

## **THE IMPACT ASSESSMENT OF VESICO-VAGINAL FISTULA AMONG WOMEN IN DEVELOPING COUNTRIES: A CASE STUDY OF NORTHERN NIGERIA**

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### **ABSTRACT**

The paper carried out the impact review of vesico-vaginal fistula among women in developing countries with particular focus on Northern Nigeria. The paper analysed socio-economic status, health care facilities and cultural practices that potent danger for the development of VVF and also took a critical look at the various physical, social and health consequences on the patients.

**Keywords:** Vesico-vaginal fistula, socio-economic status of women.

### **INTRODUCTION**

Research has shown that VVF patients are usually young girls who have no formal education, no means of livelihood, and given out in marriage by their poverty stricken parents to poverty stricken husbands. As a result, patients like that are normally malnourished in pregnancy and no personal income to take care of them and to attend antenatal clinic (Sambo, 1993, and Odu 2000).

The World Health Organizations report on obstetric fistulae (1991), says that VVF patients “come almost exclusively from poor families and communities”. Communities can be poor if they lack basic facilities to take care of their members. The report describes the women as malnourished from birth, susceptible to diseases, chronically anemic and physically stunted. Poverty leads to malnourishment, and small height. It leads to not having money to travel the distance to attend antenatal care, and it invariable leads to obstructed labour.

Harrison (1985) reported that his patients from his VVF group came from a more rural background, and came from very poor families that they were forced to sell their few family belongings to get money for their fare from their rural homes to the hospital in the city. Furthermore, Kelly 1999 identified poverty as the main reason for maternal mortality and morbidity rates in sub-Saharan Africa because of the lack of basic commodities and essentials like food, good water, simple appropriate drugs, iron and folic acid supplements, the list is endless.

Various studies have shown that poverty is a serious contributing factor to the development of vesico vaginal fistula. Abbo (1975) reported that most of his VVF patients were extremely poor and malnourished. It is a known fact that poverty will lead to malnourishment. Also Haile (1983) reported that all his patients were illiterate and poor, and that all of them depended economically on their husbands. The husbands too might be too fragile to lean on. Begum (1989) concluded that his VVF patients were from extremely poor families. Ansari (1989) also reported that all the VVF patients he treated were from poor families, and most from the rural areas.

Further studies also indicate poverty to be a serious issue in vesico vaginal fistula. Samad (1989) reported that all the women in his study group were of low socio- economic status, and most of them came from distance rural areas. Adetoro (1989) declared that all the 83 cases he managed were from a poor, rural population. Ahmed (1989) also corroborated the other findings by reporting that 38 out of 58 cases were from low socio- economic groups and had no antenatal care at all. Pendse (1989) also found out that 90% of the VVF patients were from the rural areas, almost all were illiterate and of low socio- economic status. Falandry, Dumurgier, Scham, Ivoulson and Picand (1989) concluded that the source of obstetric fistula is poverty and misery in the developing countries, and thus declared as a social and psychological tragedy for the affected women.

## **HEALTH CARE FACILITIES**

Wall (1998) noted that the Nigerian health care system is still being seriously affected from the legacy of misplaced colonial priorities, mismanagement, chronic underfunding and persistent corruption. The policies of successive governments in Nigeria for the past 25 years have had a devastating and paralyzing effects on the economic growth, and thus unable to devote resources to maternal health care. The available literature has shown that most hospitals in the developing countries especially Nigeria are established in the cities at the expense of the rural areas. Health infrastructures including local health centres, access to good roads, and well-trained health personnel are totally lacking in the rural areas.

Thaddeus and Maine (1994) in their classic paper “Too far to walk: Maternal mortality in context” analyzed the contributory factors to the delayed treatment in the developing countries. Factors were grouped into three broad categories which were termed the three phases of delay; firstly, delay is looked on the part of the pregnant women, her family or both; secondly, delay in getting to a well-established health- care facility and lastly, delay in promptly receiving health care once their destination has been reached. These delays from available literature are due to the means of getting to the exact place where adequate health-care facility can be sought. Most of the VVF patients come from very poor background, and as such cannot readily get money to transport themselves to the cities health centres. It is when the health of a VVF patient is being seriously threatened and affected can the husband or relatives gather their few belongings for sale in order to get transportation fare to and from a health centre in the city. The last delay is very peculiar to the Nigeria health system. Some of the health personnel are always very careless with the lives of others, and some get discouraged and prefer to stay at home to be attended to by the traditional birth attendants who are always very caring about the lives of others though they may not have the required knowledge education to carry out what is required of them. Apart from the carelessness of the personnel, there are shortages of supplies and equipment, and the interminable internal delays involved in making a marginal system work (Wall, 1998, Sundari, 1992).

Massoundnia (1972) in his study found out a significant contributing factor in the development of vesico vaginal fistula, which is lack of appropriate health facilities, or trained birth attendants in rural areas. Also Akhtar (1989) noted in his analysis of VVF patients that most women came from the rural areas where there are absence of trained personnel, and they had no means of transport to a maternity hospital. It can therefore be seen that health- care facilities are not readily available for the rural women, which gives room for complications during labour.

## CULTURAL PRACTICES

Hausa language is the most spoken indigenous language in the northern part of Nigeria. Majority of the people in the northern part of Nigeria are Muslims especially the core north who have very few Christians. Wall (1998) remarked that in an Hausa village, there is almost a complete absence of matured women seen in the public except for the very old ones, and this is because the Hausa Muslims have adopted a very strict form of wife-seclusion, which is also known as purdah. This is a situation where women are kept in the family compounds, and when there is a need to go out or to attend to a visitor, they must be in purdah, a situation where none of the parts of their bodies must be seen not even their eyes. And with very few exceptions, their women are subjected to very strict male control, and have very easy little personal autonomy, if there is none at all.

Wall (1998) noted that one of the principles of Hausa social organizations is the absolute control of women reproductive capacity by the men (husbands). In Hausaland, women are seen (not often), but not to be heard Callaway (1987) expressed that “to the casual observer, life behind the mud wall of the compound appears secure and peaceful, but time spent there brings hundreds of sad stories. Women complain of heavy labour, of marriages of young daughters against their wills, of child brides brought into the household, of forced sexual cohabitation at puberty regardless of mental or emotional development, of early motherhood and infant death..... said a mother of a twelve year old on her wedding day, “may the day be cursed when she was born a woman”.

One of the reasons for vesico vaginal fistula is early marriage practice in Hausaland. To this, their mothers have no say, Murphy (1981) noted that it is customary in Hausaland for their ‘babies’ (girls) to marry before menstruation commences, and also common to be less than 16 years at the birth of the first baby. Babies begetting babies- Ghatak (1992) saw this as an unhealthy custom for it destroys the lives of young, vibrant girls who should be good leaders of tomorrow.

Also in Hausaland, it is a custom or tradition that the first baby is born at home (Lister, 1984). So when a woman falls into a labour, and is expecting the first child, she will naturally be attended to by the unskilled, unknowledgeable traditional birth attendants, and when she has a problem with delivery, she is given a cut with a crude instrument which is known as gishiri cut (Tahzib 1983, Murphy 1981, Bello 1996, Odu 2000). This cut may lead to vesico vaginal fistula. Moreover, because this woman should under normal circumstances deliver her first baby at home, she is into labour for days, and will only be taken to a health centre when labour becomes difficult and obstructed which is the main cause of Vesico vaginal fistula (Harrison 1985, Harrison 1989, Murphy 1981, Tahzib 1983, 1985, 1989, Lister 1984, Wall 1998, Moronkola and Odu 1999).

Bello (1996) remarked that decision-making power is one of the social contributors to VVF even in decisions pertaining to their health. It is only the husband of a dying woman or the village head that can give consent to her taking into the hospital. The dying woman has no say and no choice, and most often the decision comes too late because it is when labour must have been obstructed that she is permitted to be taken in to the hospital. Tahzib(1985) gave a good example of women having no say regarding their health or babies. He said “in one case the husband himself had used a razor blade to cut his wife in order to widen her introitus for intercourse”. The wife dares not complain.

It can therefore be said that it is these unhealthy cultural practices that destroy the future of these young girls with vesico vaginal fistula.

## **CONSEQUENCES**

Vesico –vaginal fistula is seen as a pathological condition because of a direct communication between the urinary bladder and the vaginal, which results in the leakage of urine into the vaginal. (Ampofo, Omotara, Otu and Uchebo, 1990).

## **PHYSICAL & HEALTH CONSEQUENCES**

The immediate physical consequences of vesico vaginal fistula is urinary incontinence, and faecal incontinence may also result. Wall (1998) highlighted some of the physical consequences that may result from vesico- vaginal fistula. The pathophysiological process that leads to the formation of fistula involves a prolonged pressure, which will definitely create an injury to the wide areas of the pelvis. Apart from the creation of bladder fistula, the urethra is often permanently destroyed (Stewart, 1967; Hamlin and Nicolson, 1969; Hassim and Lucas, 1974; Arrowsmith, 1994; Waaldijk, 1989 and 1994, Wall, 1998). It is discovered that when the fistula is closed through surgery successfully, the patient will still continue to experience uncontrollable urine loss through a functionless urethra that no longer has an effective sphincter, and be left with dramatically decreased bladder capacities.

Also, the affected patient experiences cessation of menstruation due to so many gynaecological injuries. It equally results in vaginal scarring, which can lead to vaginal stenosis where by the vaginal narrows and does not allow for easy sexual intercourse again. Infertility is another physical consequence that can be experienced by the vesico vaginal patients. Aimakhu (1974), Harrison (1985), Ghatak (1992). Sambo (1993), Arrowsmith, Hamlin and Wall (1996) noted that most of the vesico vaginal patients will never become pregnant again. It is noted that most of the vesico vaginal patients develop this problem during their first pregnancy, and the resultant effect in most cases is still born. Secondary amenorrhea, vaginal scarring, pelvic infections and cervical injury contribute to secondary infertility among the patients (Bello, 1996, and Danso, Martey, Wall, and Elkins, 1996). Even in a situation where they are able to conceive, there is a low child survival rate (WHO 1991).

In an addition to all these, VVF patients may suffer direct trauma to the pelvic bones, and may experience gait disorders due to the destruction of the symphyseal union of the pubic bones (Lawson, 1967, Cockshott, 1973, Wall, 1998). Nerves to the lower limbs may also be damaged and when this happens, VVF patients may suffer from paralysis of the lower half of the body (Ghatak 1992, Foundation for Women's Health Research and Development, 2003). Furthermore, Harrison (1985) noted that the resultant effects of obstetric fistula included stillbirth, recurrence of VVF, uterine rupture, and embryology maternal and perinatal deaths.

## **SOCIAL CONSEQUENCES**

“To meet only one of these mothers is to be profoundly moved. Mourning the stillbirth of their only baby, incontinent of urine, ashamed of their offensiveness. Often spurned by their husbands, homeless, unemployable except in the fields, they endure; they exist without friends, without hope. No world charities have ever heard of them. They bear their sorrows in silent shame. Their miseries, untreated, are utterly lonely and lifelong” (Reginald and Catherine Hamlin, 1974- founders of second fistula Hospital in Addis Ababa, Ethiopia).

The social consequences for the Vesico –vaginal fistula patients are very severe. Wall (1998) described the gravity of this problem and I quote “ The affected woman suffers from a continuous and uncontrollable stream of urine or faeces coming out of her vaginal. This is both a physical and a social catastrophe. No escape is possible from the constant trickle of urine, the constant ooze of stool, 24 hours a day. These women become physically and morally offensive to their husband, their families, their friends, and their neighbours. Indelibly stigmatized by their condition, they are forced to the margins of society where they live a precarious existence, unable to earn a living except through begging or by the cheapest and most degrading acts of prostitution”.

Also, many of the VVF patients would have given birth to a stillborn baby, thus leaving the woman childless. Childlessness in Africa especially Nigeria is obviously an important factor in marital breakdown. Murphy (1981) reported that 77% of the fistula patients with two or more years were living apart from their husbands.

Earlier study by Ampofo, Omotara, Otu, and Uchebo (1990) also corroborated Murphy’s finding, and reported that many marriages have been dissolved because of the condition. Ojanuga and Ekwenpy (1999) substantiated these earlier findings in their own study, and found out that VVF patients are often divorced or separated from their husbands. Kelly (1989) also noted “ the fistula patient, incontinent of urine (and sometimes also faeces), ashamed of her offensiveness’, is readily disowned by her family and society and resorts to a live of begging”.

The vesico vaginal fistula patients are subjected to a life of isolation, and humiliating rejection by those who put them in the condition. Several studies have confirmed this: Pendes, 1989 remarked that obstetric fistula sufferers often remain isolated, usually separated from their husbands, and unable to perform their field and household work. Kempf, (1989) describes vesico –vaginal fistula as a condition of young primiparae without living children, usually abandoned by their husbands, and from poor or very poor families. In an earlier study (Haile 1983) reported that most of the vesico vaginal patients in his study felt extreme shame at their condition. Two- thirds of them stopped attending church services, which indicate they are Christians, more than half of them were divorced and ten of them were abandoned by their husbands as soon as they developed the problem. Sambo (1993) also reported that 85% of the VVF patients were abandoned by their husbands Waaldijk (1989) found out that 82% of the VVF patient in his study had been sent away by their husbands, and lived as social outcast.

Odu (2000) noted that vesico- vaginal fistula leaves a woman physically, emotionally, financially and socially traumatized. Lack of support not only from the husbands of VVF sufferers, the families and society will be the hardest consequence to bear psychologically. Some even commit suicide (Odu, 2000). A woman in torment that is rejected is a woman sentenced to a life of total despair, and can do anything in the circumstance. A patient with VVF is described as a similar situation to that of epileptics in Uganda (Orley, 1970). With no formal education, no money for petty trading, no gainful employment, no vocational training or education, no tangible means of livelihood, vesico- vaginal fistula sufferers join the group of destitute in the society, and thus begin a long journey into pain, sadness, humiliation and total rejection.

It can therefore be concluded that sufferers of vesico vaginal fistula bear all the consequences alone. It is therefore recommended that the people of Northern Nigeria should be well



educated about the consequences of VVF, and the need to allow their women take decisions regarding their health.

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