Annals of African Medicine
Vol. 2, No. 2; 2003: 54 - 57

MEDICO-SOCIAL PROBLEMS OF PATIENTS WITH VESICO-VAGINAL FISTULA IN MURTALA MOHAMMED SPECIALIST HOSPITAL, KANO

M. Kabir, Z. Iliyasu, I. S. Abubakar and U. I. Umar

Department Of Community Medicine, Aminu Kano Teaching Hospital, Kano, and Department of Community Medicine and Primary Care, Bayero University Kano, Nigeria
Reprint requests to: Dr. Mohammed Kabir, Department of Community Medicine, Aminu Kano Teaching Hospital, P.M.B. 3452, Kano, Nigeria. E-mail: mdkabir@ecnx.net

Abstract
Background: Vesico-vaginal fistula is still a persisting scourge in the developing countries with devastating medical and social consequences. These consequences were studied among patients presenting with VVF at a large referral center in Kano, Northern Nigeria.
Methods: A total of 120 patients with Vesico-vaginal fistula admitted at the VVF centre of the Murtala Mohammed Specialist Hospital, Kano were investigated using structured questionnaires to determine their medical and social problems. Additional information on clinical features was obtained from patients' case notes.
Results: Their ages ranged between 10 and 36 years with a median of 16 years. A majority of the patients 87 (72.5%) were between 10-20 years. Most of the patients 98(81.6%) had their first marriage between the ages of 10 – 15 years. Patients were found to suffer from vulval dermatitis, foot drop, amenorrhoea, recurrent urinary tract infections and dysmenorrhoea as main medical problems. Economically they cannot work because they are shunned by the society. They are considered to have brought shame and dishonour to themselves and their families, and where they manage to avoid not being divorced by their husbands they quite often lose any form of support from the husbands.
Conclusion: Special counselling and enlightenment programme on VVF, the need to train more traditional birth attendants and the need to improve referral of women likely to have VVF to facilities that offer emergency obstetric services were recommended.

Key words: Medico-social problems, vesicovaginal fistula

Introduction

Vesico-vaginal fistula (VVF) is a direct pathological communication between the urinary bladder and the vagina resulting in the uncontrolled leakage of urine into the vagina from the bladder. [1] Actual incidence/prevalence rates from community-based studies are difficult to come by because the condition is under reported due to stigma associated with it. However, in many parts of Africa especially in the more remote rural areas, it is one of the commonest distressing conditions that bring women to hospital. [2]

The condition has many causes with variation depending on the social and educational status of people. Notable among the causes are pressure necrosis following prolonged obstructed labour, trauma during operative delivery, infections and irradiation necrosis from treatment of cervical carcinoma. The problem of VVF in Northern Nigeria has been found to be associated with young girls who are denied skilled maternity care despite their high-risk pregnancies. Other factors contributing to the high incidence of VVF include illiteracy, poverty, ignorance, home delivery, non-utilisation of antenatal and intrapartum medical facilities and the habit of performing traditional episiotomy - "Gishiri cut" by untrained traditional birth attendants, husband dominance and severe deprivation and neglect. [3]

Vesico-vaginal fistula is a disease with tremendous socio-economic and health implications and consequences. The uncontrolled urine leakage causing bad odour in gatherings result in social stigma

and consequent neglect. Other problems include childlessness from loss of viable foetus from pregnancy associated with VVF, secondary infertility, vaginal stenosis by fibrosis and bands, amenorrhoea, high and unaffordable costs of repair and elective caesarean section among those who get pregnant later. Psychosocial problems of the patients include depression, loss of husband's affection, divorce and rejection by the society.

Materials and Methods

The Laure fistula centre of Murtala Mohammed specialist hospital and a patients' waiting hostel in Kwalli became operational in January 1990. A Dutch surgeon,Dr. Waaldijk comes from Katsina twice a week to operate on these patients. The centre attracts patients from all over northern Nigeria and Niger republic. The total number of repairs carried out at this centre from 1990 to 2001 was 4,261.[10] This centre serves as a national training centre for doctors and nurses. Consent was obtained from the Murtala Mohammed specialist hospital authorities as well as each patient before commencement of the study.

Between November and December 2001, 120 women with vesico-vaginal fistula who were admitted into the hospital were studied. Using a structured questionnaire, data on personal particulars of the patients including their marital status were recorded. Data collected on their health and medical conditions include gynaecological problems such as amenorrhoea, dysmenorrhoea, dyspereunia and infertility. Additional information about findings on physical examination was obtained from the patient's case notes. Social problems elicited include how the patients felt about the fact that they have the condition, as well as the societal reaction towards them.

Results were analysed using MINITAB 12.21(U.S.A) statistical software package. Median, range and percentages were used to describe quantitative and qualitative data respectively. Microsoft Excel and Word in windows 98 were used for graphics and tables in that order.

Results

The patient's age ranged between 10 and 36 years with a median age of 16 years. A majority of the patients 87 (72.5%) were between 10-20 years of age as shown in table 1. A majority of these patients 94(78.3%) were illiterate. Even among the literate ones none had tertiary education. Table 2 indicates that a majority 98(81.6%) of the patients had their first marriage between the ages of 10-15 years.

Most of the patients 93(77.5%) did not book for antenatal care during the index pregnancy preceding development of the vesicovaginal fistula. Table 3 shows that the commonest associated medical problem among the patients is vulval dermatitis (31%) followed by foot drop (23%) and 17.5% had amenorrhoea. There was an associated rectovaginal fistula in 7 (6%) of the patients.

Up to half of the patients were bitter about the condition they found themselves in and a third were psychologically depressed. Only a minority (7.5%) were indifferent. This is shown in table 4. In addition, more than half of the patients (53%) suffered from societal negative reactions as shown in table 5.

Table 1: Age distribution of VVF patients in Murtala Mohammed specialist hospital, Kano

Age (years)	No. (%)
10-15	42(35)
16-20	45(37.5)
21-25	23(19.2)
26-30	7(5.8)
31^{+}	3(2.5)
Total	120(100)

Table 2: Distribution of VVF patients by age at first marriage

Age (years)	No. (%)
10-15	98(81.5)
16-20	18(15.5)
20-25	4(3.5)
Total	120(100)

Table 3: Distribution of medical complications among VVF patients in Kano

Complications	No. (%)
Amenorrhoea	21(17.5)
Vulval dermatitis	37(31.0)
Dysmenorrhoea	9(8)
Foot drop	28(23.3)
Infertility	2(1.7)
Recto-vaginal fistula	7(5.8)
Recurrent UTI	11(9.2)
Dyspereunia	5(4.2)
Total	120(100)

UTI = urinary tract infection

Table 4: VVF patient's reaction to their condition

Patient's reaction	No. (%)
Bitter	61 (51.0)
Resigned to fate	10 (8.0)
Depressed	40 (33.0)
Indifferent	9 (8.0)
Total	120 (100)

Table 5: VVF patients' perception of societal reaction towards them

Societal reaction	No. (%)
Sympathetic	34(28.0)
Rejected	64(53.0)
Indifferent	22(18.0)
Total	120(100)

Discussion

The highest frequency of VVF was recorded in the 10– 15 years age brackets accounting for 78.5% of the patients. Thus, the age of acquisition of the disease could generally be said to be in the early teenage period. These findings agree with those of similar studies conducted in Zaria (Northern Nigeria) where the condition was found to be commoner among teenagers fifteen years or younger but very rare after the age of twenty-five years. [4, 9]

Among the patients studied 78.3% were illiterate and none of those who were literate had read up to tertiary level of education. This finding is consistent with that of Harrison[5] in which he reported a strong correlation between illiteracy and incidence of VVF in Zaria.

Most of the patients (81.6%) had their first marriage at a very young age of 10-15 years. This is consistent with the findings of Ampofo [6] that showed high incidence of fistulae among those who married early in a study conducted at the University of Maiduguri Teaching hospital. Early age of marriage is normally followed by early pregnancy when the pelvis is not adequate for labour. Marriages in Northern Nigeria take place more often than not either before or at puberty. [7] Despite the occurrence of teenage pregnancies in the developed countries, obstetric fistula is a rare occurrence, therefore, it can be argued that early marriage or early pregnancy per se are not the cause of obstetric fistula, but the unsupervised deliveries. If essential obstetric services are provided and utilized by all women; [14] harmful traditional practices like female genital cutting are eliminated in addition to girl-child education, [15] vesico-vaginal fistula could be prevented in the developing countries.

The findings of a larger proportion of VVF patients being unbooked for antenatal care in this study are consistent with other studies. [6,11,13] Reasons as to why most of the cases did not receive any form of antenatal care possibly include the fact that most were rural dwellers and had poor access to health services and facilities.

It is a well-known fact that VVF is associated with medical and psychosocial complications. Thus, VVF could be responsible for many serious problems, which can cripple the patient especially with respect to inability to bear any more children despite the young age of these patients. The significance of this will be better appreciated when one considers that bearing children is highly valued in this society. The plight of these unfortunate victims can be so devastating and dehumanising that even when cured after surgery some of them never regain their self esteem and as such shun social life. The low level of dyspereunia observed in this study could be as a result of separation, divorce or low self-esteem common among these patients. Economically they cannot work because they cannot stay in the public and will not be employed. The patient thus becomes an economic burden to others. These social problems were also observed by Murphy among VVF patients in Zaria. [12]

These problems highlight the need to design and implement an effective health education programme on female education, family life education and utilization of maternity services especially in rural communities. Local governments should have a special counselling and enlightenment programme in their localities for religious and traditional leaders on the subject of VVF in particular the need for community participation in providing transportation and other logistic support so as to avail every pregnant woman with essential obstetric care-particularly so during emergencies.

It is reported that 70 – 75% of all deliveries in Nigeria are attended by traditional birth attendants. [8] Therefore, the need by local governments to train more traditional birth attendants in their localities as a short-term measure with a view to making special emphasis on skills to enable early detection and referral of patients at risk of developing VVF cannot be over emphasized. Health workers in remote peripheral health centres should refer very early to an appropriate health facility any woman with the risk of developing VVF they come in contact with.

This study has highlighted the fact that VVF patients suffer physically, emotionally and socially. The findings here largely agree with findings

of earlier studies except for the earlier undue emphasis laid on early marriage as aetiology of the disease. The lack of skilled supervision and adequate obstetric emergency facilities are to blame. The medical and social consequences of the disease amount to agony and unqualified tragedy of its unfortunate victims while the disease is largely preventable.

Acknowledgements

We are indebted to the authorities of Murtala Mohammed Specialist hospital for giving permission to undertake the study.

References

1. Lawson J.B. Urinary tract injuries. In: Obstetrics and gynaecology in the tropics and developing countries. Arnold, London, 1988; 481-522.
2. Tahzib F. Social factors in the aetiology of vesico-vaginal fistula. Women and the family in Nigeria. Council for the development of economic and social research in Africa. Dakar, Senegal, 1985; 75-79.
3. Robertson E. M. Foreword to urologic injuries. Davies, Philadelphia. 1957.
4. Ekwempu C. C. Fistulae. Textbook of obstetrics and gynaecology for medical students. University services publishers. 1988; 46-60.
5. Harrison K.A. Childbearing, health and social priorities: a survey of 22,774 consecutive hospital births in Zaria, northern Nigeria. Br J Obstet Gynaecol (Suppl) 1985; 5: 91-97.
6. Ampofo K, Otu Y. Uchebu G. Epidemiology of vesico-vaginal fistula in northern Nigeria. West Afr J Med 1990; 9: 98-102.
7. Ibrahim T, Sadiq A.U, Daniel O.S. Characteristics of vesico-vaginal fistula patients as seen at specialist hospital Sokoto, Nigeria. West Afr J Med 2000; 19: 59-63.
8. Itina S. M. Characteristics of traditional birth attendants and their beliefs and practices in the Offot clan, Nigeria. Bull World Heath Organ 1997; 75:563.
9. Tahzib F. Vesicovaginal fistula in Nigerian children. Lancet 1985; December: 1291-1293.
10. Waaldijk K. Evaluation report XVII national VVF-project Nigeria. Federal Ministry of Health. 2001; 2.
11. Tahzib F. Epidemiological determinants of vesicovaginal fistulas. Br J Obstet Gynaecol 1983; 90:387-391.
12. Murphy M. Social consequences of vesicovaginal fistula in northern Nigeria. J Biol Sci 1981; 13:139-150.
13. Lister U.G. Vesicovaginal fistulae. Postgrad Doct 1984; October: 321-323.
14. Prevention of maternal mortality network. Barriers to treatment of obstetric emergencies in rural communities of West Africa. Stud Fam Plann 1992; 23: 279–291.
15. Ojanuga N.O. Education: the key to preventing vesico-vaginal fistula in Nigeria. World Health Forum 1992; 13: 54–56.
16. WHO. Obstetric fistula. Maternal health and safe motherhood programme. 1991 (WHO/MCH/MSM/91.5).