THE PSYCHO-SOCIAL CONSEQUENCES OF VESCO VAGINAL FISTULA AMONG WOMEN IN NORTHERN NIGERIA

Prof. Bimbola, Kemi Odu
Faculty of Education
Ekiti State University, Ado Ekit
Nigeria

Prof. John Cleland
Centre for Population Studies
London School of Hygiene and Tropical Medicine
University of London, London
United Kingdom

ABSTRACT

The focus of this paper is on the psycho-social consequences of Vesco Vaginal Fistula among women in Northern Nigeria. A descriptive research design of the survey type was adopted for the study and the sample consisted of two hundred and fifty two VVF patients. The purposive sample technique was used to select the sample. Data were collected with the aid of a self-constructed questionnaire. The data collected were analysed using percentage score and t-test analysis. The hypotheses generated were tested at 0.05 level of significance. The result revealed a significant relationship between VVF and stigmatization, positive relationship existed between VVF and self-worth and significant relationship exist between VVF and rational ability of patients. Based on the findings, it was recommended that adequate support be given to VVF patients by family and friends, they should identify with their predicaments rather than denying and isolating them. If adequate care is given their hope would be restored, low self-worth be eliminated and their rational ability restored.

Keywords: Psychosocial, VVF, consequences, women, Northern Nigeria.

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 anti natal clinic (Sambo 1993, and Odu 2000)

The World Health Organizations report on obstetric fistula (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 anaemic 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 invariably leads to obstructed labour.

Harrison (1985) reported that his patients from his VVF group came from a more 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 vesco vaginal fistula. Abbo and Mukhtar (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 and 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 sociooeconomic 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.

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 that the husband or relatives gather their few belongings for sale in order to get transportation fare to and fro 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 work. (Wall, 1998, Sundari 1992)

Massoundnia (1972) in his study found out a significant contributing factor in the development of vesco 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.

The immediate physical consequences of vesco vaginal fistula is urinary incontinence, and faecal incontinence may also result. Wall (1998) highlighted some of the physical consequences that may result from vesco- 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 gynecological 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 vesco vaginal patients. Aimakhu (1974), Harrison (1985), Ghatak (1992). Sambo (1993), Arrowsmith, Hamlin and Wall (1996) noted that most of the vesco vaginal patients will never become pregnant again. It is, noted that most of the vesco 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 recurrences of VVF, uterine rupture, and embryology maternal and paternal death.

The social consequences for the Vesco -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 steam of urine or faces coming out of her vagina. This is both a physical and 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 husbands, their families, their friends, and their neighbours. Indelibly stigmatized by their conditions, 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 life of begging".

The vesco 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 Vesco -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 vesco 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, also 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 Vesco- 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, Vesco- Vaginal Fistula sufferers join the group of destitutes in the society, and thus begin a long journey into pain, sadness, humiliation and total rejection.

STATEMENT OF THE PROBLEM

In a developing country like Nigeria, some harmful cultural/traditional practices/factors place women at the risk of VVF which results to physical discomfort they bear, and these women are often ostracized by their communities and may be left struggling to survive, abandoned by their
husbands and families. Most will remain childless, and childlessness is found to be an important factor in martial breakdown.

Some of these women are hospitalized for fistula repair, but they enjoy less or no support from their husbands who put them through this experience. While some women who remain untreated not only face lives of misfortune and isolation, they may also face a slow, premature death from frequent infection and kidney failure. They also lack financial support and they are forced to beg for their living, and they are especially vulnerable to malnutrition and violence.

HYPOTHESES

1. There is no significant relationship between VVF and stigmatization.
2. There is no significant relationship between VVF and self-worth.
3. There is no significant relationship between VVF and rational ability.

METHODOLOGY

Research Design

The survey design was used for this study since it allowed the researchers to obtain information from a representative sample of a population which led to the collection of the same or similar information through the use of a researcher constructed and validated questionnaire.

Population of the Study

The population for the study was the married women of ages 9-49 which constitute the active reproductive age group in Northern Nigeria, and who are currently suffering from vesco vagina fistula who have had the experience, and still undergoing treatment.

Sample and Sampling Procedure

The sample for this study was carried out through purposive random sampling. There are nine established vesco vagina units in various hospitals, and one rehabilitation centre also known as VVF hostel in Northern Nigeria. These centres are established in nine states (Kano, Kaduna, Katsina, Sokoto, Plateau, Bauchi, Jigawa, Kebbi and Zamfara) in northern Nigeria. The study was carried out in seven centres in six different states - Bauchi, Plateau, Kaduna, Kano, Katsina and Sokoto. Three other hospitals were visited by the principal investigator Kogi and Abuja but could not get any patient at the time of visitation, and it may be due to the fact that those hospitals are not known to have established VVF centres. The other three centres could not be visited by the researcher because of time constraint and the limited resources.

A sample size of 252 VVF patients were selected for the study from all the purposively selected hospitals, and hostel. These two hundred and fifty two patients were all the patients on admission as at the time of visitation to the hospitals by the researcher, and they all willingly presented themselves for the purpose of this study.

Research Instrument

The main research instrument for this study was a well-constructed questionnaire by the researchers. The questionnaire dealt with the bio-data information of the patients, available in the vicinity in which the patients live, and the psycho-social consequences of VVF.

Validity of the Research Instrument

To ensure the validity of the instrument, face, content, and construct validity were applied. The face validity ensured that extraneous factors and ambiguous variables were not introduced into the instrument. The questions posed in the questionnaire were directly related

to the hypotheses raised. The implication of the construct validity was that the researcher was able to interpret the information received from the questionnaire to infer under investigation.

The face, construct, and content validity were examined and ascertained by experts in the field in order to measure what it was supposed to measure.

Administration of the Instrument

The principal investigator personally administered the questionnaire, and was assisted by three research assistants, and several interpreters because the principal investigator does not understand the dialect of the people in the northern part of Nigeria, and since literature has shown that most of the VVF patients in the north are illiterates, and it was also confirmed to be so through this study, therefore the assistance of the interpreters was of much success to the study.

DATA ANALYSIS

Data analysis involved the use of descriptive statistics like frequency counts, percentages, variances and standard deviations. Some hypotheses were tested at 0.05 level of significance.

Results

The results of the hypotheses are presented below:
Hypothesis 1: There is no significant relationship between VVF and stigmatization

Table 1: Correlation between VVF and stigmatization

Variables	**N**	**r-cal**	**r-tab**
Vesco Vaginal Fistula	252		
Stigmatization	252	0.665	0.192

P< 0.05

Table I shows r-cal to be 0.665 and r-tab to be 0.192. H_o is rejected since r-cal is higher than r-tab. Therefore, there is significant relationship between VVF and stigmatization. The result also indicates a strong r-value power to agree a positive association or relationship between VVF and stigmatization.

Hypothesis 2: There is no significant relationship between VVF and self-worth

Table 2: Correlation between VVF and self-worth

Variables	**N**	**r-cal**	**r-tab**
Vesco Vaginal Fistula	252		
Self-worth	252	0.520	0.195

P< 0.05

Table 2 shows that the value of r-cal 0.520 and r-tab 0.195. H_o is rejected, since r-cal of 0.520 value is higher than r-tab of 0.195 value. Therefore, there is significant relationship between vesco vaginal fistula and self-worth. From the table above, the relationship reflects positive direction between VVF and self-worth. The result also indicates a strong R-value power to a positive association or relationship between VVF and self-worth as VVF patients suffer all forms of intimidation that lower their self-value.

Hypothesis 3: There is no significant relationship between VVF and rational ability

Table 3: Correlation between VVF and relational ability

Variables	**N**	**r-cal**	**r-tab**
Vesco Vaginal Fistula	252		
Relational ability	252	0.402	0.195

P< 0.05

Table 3 reveals that the value of r-cal (0.402) is greater than r-tab value (0.195) at a significant level of 0.05. Therefore, the H_o is rejected as there is significant relationship between VVF and rational ability. The relationship reflects positive direction between VVF and rational ability, also the r-value power is moderate enough to argue that VVF has a far reaching effect on the rational ability of patients. This is so because their unpleasant circumstances made them withdrawn from public life and hitherto become lone rangers.

DISCUSSION

The result of hypothesis 1 reveals a significant positive relationship between VVF and stigmatization. The patients suffer social disgrace when the people around her neglect her with her condition. These women are often times rejected leading to divorce, begging, prostitution and other depersonalized situations. This finding supports the earlier report of Zubair (1991) and Sako (1992) who stated that the victim of Vesco Vaginal Fistula (VVF) are forced to live as outcast wherein they are not allowed to handle food, cook or even pray.

The result of hypothesis 2 shows a significant relationship between Vesco Vaginal Fistula (VVF) and self-worth. Vesco Vaginal Fistula (VVF) has a noticeable effect on the self-concept of the patients. They prefer to withdraw to themselves to avoid disgrace, build inferiority complex in themselves, find it intimidating to participate in public affairs and activities and of it all, they find life difficult and unbearable and see themselves as worthless and depressed. This finding correlates the work of Myles (1968) that obstructed labour imposes a degree of emotional strain on the woman and severe stress precipitate depression.

The finding of hypothesis 3 reveals a positive significant relationship between Vesco Vaginal Fistula (VVF) and relational ability. It is found out that VVF incapacitates these women from relating well with other people from their neighbourhood even their interpersonal relationship with friends and relatives get poorer by the day. This finding supports the work of Hamburg (1981) who found out that the society becomes less intimate with the patients the greater the tendency for them to suffer from self-guilt which further aggravates poor interpersonal relationship.

CONCLUSION AND RECOMMENDATIONS

Vesco Vaginal Fistula (VVF) leaves a woman physically, emotionally, financially and socially traumatized. Lack of support not only from the husbands of VVF patients, the families and society will be the hardest consequence to bear psychosocially. A woman in torments that is rejected is a woman sentenced to a life of total despair, and can do anything in the circumstances.

Based on the findings above, it is recommended that VVF patients should not be stigmatized and be made to participate in public affairs. Also VVF patients should not be made to feel guilty but given adequate support and finally, members of the public should be sensitized on

the need to improve on their interpersonal relationships with Vesco Vaginal Fistula (VVF) patients.

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