria. The Antenatal Care Clinic and the AFNET Office at Mpwapwa District were the only places where the researchers found brochures having information on Obstetric Fistula. According to WDP (2003) and (2008) and Bangster (2005), the radio was the major communication channel which was used to disseminate information on Obstetric Fistula. The researchers asked the question to know a number of people who owned radios. Table 15 is self-explanatory.

Table 8: Showing Number of Respondents Who Used Radios

<table>
<thead>
<tr>
<th>Name of the Village</th>
<th>Respondents Who Had Radios</th>
<th>Respondents Who Had No Radios</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>%</td>
<td>F</td>
</tr>
<tr>
<td>Mwanakianga</td>
<td>6</td>
<td>9.4</td>
<td>8</td>
</tr>
<tr>
<td>Tambi</td>
<td>3</td>
<td>4.7</td>
<td>12</td>
</tr>
<tr>
<td>Ikuyu</td>
<td>3</td>
<td>4.7</td>
<td>15</td>
</tr>
<tr>
<td>Mlunga</td>
<td>5</td>
<td>7.8</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17</strong></td>
<td><strong>26.6</strong></td>
<td><strong>47</strong></td>
</tr>
</tbody>
</table>

Source: Field Data, 2011

According to Table 8, 17(26.6%) of the respondents had radios whereby 47 (73.4%) did not have radios and radios are the main channels which used by information generators and disseminators to disseminate Obstetric Fistula Information.
The researchers asked respondents on the challenges which they encountered in accessing Obstetric Fistula information. Although most of the respondents reported different challenges such as poverty, lack of electricity, lack of network bandwidth, illiteracy, inadequate information and lack of time to listen to radios; poverty and insufficient information were revealed as the greatest challenges facing the rural community in Mpwapwa District in accessing information on Obstetric Fistula. For example, from Mwanakianga 83%, Tambi 84%, Mlunga 81%, and Ikuyu 60% of the respondents reported that poverty was the greatest challenge which they faced in accessing information on Obstetric Fistula. They stated that they had no money to buy radios or televisions. Inadequate information was another challenge which was faced by the majority of the rural community, specifically from Tambi, Mlunga and Ikuyu. 89% of the respondents from Ikuyu, 70% from Mlunga and 60% from Tambi reported that the problem of inadequate information leads them to fail to access information on Obstetric Fistula. The majority of the respondents stated that radio advertisements could not explain into details on how someone can reach CCBRT Hospital. Respondents from Ikuyu village reported that radio advertisements concerning Obstetric Fistula treatment were not well explained. One respondent from Ikuyu village states that “we hear Obstetric Fistula treatment is offered at CCBRT Hospital and is free of
charge, but they are not explaining well on how someone can reach the place. In addition, they provide telephone numbers as contact addresses but in our village, there is a lack of network bandwidth.”

Other respondents stated that lack of electricity was an obstacle for not accessing information on Obstetric Fistula. Respondents from Tambi reported that in their village there was one person only who owned a television. Due to lack of electricity, he used a generator whereby for someone to watch the news or any programme she or he had to pay 200 shillings. The same case was found at Ikuyu village.

Another challenge which was reported by most of the women respondents was a lack of time to listen to a radio. During individual interviews and Focus Group Discussions, most of the women indicated that they had no time to hear to broadcasts since from morning to evening they were busy with farming, performing their domestic chores and other economic activities. One woman in Ikuyu village stated:

> We have many social and economic activities; we have no time to listen to radios. Sometimes our husbands can hear information, but they become reluctant to inform us because they know if they will inform us we will take action and leave them with the burden of taking care of the family.

One respondent from WDP stated that “in rural areas, women have no right to own properties, even radios. The owner of such properties is the husband”.

**Conclusion**

Findings of the study concluded that Obstetric Fistula problem is cured, and CCBRT is the only one hospital which provides treatment, food, transport from their villages up to CCBRT Hospital and accommodation free of charge. The main problem is that most of Obstetric Fistula Survivors particularly those who are living in remote areas do not get Obstetric Fistula treatment because they lack information, and sometimes they receive outdated and wrong information. This is caused by dissemination of information through channels which are not friendly to the rural community. Others still have cultural perception that, Obstetric Fistula cannot be cured because it is a curse, others believed that Obstetric Fistula could not be cured because it is caused by being
bewitched and others mainly young girls tend to live with their fear and stigmatization in silence and isolation, unknown to the health care system and they tend to hide themselves.

**Recommendation**

Information professionals should act as a bridge in the sense that they should access treatment of obstetric fistula from different channels such as radios, televisions, newspapers and social media. In order to get reliable information, sometimes they should visit different hospitals which provide free treatment of obstetric fistula. Apart from that, they should communicate with a different Nongovernmental organization which is used to help rural women such as Women Dignity Project, Tanzania Gender Networking Programme, and AMREF. After getting full information on where to get treatment and how it will be done, information professionals should repackage the acquired information into channels which are affordable and accessible by rural community members such as village meetings, outreach and establishment of information centers from division level. Berlo (1960) in his communication model suggested that the information generators and disseminators should consider the level of education, attitudes, culture, communication skills, knowledge, geographical location and social systems of the intended audience (information receiver). For the sake of awareness creation, there must be a high consideration and diagnosis of those factors before the information is generated and disseminated. Shramm (1955) argued that communication should be interactive. Both the sender and the receiver should be active during the communication process. The sender sends a message and receives feedback from the receiver. In an interactive model of human communication, there is continuity of responses between the sender and the receiver.
References


