

**WOMEN VULNERABILITY TO VESCO VAGINAL FISTULA AND
CONTRIBUTING INFLUENCES IN NORTHERN NIGERIA**

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ABSTRACT

This study investigated women vulnerability to Vesco Vaginal Fistula and contributing influences in Northern Nigeria: The research design used for this study was the descriptive research design of the survey type. Two hundred and fifty two Vesco Vaginal Fistula otherwise known as VVF patients selected through purposive sampling technique formed the sample for the study. The samples were taken from seven purposively selected centres in six different states in Northern Nigeria. The research instrument used in this study was a self-constructed instrument. Face and content validities of the instrument were ensured by the researchers and other experts in the field and the instrument is reliable to measure what it was supposed to measure. The inferential statistical technique used for data analysis in this study was mean and simple percentile, the result of the analysis revealed that all the cultural and psychosocial variables taken together significantly contributed to the causes of Vesco-Vaginal Fistula in Northern Nigeria. Based on the findings, it was recommended that hence it has been found out that the major cause of Vesco-Vaginal Fistula is obstructed labour' expectant mothers should not labour, too long before they decide to go to the hospitals / health Care Centres for delivery. Pregnant women should be at liberty to take decision to go to the hospital for delivery rather than waiting for their husbands to decide for them, women should equally embark on their journey to the hospital for delivery early enough to prevent prolonged labour and finally adequate and efficient means of transportation should be provided for pregnant women to get to the designated

Keywords: Health-seeking, treatment, consequences, Vesco-Vaginal Fistula, Northern Nigeria, cultural and psychosocial factors, VVFAIFI.

INTRODUCTION

Vesco - vaginal fistula also known as VVF is a health condition that arises from obstetric complications. VVF is an abnormal fistulous tract, which extends between the bladder and the vagina and leads to the continuous involuntary discharge of urine into vaginal vault. VVF is one of the most dehumanizing morbidities, which usually results from pregnancy and child birth.

Vesco-Vaginal Fistula is an obstetric fistula which is a breakdown of tissue in the vaginal wall communicating into the bladder or the rectum, or both. According to Adnan 1993), an obstetric fistula is usually a hole torn, often during prolonged, obstructed childbirth, between the vagina and the bladder. Vesico-vaginal fistula can also be caused by injury to the urinary tract, which can accidentally occur during surgery to the pelvic area, or a removal of a tumor in the vaginal area, or by reduced blood supply due to tissue death which is necrosis or might be caused by radiation therapy.

Obstetric fistula produces serious, long term social, physical and psychological consequences for women. It leaves a woman permanently incontinent. It remains one of the serious maternal morbidities especially of teen or young mothers especially in the developing countries (Moronkola and Odu, 1999). Vesico vaginal fistula is common in developing than developed nations.

In Nigeria, many women have suffered from VVF and the practice of female genital mutilation is deeply entrenched (Owumi and Balogun, 1997). Research has shown that maternal morbidity as a result of VVF or RVF (Recto- vaginal fistula), which is the breakdown of tissue in the vagina wall communicating into the rectum, is particularly common and high in the northern part of Nigeria.

The World Health Organization report of 1989 indicated vesico- vagina fistula is caused by the interplay of very numerous cultural, social, political, and physical factors as well as 'the economic situation and status of women especially in the developing countries in particular, northern Nigeria.

In line with the World Health Organization reports of 1989, (Ghatak (1992), also reported that vesico- vaginal fistula is the pressing problem in the core north of Nigeria. Research has shown that people in this area are rather backward due to ignorance, prejudice and unhealthy custom in the society. It has been observed that patients with fistulae are as a group of disadvantaged people with particular reference to culture, socio-economic status and education. Vesico- vaginal fistula is believed to be rampant in the northern part of Nigeria because of the obstructed labour many of these "babies" in the name of mothers experience at childbirth. And this pressing problem has wasted many lives and destroyed many generations of teenage mothers who should have been good leaders of tomorrow if properly trained.

Various studies have shown that obstructed labour accounts for 85% of all cases of VVF in Nigeria. Ghatak (1992), Sambo (1993), Odu (2000).

Obstruction normally occurs in these young girls during labour, and this is due to the fact that the pelvic of these girls are too small to allow for the passage of the baby. The pelvic of these "babies" are not well developed before they are given out in marriage. This leads to arrest of labour, and the situation is normally rescued with operative intervention. It has been observed that most of these younger mothers do not usually go to the hospitals to deliver, they stay at home. And without the operative intervention, the foetal head presses on the pelvic organs. If this condition continues, the resultant pressure may obstruct the blood supply to these tissues. The end result may be vesico-vaginal fistula or recto-vaginal fistula which is an abnormal connection between the rectum and vaginal resulting in faecal incontinence - Sambo (1993).

Research and observations have shown that some of these young mothers give birth locally by in experienced, crude and incompetent helpers. Mothers (babies) with underdeveloped pelvic bones are often helped to expand the birth canal with a cut, known as 'gishiri' cut in the northern part of Nigeria, with crude implements. Torn bladder and sometimes torn rectum are the result. From this experience often comes stillborn babies, and in a situation where the mothers survive, the resultant effect is vesico- vaginal fistula. Due to this, the affected women leak urine continuously and sometimes faeces. The resultant condition, and the accompanying offensive smell prevent them from socializing and mixing with people. To make matters worse, these girls become social outcast in the midst of those who put them

through this experience. They are often rejected and divorced by their husbands thereby compounding the situation.

Several studies have been carried on Vesico-Vaginal Fistula in both the developed and developing countries most especially the northern part of Nigeria. Northern Nigeria is depicted to have a maternal mortality ratio greater than 1,000 maternal deaths per 100,000 live births (Wall, 1998). Serious maternal morbidity resulting from vesico vaginal fistula is also common. Among the most important factors contributing to this tragic situation according to him are Islamic culture that undervalues woman, a perceived social need for women's reproductive capacities to be under strict male control, the practice of purdah (wife seclusion), which restricts women's access to medical cares, almost universal female illiteracy, marriage at an early age and pregnancy often occurring before maternal pelvic growth is complete; a high rate of obstructed labour; directly harmful traditional medical beliefs and practices, inadequate facilities to deal with obstetric emergencies; a deteriorating economy, and a political culture marked by rampant corruption and inefficiency. The convergence of all of these factors has resulted in one of the worst records of female reproductive health existing anywhere in the world".

According to the Foundation for Women Health, research and development (FORWARD) 2003, 80% of VVF cases reported in Nigeria were due to unrelieved obstructed labour during childbirth. Corroborating this view is Bello (1996) who through her study reported, that obstructed labour, accidental surgical injury relating to pregnancy and crude attempt at induced abortion influence the incidence of Vesico-Vaginal Fistula. She continued that "obstructed labour leads to VVF when prolonged and unrelieved pressure on woman's pelvic wall causes a puncture in the bladder"

Research has shown that the surgical procedure leading to VVF is of two types. The first is the injury caused to the bladder during obstetric operations which is normally performed within a hospital setting. Such procedures include caesarean section and difficult delivery (Bello, 1996). In a related study carried out by Mustafa and Ruhwan (1971), a review of 122 cases of fistula treated in Khartoum Teaching Hospital, Sudan over a period of three years lend credence to the fact that the major cause of VVF is a prolonged obstructed labour which was revealed in ninety one (75%) of the women's studied over the period, 25 (21%) from instrumental delivery which is mainly forceps, and 6 (5%) from gynecological operations. Tahzib (1983) also confirmed in his study of 1,443 patients with Vesico vaginal fistulae who were operated on at the Ahmadu Bello University Hospital in Zaria Nigeria, Northern Nigeria between 1969 and 1980 that VVF resulted mainly from prolonged or obstructed labour.

Nigeria is located in West Africa, bordering the Gulf of Guinea, between Benin and Cameroon. She covers an area of 923, 768 sq. km, and has an estimated population of 120 million which is the largest national population on the African continent. This population consists of 374 pure ethnic stocks with various dialects and languages. The official language is English but there are three other predominantly languages which are Hausa, Yoruba and Igbo. Nigeria has about 800km of coastline which confers on the country the potentials of a maritime power. There are plenty of lands in Nigeria which are good for agricultural, industrial and commercial activities. She is slightly more than twice the size of California (The World Fact book).

Nigeria got her independence from Britain on the 1st of October 1960. She is a secular nation but the two dominant religions are Christianity and Islam. She operates a three tier structure

of Government- A Federal Government, 36 State Governments and 774 Local Government administration.

Nigeria has a promising economy, the economy is a mixed one which accommodates every interest, corporate organizations, government agencies, foreigners, and individuals to invest in almost all sector of the economic activities. Nigeria is divided into two main regions which are the Southern and the Northern regions. The southern region is made up of 17 states while the northern region is made up of 19 states. The southern region is inhabited mainly by the Yorubas and the Ibos while there are over 50 smaller tribes and the main religion is Christianity.

The northern region is inhabited mainly by the Hausas, Fulanis, and the Kanuris while there are other smaller tribes. Islam seems to be the dominant religion in the north but there are about three states in the north with Christianity as the dominant religion. Research has shown that there is a serious dichotomy in the educational level of the two regions. The level of literacy in the south is very high while that of the north is very low. Literature has shown that the level of education of both men and women in the south is at par if not more on the side of the women but in the north, women are hardly educated, and only few men go to school. In the north, women are hardly seen and are never heard while there are equal opportunities between the men and the women in the southern part of Nigeria.

However, both the regions are controlled centrally by a civilian Government, and has Abuja, the Federal Capital City as the seat of power.

STATEMENT OF THE PROBLEM

Vesco-Vaginal Fistula is a serious from of maternal morbidity (Harrison 2001), particularly in northern Nigeria. From observation, VVF leaves a woman physically, emotionally, financially, and socially travmatised. The victims are often rejected by their traumatized husbands, and the society because of the accompanying offensive odour. And with no formal education, no vocational training, no gainful employment, no visible means of livelyhood most of the VVF join the group of destitutes in the society. Most of them end up as prostitutes, beggars or house helps whose services are exploited. Some even commit suicide.

According to the Foundation for Women Health Research and Development (2003) out of an estimated 150,000 cases of Vesco-Vaginal Fistula in Nigeria 70% occur in the North, and approximately 80% of the VVF cases reported in Nigeria were due to unrelieved obstructed labour during childbirth.

According to Myles (1985), obstructed labour may impose a degree of emotional strain on the woman leading to sever stress, which may precipitate psychiatric disorder, and the victim may lose contact with reality. She may have delusions, and also experience false perceptions such as hearing of voices or seen imaginary persecutors. Confusion, disorientation, liability of mood is also particularly characteristics of the psychoses occurring this time. Depression may set in, which will lead to insomnia, unusual sadness, excessive self-doubt, ideas of guilt, and thoughts of harming oneself.

The psychological implications are so weighty and grievous that the cultural and psychosocial factors as well as the treatment sought and the consequences of vesco- vaginal

fistula have to be scientifically established and documented so that enduring solutions can be propounded for the total eradication of vesco- vaginal fistula in North Nigeria and Africa.

RESEARCH QUESTIONS

1. Does the length of labour before journey to hospital influence VVF
2. Does decision taking to go to hospital or not has influence on VVF
3. Can traveling time influence VVF

METHODOLOGY

This is a research design of the survey type. The plan of study in which survey research design is used is considered appropriate because it focuses on the observation and perception of the existing situation. This plan of study describes and interprets what is concerned with issues, conditions and practices that prevail and exist or views that are going on, it help us to have a systematic analysis of the present situation and it studies relationships existing among variables.

Population

The population for this study is made up of all women of reproductive age group of 9-49 years who are VVesco vaginal Fistula patients in Northern Nigeria.

Sample and Sampling Technique

To select the needed samples for this study, a total of 252 Vesco vaginal Fistula were purposively selected from seven centres in six different states: Bauchi, Plateau, Kaduna, Kano, Katsina and Sokoto out the nine established vesco vaginal units in various hopitals and one rehabilitation centre also known as VVF hostel in northern Nigeria.

Research Instrument

The instrument used was a self-designed instrument. The instrument dealt with the bio-data information of the patients, occupation, socio-economic status of the family, cultural influences, health care facilities available in the vicinity in which the patients live.

Administration of the Instrument

The researcher administered copies of the instrument with the assistance of some trained research assistants and some interpreters. The assistance of the interpreters was sought because of language barrier, and this contributed so much to the success of the study.

DATA ANALYSIS

Descriptive statistical techniques used were means, standard deviation and simple percentile. All the research questions raised were tested.

Results

This section presents the result of the data analysis for this study. The results are presented according to the research questions which guided the study as shown in table 1, 2, and 3.

Research Question 1: Does the length of labour before journey to the hospital influence VVF

Table 1: Length of labour before journey to hospital and VVF

	Residence		Husbands Literacy		Economic Status			Total Sample %
	Urban %	rural %	Literate %	Illiterate %	Poor Average %	Intermediate %	Above %	
Length of labour before Journey to hospital 0-11 hours	8	8	10	6	8	10	4	8
12-23 hours	78	74	75	76	75	81	69	75
24 or more hours	14	18	16	18	18	10	27	17
All	100	100	100	100	100	100	100	100
	(p= 0.807)		(p= 0.752)		(p= 0.434)			

Table 1 above reveals that 75% of pregnant women had a long length of labour before they are taken to the hospital or health centre. The length of labour of between 12-23 hours which about a day poses a great danger to the pregnant women. Only 8% of the samples laboured for 0-11 hours before they journey to the hospital or health centre.

Research Question 2: Does decision to go to hospital or not has influence on VVF

Table 2: Whose decision to go to hospital and VVF

	Residence		Husbands Literacy		Economic Status			Total Sample %
	Urban %	rural %	Literate %	Illiterate %	Poor Average %	Intermediate %	Above %	
Whose decision to go to hospital								
Husband	60	42	55	47	48	46	62	50
Self	8	8	10	6	8	12	-	8
Doctor /midwife / TBA	5	4	5	8	2	10	4	5
Others	27	42	35	39	43	32	35	38
All	100	100	100	100	100	100	100	100
	(p= 0.463)		(p= 0.180)		(p= 0.239)			

Table 2 shows that only 8% of the samples can take decision on their own on whether or not to go to the hospital when in labour. While 50% of the samples agree that it is only their husbands who are the heads of families that have the exclusive right to decide whether or not to be taken to the hospital or health centre for medical attention. On the other hand people such as the village head other than the pregnant women still can take decision on behalf of the pregnant women as this takes 38%

Research Question 3: Can traveling time influence VVF

Table 3: Traveling time and VVF

	Residence		Husbands Literacy		Economic Status			Total Sample
	Urban %	rural %	Literate %	Illiterate %	Poor Average %	Intermediate %	Above %	%
Traveling time								
< 30 mins	32	5	10	15	13	20	4	13
30-59mins	30	12	26	11	13	15	31	17
60-119mins	11	27	28	19	27	17	19	22
120 +	27	56	37	54	48	49	46	48
all	100	100	100	100	100	100	100	100
	(p= 0.000)		(p= 0.065)		(p= 0.239)			

Table 3 reveals that 48% of the samples regardless of their place of residence, literacy and economic status would still need to travel for over an hour (120 + minutes) before they could access medical facilities and attention while only 13% of them would only have to travel for less than 30 minutes to access medical facilities which is a reasonable travel time.

DISCUSSION

The result of the research question 1 shows a significant contributing factor in the development of Vesico Vaginal Fistula and length of labour before journey to hospital or health centre because it has been noted that prolong labour is majorly responsible for the development of VVF, therefore failure to seek medical attention on time could lead to complication. This finding is in consonance with Akhtar (1968) who in his analysis of VVF patients reported that most women have to labour for a long period of time before they are taken to the hospital for delivery because of so many factors which include lack of adequate transportation, lack of decision making by the women and male domineering influence on their wives which is unhealthy for the safe delivery of this pregnant woman.

The result of research question 2 shows that there is a significant contributing influence of decision taking to go to the hospital or not on the development of VVF. In the analysis of data it is discovered that tradition has placed the control of the home and decision making on critical issues on the husband including health related matters, and this portends a great danger to the woman. In most cases the women lack power to decide on their own to access medical care without the approval of their husbands which most time leads to obstructed labour and attendant complications. This finding supports the work of Bello (1996) which found out that decision making power is one of the social contributors to VVF even in decision 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 decision comes too late because it is when labour must have been obstructed that she is permitted to be taken to the hospital.

The result of research question 3 shows that there is an influencing relationship between traveling time and the development of VVF which is significant enough to conclude that time taken to travel to seek professional attention would prevent obstructed labour which could lead to VVF. Therefore if medical care is not sought in good time the woman might have

complications from obstructed labour. The woman who seeks medical attention late stands the risk of developing VVF. This finding is in support of Akhtar (1989) that argued that most women come from the rural areas where there is an absence of trained personnel, and they have no means of transport to a maternity hospital. Sometimes these women have to cover several kilometres and travel for long hours to access medical facilities. It can therefore be seen that many women have to cover several kilometres for professional attention which gives room for complication during labour.

CONCLUSION AND RECOMMENDATIONS

In a developing country like Nigeria, some harmful cultural practices/factors place women at the risk of VVF which results to psychosocial consequences, and these women are often ostracized by their neighbourhood and left struggling to survive, abandoned by husbands and family members. Some of these women are hospitalized for fistula repairs, but they enjoy less or no support from their husbands who put them through the experience. While other who remains untreated not only faces a life of misfortune and isolation, they also die prematurely death from frequent infection and kidney failure. They lack financial support and forced to street begging for their living, most often vulnerable to malnutrition, violence, abuse and other social indignation.

Based on the findings of the study it is recommended that adequate sensitization and orientation be conducted on the evils of obstructed labour, husbands, village heads, pregnant women and other stakeholders should see the need for prompt response to take pregnant women to the hospitals for attention early enough whenever they fall in to labour to prevent obstructed labour and its attendant complications.

Again, to avoid the development of VVF due to obstructed labour, women should be allowed a measure of autonomy to be able to take decision on their own even in the absence or without the consent of their husbands to go to the hospital for care whenever they fall in to labour to avoid complications.

Finally, adequate measure should be put in place, adequate and efficient transport system should be available to reduce the traveling time from place of residence to access medical facilities. Medical facilities and services should also be made available in strategic places within the neighbourhood where possible to avoid irreparable loss.

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