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Original Article

Community misconception about the aetiopathogenesis and treatment of vesicovaginal fistula in northern Nigeria

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ABSTRACT

Background: The increasing incidence of obstetric vesicovaginal fistula (OVVF) in Nigeria has justified the need for continued exploration of ways to prevent the occurrence of this debilitating maternal morbidity. **Aim:** The study set out to gain insight into the rural people's perception about the cause and treatment of obstetric fistula using focus-group discussions. **Materials and Methods:** A series of focus-group discussion sessions were held with the local people of obstetric fistula-prevalent areas of northern Nigeria during a medical outreach. **Results:** Most (74.9%) of the participants had no formal education, while the majority (62.0%) of them were married at the time of the study. Most of the healthy females and a few male participants believed OVVF was a punishment from the gods to affected women for their infidelity. The majority of the men believed VVF resulted from unforeseen natural forces during childbirth. The majority of the women with obstetric fistula believed their condition either resulted from the effect of a poison from the skull bone of the dead macerated fetus that they were delivered of or from the manipulation of the Traditional Birth Attendants (TBA) while trying to deliver the dead fetus from their birth canal. On the possible treatment for VVF, the majority of the men in the study population and a few healthy women believed VVF had no cure. All the women awaiting repair of their VVF believed the condition could be corrected in the hospital. A few of the healthy women posited that OVVF could be treated with herbal products by experienced TBAs. **Conclusion:** There is a high level of misconception about the aetiopathogenesis of OVVF in rural areas of northern Nigeria. This calls for continued enlightenment of the populace on the cause and treatment of obstetric vesicovaginal fistula.

INTRODUCTION

Obstetric vesicovaginal fistula (OVVF) has continued to occur in developing countries notwithstanding the efforts of governments and other stakeholders to draw attention to the condition and establish dedicated centres for the repair and rehabilitation of affected women.

In developed countries of the world, obstetric vesicovaginal fistula is virtually non-existent save for sporadic cases of genitourinary fistula resulting from surgical trauma, radiotherapy of the pelvis and genital tract malignancies.[1,2] Sub-Saharan Africa on the other hand, is estimated to have 33,000 new cases of OVVF yearly, while Nigeria has 20,000 new cases added yearly to the prevalent population of unrepaired cases.[3,4] Currently, the annual obstetric fistula incidence in Nigeria is estimated to be 2.11 per 1000 births.[5]

Obstetric vesicovaginal fistula usually results from prolonged obstructed labour, when the fetal head is impacted in the pelvic cavity leading to compression of the maternal soft tissues of the vagina, rectum and urinary bladder against the mother's bony pelvis.[6] If the obstruction is not relieved within 24 hours through an emergency surgical intervention, ischaemia of the intervening maternal soft tissues could result. In neglected cases, tissue necrosis supervenes and the necrotic tissue eventually sloughs off leaving a fistulous communication between the urinary bladder or rectum and the vagina.[6,7] Interestingly, obstructed labour is peculiar to humans due to the erect bipedal posture, which has imposed anatomical restriction on the human pelvis, and the increasing size of the fetal head over time.[6]

The symptoms of obstetric vesicovaginal fistula are often distressing to the affected woman and obnoxious to her spouse and other close relations. The condition is characterized by uncontrollable urinary leakage and persistent perineal wetness leading to perineal excoriation.[8,9] Affected women usually have a constant urinary stench that makes them repulsive to other persons. With this debilitating symptoms, the woman loses self-esteem and becomes socially withdrawn.[8,9] If she is unfortunate, she soon loses the sympathy of her spouse and family members, who may stigmatized and ostracize her from the community.[10,11]

A couple of reasons have been adduced to possibly explain why women in developing countries shun orthodox health facilities for their childbirth and rather choose to deliver at their homes or in unlicensed maternity centres operated by Traditional Birth Attendants (TBAs) or Spiritual Church Leaders where emergency obstetric care are lacking. Some of the reasons given are, illiteracy, ignorance, poverty, and inability to pay the relatively high user-fees charged in orthodox health facilities.[12,13] Other reasons include, lack of access to a licensed health facility or prophetic warnings against delivery outside the church.[13,14]

Many research studies have been done on the demographic characteristics of women who develop OVVF and the epidemiology of the condition, but there are very few studies that focus on the individual's perception of what causes OVVF and how they think the condition can be remedied. This concern is important because if an affected woman does not know that the obstetric fistula resulted from prolonged obstructed labour, which she had in her last delivery, she would not see the need for delivery in an orthodox maternity centre where an emergency caesarean section can be performed if the need arises; neither will she seek help for possible repair if she does not know that the condition can be corrected surgically.

This study was designed to use a series of focus- group discussions to gain insight into what the local people in an obstetric fistula-prevalent area in northern Nigeria felt were the possible causes of OVVF and how they thought the condition could be remedied. It is envisaged that the findings of this study would help in the design of a protocol for health enlightenment and counseling of Nigerians on how this very important maternal morbidity can be prevented.

MATERIALS AND METHODS

Study design and study population

This study was designed to assess the perception of the local people of Taraba and Adamawa states of Nigeria about what they thought causes obstetric fistula and how they felt the condition could be remedied. A total of 30 focus-group discussion sessions comprising about 15 participants each were conducted in 10 communities of the two states during a free medical outreach sponsored by a non-governmental organization that provides free surgical care to poor rural dwellers in Nigeria. The groups were classified into three namely; men-only, healthy women and women awaiting OVVF repair. This classification was

carried out to eliminate any stigmatization of affected women and to allow the participants to express themselves freely without any bias. The focus-group discussion sessions were conducted in hausa, the local language of the people after counseling the participants on the purpose of the study assuring them that there would be no penalty for any opinions and comments made. The discussions were tape-recorded in addition to note-taking by trained research assistants.

Participants were encouraged to express themselves freely and to say what they felt were the causes of OVVF and how they thought the condition could be remedied. A brief pre-coded questionnaire that had been pretested successfully was administered to each participant in order to obtain their age, gender, marital status and their level of education. Questions to be asked during the focus group discussion were also included on the questionnaire.

Study area

Taraba and Adamawa states are located in the north-eastern geopolitical zone of Nigeria, which has been noted to have a high prevalence of obstetric fistula due largely to early marriage and failure to utilize modern maternity services during pregnancy and delivery.[5] Both states share the same culture and religion with about 45% Muslims, 53% Christians and 2% African Traditional Religion practitioners.[15] The local people engage in peasant farming, petty trading and cattle rearing. Maternity services are provided in both states by orthodox public and privately-owned health facilities as well as unlicensed Traditional Birth Attendants (TBAs) using their homes or the woman's home for their practice. Only 35% of mothers utilized orthodox maternity centres for their delivery in Nigeria.[15] Taraba state has a population of 2.3million with females accounting for 48% and 60% of the people live in the rural areas.[16] Adamawa state has a population of about 3million people with females accounting for 50% and about 60% of the people live in the rural areas.[16]

Data analysis

The data generated from this study are presented in the form of numerical, simple proportion and percentages. The responses of the participants are presented as stated by them. Some data are presented in tabular form for ease of perusal. Conclusions were drawn using descriptive and inferential statistics.

RESULTS

A total of 450 participants took part in the focus-group discussion sessions, 350 women and 100 men. Out of the 350 women, 150 (28.6%) had obstetric vesicovaginal fistula awaiting repair. Twenty (20%) out of the 100 men were husbands of women with unrepaired OVVF. All the participants gave their informed consent to take part in the study and expressed themselves freely without any reservations.

The table shows the breakdown of the age groups, educational level and marital status of the participants. The majority (23.3%) of the women belonged to the 20-25 years age group. A vast majority (74.9%) of the participants had no formal education. The majority (62.0%) of the participants were married at the time of the study.

Perception about the causes of obstetric fistula

Most of the healthy female and a few male participants believed obstetric fistula was a punishment from the gods to affected women for their infidelity. The majority of the men believed OVVF was due to unforeseen natural forces or destiny of the affected women. A vast majority of the women with unrepaired obstetric fistula believed that the condition either resulted from the effect of a poison from the skull bone of the dead macerated fetus, that they were delivered of or from the manipulation of the Traditional Birth Attendants while trying to deliver the dead fetus from their birth canal. A few of the men thought that OVVF resulted from a tear on the mother's birth canal by a male fetus if the mother did not like her spouse.

Perception about the prospect and possible remedy for obstetric fistula

The majority of the men in the study population and a few healthy women believed that OVVF had no cure. All the women with unrepaired OVVF believed that the condition could be corrected in hospital asserting that they came out for the outreach in order to be treated. A few of the healthy women posited that OVVF

Table 1: Socio-demographic characteristics of participants in the study

Age groups	No. of women	No. of men	Total (%)
20-25	83	22	105 (23.30)
26-30	82	16	98 (21.80)
31-35	70	11	81 (18.00)
36-40	47	13	60 (13.30)
41-45	35	24	59 (13.10)
46-50	17	9	26 (5.80)
>50	16	5	21 (4.70)
Educational level			
No formal education	275	62	337 (74.9)
Primary	51	31	82 (18.2)
Secondary	18	5	23 (5.1)
Post-secondary	6	2	8 (1.8)
Marital status			
Single	15	0	15 (3.4)
Married	193	86	279 (62.0)
Separated	10	6	16 (3.5)
Divorced	96	3	99 (22.0)
Widowed	36	5	41 (9.1)
Total	**350**	**100**	**450 (100.0)**

could be treated with herbal products by experienced Traditional Birth Attendants.

DISCUSSION

The increasing incidence of OVVF in Sub-Saharan Africa has justified the need for continued exploration of ways to prevent the occurrence of this crippling maternal morbidity. This study engaged a total of 450 local people in an obstetric fistula-prevalent area of northern Nigeria in a series of focus-group discussion sessions in order to gain insight into what they felt could cause obstetric fistula and how they felt the condition could be remedied. The participants cut across all age-groups (20-25years to over 50 years) comprising young and middle-aged men and women, who were in their active phase of life. This was important as their opinions would represent the perception of the community on obstetric vesicovaginal fistula; in addition, 28.6% of the women were awaiting the repair of their OVVF, while some of the men were husbands of these women. A breakdown of the educational level of participants revealed that a vast majority (78.5%) of the female participants had no formal education. This was not surprising as the National Demographic Health Survey has revealed that 36.0% of Nigerian women and 19% of Nigerian men have not attended even primary school.[15] This occurs against the backdrop that formal education of women has been found to influence their health seeking attitude positively.[17,18] A series involving 130 women with OVVF in Sokoto, Nigeria revealed an illiteracy rate of 93% among affected women.[19] The participants in this study cut across all marital status with the majority (62.0%) being married at the time of the study. This was essential as the opinion of those who were actively reproducing is important and the spectrum of the participants reflected the social heterogeneity of the community studied.

On the causes of obstetric fistula, opinions were divided based on the gender or health status of the participants. While the majority of the men were sympathetic to the plight of affected women, the healthy women felt the latter were suffering for their wrong-doings attributing the OVVF to punishment from the gods for their infidelity. This probably explains why affected women are often neglected and eventually ostracized from the community without any sympathy.[10,11] In a study in north-western Nigeria, the healthy women in that series went further and suggested that women with OVVF should be isolated from other members of the family.[18] As would be expected, women with OVVF felt it was not

their fault, attributing the cause of the condition to either the mistakes of the TBA in the process of delivery or unforeseen natural forces. This trend where women with OVVF often absolve themselves of any blame is common as a study in Tanzania noted women with OVVF attributing their condition to either the poor skills or the mistakes of Nurses and Doctors during their delivery vaginally or during emergency caesarean section to relieve the obstructed labour.[1]

Participants were divided on their opinion of how OVVF can be remedied. The vast majority of the men believed the condition had no remedy, while half of the healthy women felt the condition could be treated with herbal products by experienced TBAs. Interestingly, all the women with OVVF posited that the condition could be remedied in hospital, asserting that they came out for the medical outreach in order to avail themselves of the opportunity to have their conditions corrected. In a study in Cameroon, at least 18.8% of women with OVVF knew that the condition resulted from prolonged obstructed labour, although, over 30% of them did not know that the condition could be corrected surgically.[19] The findings of this study is worrisome as none of the participants knew the cause of obstetric vesicovaginal fistula and how the condition could be corrected.

In conclusion, there is a high level of misconception in the rural areas of northern Nigeria about the cause of obstetric vesicovaginal fistula and how the condition can be corrected. This development calls for a systematic and comprehensive health enlightenment programme to educate the people on the aetiopathogenesis and treatment of obstetric vesicovaginal fistula. Knowledge of the causation of obstetric fistula could help rural women make a decision for antenatal care and hospital confinement, which has the potential to reduce the increasing incidence of obstetric fistula in Nigeria. The government should not relent on its efforts to encourage the education of the girl-child.

REFERENCES

1. Kazaura M.R, Kamazina R.S and Mangi E.J. Perceived causes of obstetric fistula from rural southern Tanzania. Afr Health Sci 2011;1:377-382.
2. Wall L.L. Fitsari ‘dan Daniya. An African (Hausa) praise song about vesicovaginal fistula. Obstet Gynecol 2002;100:1328-1332.
3. Vangeenderhuysen C, Prual A, Ould el Joud D. Obstetric fistula: incidence, estimates for Sub-saharan Africa. Int J Gynecol Obstet 2001;73:65-66.
4. United Nations Population Fund (UNFPA) Nigerian fistula Fortnight. United Nations Technical Report. www.unpfa.org/reproductivehealth.html
5. Ijaiya M.A, Rahman A.G, Aboyeji A.P. Vesicovaginal fistula: a review of Nigerian experience. West Africa Journal of Medicine 2010;29:293-298.
6. Wall L.L. Obstetric vesicovaginal fistula as an international public health problem. The Lancet 2006;368:1201-1209.
7. Arrowsmith S, Hamlin E.C, and Wall L.L. Obstructed labour injury complex: Obstetric fistula formation and the multifaceted morbidity of maternal birth trauma in the developing world. Obstet Gynecol Survey 1996;51:568-574.
8. Danso K.S. Genital tract fistula. In: Kwawukume E.Y and Emuveyan E.E (Eds.) Comprehensive Gynaecology in the Tropics. Graphic Packaging Ltd. 2005;1:174-181.
9. Karshinia J.A and Otubu J.A.M. Genital fistula. In: Agboola A. (Ed.) Textbook of Obstetrics and Gynaecology for medical students. 2nd Edition. Heinamann Educational Books (Nig.) Plc.2006;39-51.
10. Umoiyoho A.J, Inyang-Etoh E.C, Abah G.M, Abasiattai A.M and Akaiso O.E. Quality of life following successful repair of vesicovaginal fistula in Nigeria. Rural and Remote Health Journal 2011;ID1734:1-7.
11. Umoiyoho A.J and Abasiattai A.M. Review of obstetric fistulas in a rural hospital in South-south Nigeria. Urogynaecologia 2011;25:e7 p. 25-27.
12. Etuk S.J and Ekanem A.D. Sociodemographic and reproductive characteristics of women who default from orthodox obstetric care in Calabar, Nigeria. Intl J Obstet Gynecol 2001;73:57-60.
13. Umoiyoho A.J, Inyang-Etoh E.C and Etukumana E.A. Obstetric fistula repair: experience with hospital based outreach approach in Nigeria. Global Journal of Health Science 2012;4:40-45.
14. Etuk S.J, Itam I.H and Asuquo E.E.J. Role of spiritual churches in antenatal clinic default in calabar, Nigeria. East African Medical Journal 1999;11:639-643.
15. Olusanya O, Okpere E, Ezimokhai M. The importance of social class in voluntary fertility control in a developing country. West African Journal of Medicine 1985;4:205-211.
16. National Demographic Health Survey (NDHS). Religion, Gender and Educational level of Nigerians. National Demographic Health Survey 2008. www.healthmetricsandevaluation.org/ghdx/record/nigeria

17. National Population Commission. (Nat. Pop. Comm.) The population of Taraba and Adamawa states of Nigeria. Results of the Nigerian population census 2006. www.population.gov.ng/index.php
18. Hassan M.A and Ekele B.A. Vesicovaginal fistulas: do the patients know the cause? Ann Afr Med 2009;8:122-126.
19. Tebeu P.M, de Bernis L, Boisrond L, Le duc A, Rochat C.A. Knowledge, attitude and perception about obstetric fistula by Cameroon women. Prog Urol 2008;18:379-389.

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