Aspects of Social Problems of Vesico-Vaginal Fistula Patients in Kano

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Abstract

Objective: To review some of the medical and social problems experienced by vesico-vaginal fistula patients.
Methods: A hundred and ninety-one consecutive vesico-vaginal fistula patients coming for repair at the Murtala Mohammed specialist hospital, Kano were interviewed using a pre-tested questionnaire. The data generated was analysed using basic descriptive statistics.
Results: The mean age of these 191 patients was 28.8 ± 8.4 years. They have had fistula for an average of 3.4 years. A hundred and twenty-eight (67.1%) were either divorced or separated from their spouses because of the fistula, majority are illiterates, engaged in menial jobs. They travel long distances before accessing repair services. Eighty-four, (34%) have had at least 1 previous failed repair.
Conclusion: Patients with vesico-vaginal fistula, experience great deal of social problems and are often times neglected even by their immediate family. Repair services are scarce and few are of good quality.

Introduction

Obstetric fistula is the most devastating consequence of obstructed labour and has eminently dominated the wider spectrum of injuries resulting from it.[1, 2, 3]. Vesico-vaginal fistula as a sequelae of obstetric events is still common in developing countries, many years after it has been eradicated in societies where obstetric care has advanced.[4] Neglected obstructed labour causing ischaemic necrosis of the bladder account for over 90% of the cases[2]. The medical problems of patients with obstetrics fistula have been described[5, 6], some of these are shown to persist even after a successful closure[1]. Reports on the social problems of VVF patients are however few[7, 8]. Yet vesico-vaginal fistula poses both social and physical challenge to the patients. In fact, it is argued that while most physicians think in terms of clinically definable injuries, much of the suffering that fistula patients endure is a result of the social consequences of their condition[9]. Whereas, some of the medical problems persist even after successful repair, the social problems almost completely reversed upon an effective repair[8]. Unfortunately efficient repair services are scarce and not readily affordable.

The objective of this study is to highlight the medical and social problems of VVF patients as seen in the VVF Centre in Kano state.

Patients and Methods

This is a cross sectional survey of consecutive obstetric fistula patients coming for repair in the Murtala Mohammed Specialist Hospital between 1st January 2002 and 30th June 2002. Two trained community health extension workers administered a pre-tested survey instrument to the patients. Information relating to their bio-data, demographic characteristics, antecedent pregnancy, labour and the after care were obtained. Duration of time for which they had the fistula and the number of previous repair were recorded. The data was analysed using basic descriptive statistics and presented in tables and percentages.

Results

In the period under review 200 consecutive VVF patients were interviewed. A hundred and ninety one (95.5%) had complete information and were included in the analysis. The mean age of the patients was 28.8 ± 8.4 years, (14-55 years). Average age at marriage was 15.4 years (12-23 years) and the average age at first pregnancy was 16. 3 years. The mean duration for which they have had the fistula was 3.4 years (<1 year to 27 years).
Only 140 (73.3%) of these patients were still married legally, of which 55 (39.2%) were currently leaving with the husbands, 85 (44.9%) were separated because of the fistula while 45 were divorced, 43 (22.5%) after sustaining the fistula. Two patients aged 50 years and 55 years were both widowed for over 20 years. 72 (51.4%) of the 140 patients legally married were in polygamous settings, 61 (84.7%), of which had their husbands taken a wife after they sustained the fistula.

A hundred and forty-four (75.4%) of the patients had no education whatsoever, 14 (7.3%) had informal education while 19 (9.9%) were educated up to primary school level. Only 1 had tertiary education. Most of their parents were similarly illiterate (Mothers 180 (94.2%), fathers 163 (85.3%). Their spouses were largely illiterate also. The average monthly income for the patients was N541.66 (US$3.9) (range N20-2,500), the corresponding figure for their spouses was

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N7,220.83 (US$52.3) (N1,000-20,000). 109 of the patients were not gainfully employed, the remainder engaged in various handcrafts (table II). Majority of their spouses, were subsistent farmers and labourers. 23 (16.4%) of the patients not currently married were self-employed and support themselves exclusively but decline to disclose the nature of their trade.

The table showed the parity distribution. Only 15 (7.9%) patients had living children from the antecedent pregnancy, 118 (61.8%) had fresh still birth 45 (23.6%) macerated still birth and early neonatal death in 8 (4.2%) cases. 107 (56.0%) patients had no previous attempt at repair 50 (26.2%) had a failed attempt, 21 (11%) had 2 previous attempts (table IV). Twenty-three (12.0%) of the patients had "Gishiri Cut", 17 (73.9%) because of obstructed labour, 3 genital prolapse, the rest for coital and menstrual problems.

Only 68 (35.6%) of the couples have heard of obstetric fistula before the incident. On access to place for repair, majority of the patients 158 (82.7%) had to travel long distances by lorries or vans to access repair, after residing for several weeks in waiting homes. Over 50% of them had to travel various distances on foot to market places/stations where they could board the lorries/vans. A patient with bilateral foot drop was brought into the hospital on a wheelbarrow.

Discussion

Statement of the principal findings

In this review, spousal response to the calamity of obstetric fistula was divorce in 43(22.5%) cases, separation in 85(44.9%) cases and prolonged widowhood in the case of two patients. In 61(31.9%) cases the spouses took in an additional wife. Vesico-vaginal fistula has since been identified as a major cause of divorce and marital disharmony [7]. In Ethiopia, the rate of divorce or separation among these patients was up to 50%[9]. The major highlight in this study however is that these patients live under these conditions for an average of 3.4 years in some cases up to 27 years before accessing repair.

This becomes quite worrisome if one reflects on their social standing and means of sustenance. 144 (75.4%) of the patients had no formal education and 9(4.7%) had secondary school education. Indeed most of the patients 119 (62.3%) were not gainfully employed even those with identifiable source of income were mainly in low earning menial jobs. Not surprisingly the average monthly income in these patients was N541.66 (US$3.9) the income among their spouses, parents, and their literacy levels were similarly low. In our discussion with these patients, 23(12.0%) unmarried women, said they live by themselves, support themselves and were self employed however they all decline to disclose the nature of their trade. Some people have posited the possibility of commercial sexual activity among fistula patients toward the end of their ostracisation spectrum[7]. Should this be the situation in this high number of patients, the main concern today will border on the spread of HIV considering the likelihood of unsafe sexual practices in patients who are at increased risk of gynaetresia.

Table 1: Social and Clinical Characteristics of the Patients

Age	**n**	**%**
<15	4	2.1
15-19	62	32.5
20-24	60	31.4
25-29	25	13.1
30-34	16	8.4
≥35	24	12.5
Total	191	100
Parity	**n**	**%**
1	109	57.1
2	25	13.1
3	21	11.0
4	11	5.7
5	4	2.1
>5	17	8.9
None	4	2.1
Total	191	100.0
Marital Status	**n**	**%**
Married -living with the husband	55	48.8
Separated	85	44.5
Divorced	45	
-Before the fistula	2	1.0
-after the fistula	43	22.5
Not stated	4	2.1
Widow	2	1.0
Total	191	100.0
No. of attempts At repair	**n**	**%**
None	107	56.0
Once	50	26.2
Two	21	11.0
>2	13	6.8
Total	191	100.0

Strengths and weakness of the study

The strengths of this study include the fairly large number of subjects and the fact that it was prospectively conducted, thereby allowing for more comprehensive data sourcing. Most other reviews were retrospective and are often on smaller number of patients[8,12].

Comparison of current findings with those of other studies

Vesco-vaginal fistula complicating obstructed labour is still a major morbidity in our practice. This

complication is a major source of social distress to the patients. The mean age of the patients at marriage was 15.4 years (range 12-23years) and average age at first pregnancy was 16.3 years (range 13-24 years), this is similar to what Tahzib and Harrison reported earlier [7,8] from Northern Nigeria. In Southern Nigerian where obstetric fistula is far less prevalent majority of the patients are between 20-29 years at the time they sustained the injury[4,5]. Majority of our patients 107 (56%) were nulliparous, and only 22 (11.5%) were of high parity. These again contrast clearly from reports in other parts of Nigeria [9, 10] and agree with all the reports [7,8,12] from the north. Beyond this however is the extent of fetal wastage that come to bear even at the high cost of vesico-vaginal fistula, for example only 2 of the 107 patients with one previous pregnancy had a living child from these pregnancies. Overall in this review the fetal case fatality was 91.4%. Similar high perinatal wastage has been reported among patients with obstructed labour with far reaching psychological sequelae[1]. This psychological concern is accentuated where the patient in addition has a fistula as in our cases.

Overall meaning and implications of the study

The implications of these findings are that, effort should be made to treat fistula patients early, to ensure timely social re-integration. Policies should evolve that enhance girl child education, discourage early marriage and enhance women empowerment. As noted in this study access to repair is difficult, and it is evident that the quality of available repair services is still of concern. In this population, 158 (82.7%) had to travel long distances in lorries and/or vans before reaching the repair centre. Only 107 (56%) of the patients were coming for first repair the rest had varying number of attempts with one patient coming for the seventh attempt. This patient had severe acquired gynaetresia obliterating the whole vagina with the attendant sexual and reproductive consequences.

It was remarkable that 23 of these patients had "Gishiri Cut", 17 (73.9%) on account of obstructed labour. This practice mitigate on the sexual and reproductive rights of women,[13] is harmful, dangerous and needless and shall be specifically targeted especially with the epidemics of HIV/AIDS and Hepatitis B and C in our population.

Unanswered questions and areas for future research

Further studies need to look at specific issues such as psychological disorders in this population, sexual practices and sexually transmitted infections including HIV, Hepatitis B and C.

Conclusion

Childbearing in teenage, amongst illiterate people in our society has continued to fuel the devastating medico-social problem of obstetric fistula. The young patients suffer undue amount of hardship which life has not adequately prepared them for. The personal menace persists for a long time owing to dearth of quality repair services, and the very low social status of the people involved. Strategies to address this menace must centre squarely on the education of the female child, as that is the only means of sustainable empowerment. On a short-term basis free care services and rehabilitation of the affected patients may prove useful. For this to be far reaching it must be supported by comprehensive health education to the affected population.

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