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'Better off Dead' - Sasha's Story of Living with Vaginal Fistula

Glory Joy Gatwiri¹ & Helen Jaqueline McLaren²

Abstract

This paper draws on the narrative of a Samburu woman, whom we call Sasha, from northern Kenya. She has been living with recto- and vesico-vaginal fistula for more than ten years. Her homeland is characterized by abject poverty, patriarchy and traditional practices involving witchcraft, which is intertwined with the teachings of Christian evangelist missionaries that traverse the last two centuries. Sasha's research interview offered representations of the broader social and political aspects affecting women with vaginal fistula and how this influences their lived experiences. We suggest that this condition is more than a biomedical issue, which we explain through our interpretive feminist analysis of Sasha's story. An African feminist lens enables attention towards the influences of patriarchy, African ethnicities and underdevelopment of the African continent.

Keywords: Obstetric Fistulas, African Feminism, Kenya, Patriarchy, Leaking Bodies, Cultural Practices

Introduction

The logic for this paper rests upon a cliché: 'one picture is worth a thousand words.' In doing so, we propose that our case study of one woman's story conveyed herein represents the stories of thousands of others who have experienced some of the most profound gender-related health issues. These women are often given limited space to be heard, or otherwise too scared to speak out. Our focus is on the narrative of one Samburu woman from Kenya who is living with a vaginal fistula. This condition is best described as a tear in a woman's body that results in an opening between the vagina and an alternative part of the body, usually the bladder or bowel (Sims, 1852). This opening causes urinary and/or fecal incontinence, resulting in constant leakage of waste matter from the vagina. While research ethics does not permit us to use Sasha's real name, we respect the importance of giving women like her a name and a real identity. However, what compounds Sasha's identity formation and experiences in her world are the cultural imperatives informing people's understanding of vaginal fistula. These constructs guide social responses towards women like Sasha. At the same time, women conform to self-policing their own existence. Lay understandings relating to the women who have vaginal fistula are impacted by the profundity of spiritual beliefs and misunderstandings that intertwine human existence and death. These are elucidated herewith through Sasha's story.

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We commence this paper by introducing Sasha. A brief explanation of Samburu cultural practices, from where Sasha comes, is offered. By telling Sasha's story, we explore the theoretical foundations of gender inequality, power and patriarchy. These underpin the discussion on vaginal fistula and add meaning to the lived experience of women and girls. We apply a critical African feminist perspective to ground Sasha's story in this broader socio-cultural and political dynamic. In doing so, this brings to bare her lived experience as defined by the systems and structures external to her. Paradoxically, Sasha's own participation in discursive constructs became critical to her own self-identity, sense-making and dreams.

Introducing Sasha

In her research interview, Sasha told her story about living in a patriarchal and oppressive culture that saw her being 'married off' at nine years of age shortly after she was circumcised, otherwise known as Female Genital Mutilation. Sasha was impregnated and first experienced birthing a child at the age of eleven. Childbirth was far from pleasant due to a prolonged and obstructed labor that lasted six days. For the nearly the whole duration of her labor, one arm dangled from Sasha's vagina. Multiple attempts were made by the traditional birth attendants in her community to reposition and deliver her baby without success. Medically termed as cephalopelvic disproportion, the baby was just too large to fit through her immature pelvis. Consequently, the pressure of the baby's head against Sasha's vaginal wall stopped the blood supply to this region and caused necrosis; her dying flesh resulted in the development of recto- and vesico-vaginal fistula.

It took Sasha days before getting help to travel to the nearest medical clinic. Her already decomposing baby was expelled from her vaginal canal and uterus causing her severe pain, trauma and injury. The doctors engaged in a rough procedure that involved vacuuming the carcass of the baby from her body, piece by piece. Sasha's petite frame was too fragile for this procedure and she collapsed. She does not remember much after she collapsed, but when she woke up, she was in a pool of her own urine. From that time, the fouling of urine and feces experienced by Sasha has been unremitting. While she told of her experience during her interview, Sasha bellowed numerous hearty laughs. Her demeanor was a façade for the embarrassment and deep shame she was still experiencing. It was painful for her to talk about her thoughts, feelings and experiences. As an eleven-year-old child, Sasha was not emotionally strong enough to endure childbirth, the medical procedure required for removing the rotting fetus and the death of her child. With disregard towards her physical and emotional pain, her family, friends and community then ostracized Sasha due to her offensive smell and being constructed as cursed. Most members of her community believed that she was cursed, due to a punishment from God, for a sin that no one could name. For the last ten years, Sasha's life has been characterized by a sense of multiple losses, constant suicidal thoughts, isolation, shame and marginalization.

Theorizing Sasha's experience

Being female, Black, living in a prodigiously patriarchal, post-colonial world, in abject poverty or with a debilitating illness. All these variables can each present as a significant barrier for living a fulfilling life that is free from abuse, harm and discrimination. When these phenomena co-exist, oppression is multifarious and complex. Life in this form would be unimaginable for most. However, it is the life that is endured by so many women. Sasha is merely one exemplar.

She is a Samburu woman, indigenous to north-central Kenya. Sasha's daily existence, as Moore (1994) would put it, is characterized by the experience of being a *woman* and *Black*. However, both of these variables can never exist in a singular. They 'will always be dependent on a multiplicity of locations and positions that are constructed socially' (Moore 1994: p.4). For Sasha, her adversity is burdened by at least seven intersecting encumbrances. These are oppression from intrusions external to her (colonialism and neo-colonialism), legacies of traditional African structure (culture), the man (patriarchy), her color (race), her 'backwardness' (poor access to education, money and health care), herself (internalized oppression) and her abject body (illness and disability). The first six variables are described by Ogundipe-Leslie (1994), as the six mountains that African women carry on their backs. In having vaginal fistula, we argue that Sasha carries a seventh mountain. The intersectionality of all seven mountains serves to define the identities of women like Sasha and their intersubjective experiences. Within a given patriarchal social system, intersectionality contributes to shaping women's individual and social experiences. In Sasha's case, her adversity is compounded by her abject body and its intersection with the other six oppressions.

Explanations of fistula have been told in multiple ways since Sims (1852). It is most often articulated from a white, middle-class or medical perspective that is altered and mostly diffused. Interpretive analysis and critical perspectives provide a new way of explaining women's experiences of fistula, such as in this case where we co-create a narrative of Sasha's subjective experiences. We show how these are manifested, maintained and perpetuated by a hierarchal system that extends beyond her immediate community. Her pre-fistula state already locates her at the bottom of a social structure by virtue of being a child, then a woman – then even further down when she became a woman with a leaking body in a third world country. The inhumane responses from all those around her took every sense of identity and/or belonging from Sasha. As an expression of her existence, she said, "I am nothing." This sense of nothingness elucidates her voicelessness, hopelessness and powerlessness in her social world. She wished she was dead, but, in a sense, she was already dead – living dead.

According to Sasha, living with a vagina fistula makes it impossible to enjoy life. Her youth and childhood were stolen from her by persistent patriarchal beliefs and practices that are a legacy of pre-colonial traditions in Africa, mixing with subsequent intrusions of colonialism (Ogundipe-Leslie 1994). Her adversity was reinforced by low social capital and her own participation in abusive dominant discourses, informing women's low worth (McLaren 2013a, 2013b, 2016b; Gatwiri & McLaren 2016a, 2016b; Gatwiri & Mumbi 2016; McLaren & Gatwiri 2016), as well as her abject body and poverty. Poverty, in particular, interacts with shame when women cannot access basic needs such as sanitary towels or adult pampers to contain the continuous fouling. The lack of formal education in rural and remote regions of Kenya, and the lack of priority to educate girls, gives women like Sasha little hope of rising out of their situation. Now a single mother, this status has pushed Sasha further down the social hierarchy. After six surgeries to repair her fistula, not one has been successful because of the magnitude of her injuries. The powerful forces of Samburu traditions mean that, even if her fistula were repaired one day, there would be no going back to the life she once had. She has been constructed by her family and community as an outsider and disgraceful forever and Sasha often shares this belief about herself too.

Putting Samburu in Context

Sasha's interview explained how Samburu traditions sanctioned the rape of young girls. This practice is commonly known as 'beading'. With the permission of parents, men who are community 'warriors' place beads around the neck of young female children as a sign of the girls' sexual enslavement to them (Amzat & Razum, 2014). This practice often leads to multiple older sexually experienced men, some who may be as old as the 'beaded' girl's fathers (Wanyoike, 2011), having sex with them. The practice is believed by Samburu elders to help girls develop into women and to prepare them for marriage (Amzat & Razum, 2014). Due to lack of contraception, most girls become pregnant prior to marriage and this is managed by either crude abortion or infanticide (Wanyoike, 2011). Large numbers of girls, like Sasha, who are the victims of 'beading' and subsequent child marriage, develop significant health complications. This is because young children's genital organs are not developed sufficiently for either sexual intercourse or childbirth. Vaginal ruptures during intercourse make the girls vulnerable to sexually transmitted diseases from older men, who have multiple sexual partners (Wanyoike, 2011), and birthing through a child's vaginal canal most often results in significant physical trauma. A large majority of Samburu girls are anecdotally known to have been raped, impregnated, and forced to have abortions long before they are married. Due to African women's seven mountains of oppression, this is infrequently reported by them or others.

Traditional practices associated with beading, FGM and child marriage contributed to Sasha's propensity to develop fistula. Her age, the discursive power over her and her own 'backwardness', as Ogundipe- Leslie (1994) would say, limited her ability to seek or access medical support upon developing her fistula. However, medical treatment can be theorized as 'necessary' for the attainment of a 'normal' body that is marriageable and acceptable for the patriarchal gaze. The construction of a 'normal' body interacts with the traditional and patriarchal notions that control women and locate their bodies as sites of oppression. This sexualization and modification of women and girls' bodies for the benefit of Samburu and other men, begins at an early age (Coy, 2009, p. 373). Just like in Sasha's case, prioritizing boys' education, FGM, 'beading' practices and otherwise preparing young girls for womanhood limits their access to education and alternative life opportunities. This serves to perpetuate associations of masculinity with predatory sexual prowess and justify sexual violence and silencing of girls' and women's wellbeing and needs.

Methods

The broader doctoral Research was approved by the Social and Behavioural Sciences Human Research Ethics Committee at Flinders University, South Australia and the Kenyan Research Ethics Board. After the approval, the first author was granted a research clearance permit issued by the National Council of Science and Technology in Nairobi to ensure that the research was conducted in accordance with standard human research conventions that include principles of confidentiality, voluntariness and informed consent. Data collection was conducted in two treatment facilities namely, 1) Kenyatta National Hospital and 2) Gynocare Centre-Eldoret, which is a clinic funded by international donors. Thirty women living with fistulas, who were receiving treatment for their condition at these facilities, were recruited to participate in research interviews. Sasha is one participant. She had taken two days to travel from her village in Samburu County to the hospital for treatment and expressed being relieved to have a comfortable bed and regular meals. Like many other participants, Sasha was not formally educated and lived a materially

impoverished life in the village, where she usually assisted in herding cattle. She was waiting for the scheduling of her surgery, which would be the doctor's third attempt at trying to 'fix' her.

With a phenomenological approach, we valued how meaning creation takes place in Sasha's world (Smith, Flowers, & Larkin, 2009). As well, phenomenology prioritizes interests in individual differences and contextual variation (Yardley, 2008). The aim was not to quantify any information (Silverman, 2010) given by Sasha, but to generate explanations of phenomena through this chosen theoretical approach (Elliott, Fischer, & Rennie, 1999). In making meaning of, and interpreting Sasha's and other women's narratives, phenomenology offered an opportunity to focus on how she and other women made meaning of their lived experiences (Smith et al., 2009). An African feminist lens contributed further opportunity to interpret Sasha's meaning making and to co-create a critical perspective, with respect to her own culturally informed perceptions.

The application of a broader research framework that married together phenomenology and a feminist approach acknowledged the powers over Sasha, in that she was unable to name African women's mountains of oppression by herself in making sense of her experiences. Feminist and phenomenological lenses have been used correctively to synergize research interpretation of Sasha's experience. An African feminist lens incorporates both Black feminism and African feminism, but makes clear the unique experience of Black women in Africa. It captures the depth of Sasha's experience of vaginal fistulas being largely a Black African issue constructed by Africanness and not simply blackness in racial terms. In sub-Saharan Africa, it is the variables constituting one's Africanness that confront and compound issues of inequality, define one's identity and thereby severity of oppression. Variables in African cultural norms and belief systems endorse and, indeed, enforce early marriage and traditional gender discrimination (Otoo-Oyortey & Pobi, 2003; Shamaki & Buang, 2014). Hence, patriarchy, African ethnicities, cultural traditions and underdevelopment of whole societies underpin the analysis of the women's predisposition to vaginal fistulas that inhibit recovery. This methodological mix of theory enabled a new narrative that serves to explain how fistula is more than a physical and a medical phenomenon. It is personal and political, local and trans-national. We maintain that the existent narrow views of fistula in preexisting, particularly medical, research need disrupting.

Excerpts and Analysis

Sasha's pain was deep and not even her approachable nature or hearty laughter could hide the underlying shame. Because of her inability to hide the pungent smell associated with her disease, she expressed being overwhelmed by being trapped in a body that was socially humiliating. Unrelenting mental agony, associated with the shame she experienced, frequently led her to consider suicide, which became a consoling feature of a life without hope. Alio et al. (2011) studies the psychosocial impact of vesico-vaginal fistula in Niger and reported that some of their participants often contemplated suicide. In other studies (Weston et al. 2011; Filippi et al. 2007; Hamlin 2013), participants also reported suicidal ideations when longing for their misery to end; ending their lives was the only foreseeable way to end the pain.

Contemplating Suicide

When asked what stopped her from ending her own life, Sasha told how suicide was prohibited by her culture and religion. When exploring this further, she exposed a mixture of beliefs in curses from witchcraft and God's will. Sasha told of her Christian beliefs and being afraid of hellfire if she committed the sin of suicide. She constantly prayed for death at the hand

of another because her Christian beliefs meant that she could not do it herself. The following excerpt is of the constant suicide thoughts she endured:

I think about killing myself all the time. I am not asking God for much, just that He heals me. A couple of times, I have made a plan to kill myself, I have thought it through, and every time I have had no courage to push through with it. It's not that I am not afraid to die, but I am afraid if I kill myself I will go to hell.

Sasha made sense of her world through illogical meaning making, generated from traditional spirituality mixed with Christian teachings. When her Christian teachings provided no reason for her fistula, she reverted to pre-colonial traditional beliefs informing that she was cursed. Sasha was waiting for God to decide when she had repented sufficiently, and, only then she believed that medical treatment would be successful. This irrational mixture of beliefs had been inculcated and was so strong that Sasha had no capacity to derive an alternative story. In being shunned by her community and in having little education, she was excluded from avenues, in which she could create alternative meanings. While she thought about suicide, the imagined alternative of hell prevented it, hence, her suffering. She failed to see that her life with fistula was akin to hell on earth.

Sasha rationalized that the fistula, in and of itself, was not as bad as its consequences. While her body was no longer in physical pain, the emotional trauma as a result of fistula was torturous to her. In her own words, Sasha explained her experience of living for ten years at the intersection of oppression based on her gender, class and disability:

I think the rejection you get from others makes you think of yourself as useless. Better off dead. Now look at me; I am worse than a cripple. I cannot work, I smell, and I have no family. I have lost all my friends and I have to wake up very early in the morning at 4am to go to the well to fetch water before other women from the village start going at 6 am because they laugh at me and call me a useless dirty woman. You really are nothing with this disease.

While Sasha was ostracized by others in her community, the discursive power enforcing other's actions also influenced her engagement in disciplinary structures, when surveilling the self. This paradox is explained by Foucault (1972, 1980) and is evident in other feminist writings (McLaren 2013b, 2016a, 2016c). Through her own conformity, which was characterized by excluding herself from social interaction, Sasha ironically contributed to reinforcing her own oppression. These multiple demands, by others and of herself, resulted in her endurance of life with shame and pain.

Struggling to Make Sense of Counter Discourses

Sasha gave a picture of the level of poverty that she experienced as a woman living in remote Kenya and how that contributed to the longevity and complexity of her medical condition. Even when she learned about medical treatment, she could not afford to get it. Sasha explained:

I did not know that there was a hospital that treated fistulas for free; we also did not have money. I decided to stay at home and take traditional medicine.

Echoing other studies from across Africa (Amzat & Razum, 2014; Gearhart & Abdulrehman, 2014; Shamaki & Buang, 2014), our emphasis here is to note that Sasha sought traditional treatment because of underlying issues such as poverty, unaffordability and inaccessibility of health care services. As well, the powerlessness to make decisions about her own health were also at play. Shamaki and Buang (2014), explains how tackling beliefs in favor of tradition-inspired healing practices and herbs is difficult. In Sasha's case, she believed that her ability to access medical treatment, the type of treatment and ongoing failure in attempts to repair of her fistula, was in the hands of God. It did not ultimately matter whether the hospital treated fistulas for free, as God would heal her when *He* decided Sasha was deserving of being healed. So many failed attempts confirmed to Sasha, that she was not worthy of repair and, therefore, she continued to wish for death at the hands of another.

Over time, Sasha has developed some awareness of how cultural practices predisposed her to developing both vesico- and recto-vaginal fistulas. Due to her constant interactions with the nurses and doctors attempting to repair her fistula, she has become aware of the associations between the development of fistula among Samburu girls who are married off young, not formally educated, and have small body stature because of malnutrition in the rural semi-arid community. On reflection she lamented on was the unfairness of her lost childhood to patriarchy and other oppressions affecting girls and women. But at the time, all the old men in her community gathered in force to give her away. There were no means for Sasha to resist or rebel the discursive practices towards girls and women.

You know in Samburu how young girls are given away for marriage? In my case, this man came to ask for my hand in marriage and I was given away by my father and my uncles. He was an old man. We stayed together, he used to push himself inside me almost every night, and I cried every night because I had not healed [from the circumcision] properly. I wanted to go home to my father but he stopped me and said I needed to be with my husband so as not to bring shame to him. One time, I was looking for other children to play with, my husband told me that I should stop playing with children because I was his wife now.

Sasha expressed the need for a childhood, as opposed to being compelled to cultural demands of her as a child. While she understood associations between being married off at the age of nine and her lost childhood, she continues to accept the dominant cultural practice in her community. This is because women's submissiveness is a dominant practice to which she must conform. By preventing the men in her life (her father and husband) from being publicly shamed in her community, Sasha must repress her needs and her happiness, owing to the patriarchal conduct in her world.

Early marriage it is a cultural practice deeply ingrained in Samburu communities, where poverty and gender inequality is accepted as normal. It is not surprising that the poorest and most unequal societies in the world are the ones that have the highest rates of child marriages and other non-progressive practices that intersect with multiple oppressions associated with being female. As argued by other researchers (Nour, 2006; Otoo-Oyortey & Pobi, 2003), these practices are sustained because the communities have little understanding of the longer-term deleterious effects on the female child's development and women's well-being. Instead, they locate blame on witchcraft or God as being responsible for the causation of the fistulas.

Discussion

Women living with vaginal fistulas interpret their condition in different ways. During the analysis, we noticed that Sasha, and other women, explained their condition in two competing ways: they knew it had developed through childbirth and that there were medical explanations, but when they saw other girls their age who birthed children without developing fistula, the medical explanations confused them. When studying illnesses that caused individuals to question “but why me and not my neighbor?,” Van Dyk (2001, p. 5) found that people seek alternative explanations when scientific and medical reasons do not make sense to them. Sasha was more content with explanations that located blame for her fistula to ‘nature, universe or gods’, rather than questioning the oppressive cultural practices in her community that were responsible for her now damaged and injured body.

Cultures in rural sub-Saharan Africa are diverse. Despite this, many embrace viewpoints informing that witchcraft or God is responsible for illness and that illness experienced by an individual is a punishment for moral or spiritual failings (Nelms & Gorski, 2006; Sabuni, 2007). The Samburu culture is one example of practices in which these beliefs have persisted and dominated over science and logic. With reference to fistula, cultural beliefs inform it as a punishment of women who have sinned. Consequently, recovery is also believed to be at the hand of supernatural forces. There is little to compel women to access clinically proven medical care (Cameron & Leventhal, 2003) when beliefs exist that God or another deity will fix women, if and when they are deserving. However, when not medically treated, fistulas have a profound effect on women’s, psychosocial, physical and spiritual wellbeing. Without knowledge of the origin of their sin, these women do not know how to repatriate, nor see reason in seeking medical help. In Sasha’s case, she is not fully convinced that vaginal fistula is a medical condition, while she has received medical help, any surgical success she will be attributed to God.

Spirituality for Sasha is integrated into a complicated and multifaceted, cultural and structural system of beliefs that was introduced by colonialists and which is maintained by patriarchy. This belief system is frequently used by the community to justify stratification, marriage practices, religion, and attitudes toward disease, contraception and intercourse, access to health care – and of course gender. All these contribute to the complexity of life for most women in Kenya, even more so for rural women in remote regions of sub-Saharan Africa, who have multiple disadvantages or live at the intersections of oppression and marginalization. For Sasha, observable is her desire to understand why she was ‘chosen’ to be a carrier of such a misfortune. She continues to search for answers as a means to understand how to undo the curse or, alternatively, how to repent her sins. With this confused perception, Sasha conceives that future recovery is only possible if she could achieve her community’s or God’s forgiveness. This is reinforced by limited knowledge about fistula, particularly among the communities that are most often affected by it. Geographical remoteness and lack of communication with alternative meanings also contribute to maintaining misunderstandings that serve to banish women with fistula from all forms of engagement in social life in their communities.

Without appropriate education and knowledge, there is often no other way for rural women in sub-Saharan African communities to understand fistula outside of metaphysical explanations. The women are so inculcated by their cultural beliefs that scientific reason is negated. After being outcast by their communities, many women lead solitary lives and this limits their opportunities to learn that many others are inflicted with the same condition. Their daily lives are surrounded by women who have ‘normal’ bodies, which reinforces notions that they have been singled out by God for their sins. While the original physical pain goes away, women endure the indignities of

leakage and social expulsion in silence. This contributes to women's feelings that life is not worth living. For women like Sasha, who is a Christian, she also seeks an explanation from other supernatural realms. The void in this reasoning pushes women with fistula into wishing for death as a viable option but not through suicide. But the strength of belief in God's teachings prevents women like Sasha from committing suicide. This is because life is already unbearable and the thought of further punishment from God in the afterlife is even more terrifying.

An African feminist perspective offers a critical understanding of Sasha's story in terms of African women's oppression at the hands of patriarchy, which is shared among women worldwide who decry male supremacy. African feminist thought considers intersections between cultural traditions and ethnicities, colonization and patriarchy, as opposed to just race (Mikell, 1997), and advocates for the integration of the range of African cultural knowledge into modern frameworks, instead of expelling them (Kennedy, 2005). As well, African feminist thought acknowledges the underdevelopment of African societies and how 'backwardness' contributes to the adverse experiences of African women (Ogundipe-Leslie 1994).

Conclusion

There is more to this issue than the leakage of urine and feces and exclusion by society because of the stench. There are associations between the personal, social and political structures over time. Leakage, shame and social exclusion are symptoms of something much deeper. African feminist perspectives provide that Sasha's social existence is complex and multidimensional and needs to be understood as such. Sasha's story illustrates the inculcation of multiple oppressions affecting African women, like her. If her fistula is eventually repaired, the likelihood of experiencing a good life will still be constrained by the historical inequities that lead to expulsion from her community.

This paper has elucidated that it is often the poorest of the poor in Kenya, that are generally women from marginalized tribes, that are more likely to develop conditions such as fistula. The Samburu tribe, where Sasha hails, is one example of an ethnic tribe that has been disenfranchised from political and economic leadership. This systemic exclusion, nationally and internationally, along with their geographical remoteness, agricultural non-productivity and lack of contribution to national wealth, exacerbates women's hopelessness. Poverty and ethnic positioning of the women are some of the biggest underlying and predisposing factors of developing vaginal fistula (Ahmed, Genadry, Stanton, & Lalonde, 2007; Hawkins, Spitzer, Christoffersen-Deb, Leah, & Mabeya, 2013; Khisa, Stephen, & Mwangi, 2011; Mabeya, 2004; Muleta, 2004; Wall, Karshima, Kirschner, & Arrowsmith, 2004).

We have argued that having fistula impacts on quality of life and, often, presents limited choices in how to respond to the social pressures related to it. When there is no hope, no help, and no alternative can be imagined, it is not surprising why women like Sasha feel their lives are worth nothing and not worth living. While suicide is entertained, religion and spirituality get in the way and negate it. 'Living dead' may be the best way for Sasha to explain her perception of multiple intersectionality as a phenomenon. With the possibility of a 'good life' not being an option, what is left for these women? We make some recommendations herewith in moving forward.

Maternal health care and education are a basic prerequisite for meeting the needs of women in Kenya, and must be acknowledged in all federal and county policies. There needs to be a broader recognition of how women are affected by social structures, including how women have been systemically victimized and silenced by Kenya's histories of colonization, patriarchy and even the

contemporary systems that are supposed to protect them. We recommend that public education and population health campaigns focus on gendered forms of violence, with zero tolerance to the most oppressive abuses, such as – FGM and child marriage – as a start. A whole of society’s shift in thinking is needed in relation to respecting women, appreciating women’s disadvantage in such cultural dynamics and the effects on girls and women’s life chances for equitable living. While societal change and the prevention of vaginal fistula are paramount, Kenya still needs more medical specialists and fully equipped obstetric clinics across Kenya to meet its current treatment demands.

References

- Ahmed, S., Genadry, R., Stanton, C., & Lalonde, A. (2007). Dead women walking: Neglected millions with obstetric fistula [editorial]. *International Journal of Gynecology and Obstetrics*, 99, S1-S3.
- Alio, A. P., Merrell, L., Roxburgh, K., Clayton, H. B., Marty, P. J., Bomboka, L., . . . Salihu, H. M. (2011). The psychosocial impact of vesico-vaginal fistula in Niger. *Archives of gynecology and obstetrics*, 284(2), 371-378.
- Amzat, J., & Razum, O. (2014). A sociological study of health problems in Africa. *Medical Sociology in Africa*. Heidelberg: Springer.
- Anderson, C., John, O. P., Keltner, D., & Krings, A. M. (2001). Who attains social status? Effects of personality and physical attractiveness in social groups. *Journal of personality and social psychology*, 81(1), 116.
- Cameron, L. D., & Leventhal, H. (2003). *The Self-regulation of Health and Illness Behaviour*: Routledge.
- Collins, P. H. (2002). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment* (2nd ed.). London and New York: Routledge.
- Coy, M. (2009). Milkshakes, lady lumps and growing up to want boobies: How the sexualisation of popular culture limits girls' horizons. *Child Abuse Review*, 18(6), 372-383.
- Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38(3), 215-229.
- Filippi, V., Ganaba, R., Baggaley, R. F., Marshall, T., Storeng, K. T., Sombié, I., . . . Meda, N. (2007). Health of women after severe obstetric complications in Burkina Faso: a longitudinal study. *The Lancet*, 370(9595), 1329-1337.
- Foucault, M. (1972). *The Archaeology of Knowledge*. Tavistock, London.
- Foucault, M. (1980). Two Lectures. In: *Power/Knowledge: Selected Interviews and Other Writings, 1972–1977* (ed. C. Gordon), pp. 78–108. Pantheon Books, New York.
- Gatwiri, G., & McLaren, H. J. (2016a). Discovering my Own African Feminism: Embarking on a Journey to Explore Kenyan Women's Oppression. *Journal of International Women's Studies*, 17(4), 263.
- Gatwiri, G., & McLaren, H. J. (2016b). Discovering my Own African Feminism: Embarking on a Journey to Explore Kenyan Women's Oppression. *Journal of International Women's Studies*, 17(4), 263.
- Gatwiri, G. J., & Mumbi, K. A. (2016). Silence as power: Women bargaining with Patriarchy in Kenya. *Social Alternatives*, 35(1), 13.
- Gearhart, R., & Abdulrehman, M. S. (2014). Concepts of illness among the Swahili of Lamu, Kenya. *Journal of Transcultural Nursing*, 25(3), 218-222.
- Hamlin, C. (2013). Giving hope to rural women with obstetric fistula in Ethiopia. Interview by Fiona Fleck. *Bulletin of the World Health Organization*, 91(10), 724-725.
- Hawkins, L., Spitzer, R. F., Christoffersen-Deb, A., Leah, J., & Mabeya, H. (2013). Characteristics and surgical success of patients presenting for repair of obstetric fistula in western Kenya. *International Journal of Gynecology & Obstetrics*, 120(2), 178-182. doi: <http://dx.doi.org/10.1016/j.ijgo.2012.08.014>
- Jordan, G. (2004). The causes of poverty cultural vs. structural: Can there be a synthesis. *Perspectives in Public Affairs*, 1, 18-34.

- Jütting, J. P., & Morrisson, C. (2005). Changing social institutions to improve the status of women in developing countries. *Available at SSRN 871445*.
- Kennedy, D. A. (2005). Transversal feminism and transcendence. *S. Cal. Rev. L. & Women's Stud.*, 15(1), 65-93.
- Khisa, W. W., Stephen, M. M., & Mwangi, J. W. (2011). Demographic and medical profiles of patients with obstetric fistula in Kenyatta National Hospital, Kenya.
- Mabeya, H. (2004). Characteristics of women admitted with obstetric fistula in the rural hospitals in West Pokot. *Kenya Moi Referral and Teaching Hospital Eldoret, Kenya*.
- McLaren, H. J. (2013a). Domestic violence, housing and employment: Workers' perspectives on employment assistance in supported accommodation. *The Australian Journal of Social Issues*, 48(4), 415.
- McLaren, H. J. (2013b). (Un)-blaming mothers whose partners sexually abuse children: in view of heteronormative myths, pressures and authorities. *Child & Family Social Work*, 18(4), 439-448.
- McLaren, H. J. (2016a). Adult women groomed by child molesters' heteronormative dating scripts. *Women's Studies International Forum*, 56, pp. 66-73.
- McLaren, H. (2016b). Falling in love with romantic ideals: women in relationships with child molesters. *Culture, health & sexuality*, 18(2), 143-155.
- McLaren, H. J. (2016c). Silence as a Power. *Social Alternatives*, 35(1), 3.
- McLaren, H. J., & Gatwiri, G. (2016). Black women with vaginal fistula: The power to silence via Internet imagery. *Social Alternatives*, 35(1), 47-52.
- Mikell, G. (1997). *African feminism: The politics of survival in Sub-Saharan Africa*. Philadelphia: University of Pennsylvania Press.
- Muleta, M. (2004). Socio-demographic profile and obstetric experience of fistula patients managed at the Addis Ababa Fistula Hospital. *Ethiopian Medical Journal*, 42(1), 9-16.
- Nelms, L. W., & Gorski, J. (2006). The role of the African traditional healer in women's health. *Journal of Transcultural Nursing*, 17(2), 184-189.
- Nour, N. M. (2006). Health consequences of child marriage in Africa. *Emerging infectious diseases*, 12(11), 1644.
- Ogundipe-Leslie, M. (1994). *Re-creating Ourselves: African Women & Critical Transformations*. Trenton, New Jersey: Africa World Press.
- Otoo-Oyortey, N., & Pobi, S. (2003). Early marriage and poverty: Exploring links and key policy issues. *Gender & Development*, 11(2), 42-51.
- Parkin, F. (2013). *The social analysis of class structure*: Milton Park: Routledge.
- Sabuni, L. P. (2007). Dilemma with the local perception of causes of illnesses in central Africa: muted concept but prevalent in everyday life. *Qualitative Health Research*, 17(9), 1280-1291.
- Shamaki, M. A., & Buang, A. (2014). Sociocultural practices in maternal health among women in a less developed economy: An overview of Sokoto State, Nigeria. *Geografia: Malaysian Journal of Society and Space*, 10(6), 1-14.
- Silverman, D. (2010). *Qualitative research*: Sage.
- Sims, J. M. (1852). On the treatment of vesico-vaginal fistula. *The American Journal of the Medical Sciences*, 45, 59-82.
- Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*: Sage.

- Smith, L. T. (1999). *Decolonizing methodologies: Research and indigenous peoples*. London: Zed books.
- Van Dyk, A. (2001). "Why me and not my neighbour?" HIV/AIDS care and counselling in a traditional African context. *Curationis*, 24(3), 4-11.
- Wall, L. L., Karshima, J. A., Kirschner, C., & Arrowsmith, S. D. (2004). The obstetric vesico-vaginal fistula: characteristics of 899 patients from Jos, Nigeria. *American Journal of Obstetrics and Gynecology*, 190(4), 1011-1016.
- Wanyoike, P. N. (2011). *The perceptions of rural Samburu women in Kenya with regard to HIV/AIDS: towards developing a communication strategy*. (Doctor of Literature and Philosophy PhD), University of South Africa.
- Weston, K., Mutiso, S., Mwangi, J. W., Qureshi, Z., Beard, J., & Venkat, P. (2011). Depression among women with obstetric fistula in Kenya. *International Journal of Gynecology & Obstetrics*, 115(1), 31-33.
- Yardley, L. (2008). Demonstrating validity in qualitative psychology. *Qualitative psychology: A practical guide to research methods*, 2, 235-251.