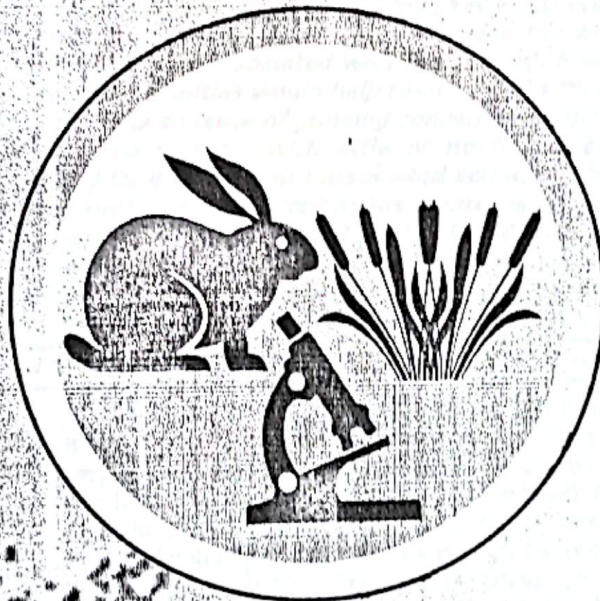


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VESICO-VAGINAL FISTULA (VVF): A SOCIAL MENACE IN JOS NORTH, PLATEAU STATE, NIGERIA

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ABSTRACT

Following the growing concern over the increasing reports of morbidities associated with delivery in the Northern and North-central parts of the country. Socio-economic impact survey of vesico-vaginal fistula (VVF) in young women was conducted in Jos-North local government area in Plateau State, Nigeria using hospital file records, questionnaires, supported with oral interviews and discussion session with 50 VVF patients. The study was carried out at the ECWA Evangel Hospital (Bingham University Teaching Hospital) popularly called "Jankwan Hospital" in Jos metropolis. The findings showed that young married women (76.0%) between the ages of 14-20 years who were experiencing their first delivery as at the time of this ailment were mostly affected. Most of these victims were housewives (48.0%) with primary school education training and majority (60.0%) practicing doctrines of Islamic faith. However, 38.0% of these victims were Christians and a few (2%) traditionalists. Investigations revealed early marriage, prolonged labour and poverty were the striking causes of VVF. Further interview with the victims revealed that victims are often rejected by their wards, siblings and health care personnel. They also find it difficult to re-integrate in to their societal economic chores and would rather prefer the household activities due to stigmatization following complications associated with the ailment. Most victims (76.0%) were of the opinion that creating job opportunities would help re-integrate sufferers back into their various communities. In conclusion, VVF is an issue of growing concern amongst young early child bearing, low income generating, married women, with little or no formal education in some Muslim communities in Jos-North and its environs with associated serious social, economic, and religious implications. It is therefore suggested that continuous awareness and advocacy programmes on the ailment be conducted particularly in regions of high risk and endemicity at grassroots level in collaboration with Government, Non-governmental and faith-based organizations. The goals of Gender and Development and the need for adolescent girls and young women to negotiate for safe sex, matured age of marriage as well as girl child education should be emphasized.

Keywords: Vesico-vaginal fistula, socio-economic impact, young women, Jos-North.

INTRODUCTION

Vesico-vaginal Fistula (VVF) is one of the worst morbidities associated with delivery. It is an abnormal opening of the vaginal wall to the bladder or rectum or both at the same time that results in the leakage of urine (VVF) or faeces (RVF) or both (Sambo, 2003). This preventable, distressing and dehumanizing public health condition is still prevalent in developing countries of the world (Iyaya, 2002) and has continued to affect the status of young women and their child bearing capacities especially in West Africa (Waalwijk and Armiya'u, 1993). Historical reports reveal that occurrence of VVF dates back to 2050BC when it was observed in the mummies of Ancient Egypt. The first reference was to 1550BC and later linked to obstructed labour in 1030AD (Salfuddin and Holtz, 2005). Between the 17th and 19th centuries VVF was a problem in much of what is now the

developed world, including the US and Europe (Aldridge, 1953). The principal cause of VVF is "unrelieved" obstructed labour, this means that in an situation, where health facilities is available to prevent obstructed labour and pregnancy monitored six months prior to the onset of labour, the likelihood of obstructed labour is minimized (Iyaya, 2002). However, Many factors have been associated with this problem amongst women such as the Islamic culture, the practice of Purdah (wife seclusion) which restricts women access to medical care and universal female literacy, early pregnancy and marriage before maternal pelvic growth is completed, high rate of obstructed labour, harmful traditional beliefs and practices of genital mutilation such as the harmful and poorly conducted gishiri cut and cutting of vagina to widen the birth canal (Wall, 1998).



Today, in Nigeria, the problem of VVF is on the increase as the general development of the community declines, despite the availability of VVF repair facilities in some hospital. This has been associated with the general under-development of the community health services, structures and widespread poverty that has entrenched the lives of majority of the populace (Mohammed, 2002). These injuries may lead to cascade of physical, social, and physiological catastrophes, leaving victims as outcast, enduring unimaginable pains (Sambo, 2003). Socially, over 90% of women affected with VVF are rejected by their husbands and the society due to their childlessness (Ijaiya and Aboyeji, 2004). Emotionally, they lose their self esteem and remain a recluse and often end up on the street begging for survival (Sambo, 1994). Besides the continuous leaking of urine and some faeces, physical and physiological effects can be noticed which include; Amenorrhea (Harrison, 1998), Vaginal necrosis (destruction), making sexual activity nearly impossible following healing and scar formation (Saifuddin and Holtz, 2005) and Foot-drop: This limit the woman's mobility and ability to perform her day-to-day activities thus becoming economically unproductive (Mohammed, 2002). In the rural areas the reported prevalence rate is high due to inadequacy of facilities for pre-and-post natal care, inaccessibility of patients to repair centres due to long distance locations, high cost of care, ignorance and poor nutrition. Available data show a very high incidence and prevalence of VVF in the northern, south-eastern, and middle belt regions of Nigeria (FMH, 1999; Ijaiya, 2002; Sambo, 2003; Sambo, 2008) as being a function of early age at delivery, that tends to occur mostly below the age of 15 years (39.02%) and between ages of 15 and 19 years (36.59%) (Tanko and Sambo, 2006) with associated serious child birth complications, high morbidity and maternal mortalities (Ijaiya, 2002). Recent reports revealed an estimated 2,000 women are living with Vesico-Vaginal Fistula (VVF) in Bauchi State (Ehiabhi, 2011). It is against this background that the present study seeks to establish the occurrence and socio-economic scenario of VVF as it affects woman victims in Jos-North, Plateau State as well as proffer suggestions to help curb the social menace.

MATERIALS AND METHODS

Materials

The hospital, which was popularly called "Jankwano" is now known as Bingham University Teaching Hospital and is located in the city of Jos, near the Polo ground was used for this study. The material used in conducting this research to harness primary data included questionnaires (Appendix I) and open-ended oral interviews with victims at the VVF ward of the ECWA Evangel Hospital, Jos as earlier conducted by

Tanko and Sambo (2006). The questions were designed to explore the common causes of VVF amongst young women and how they were perceived by the society as well as the possible effects of this ailment on their economic chores post discharge from the hospital. Existing records from hospital case files of the selected victims were used to gather secondary data (personal characteristics) such as age of patients, marital status, religion, profession and the final diagnosis (Ijaiya and Aboyeji, 2004).

Study area

Jos is a city and the administrative capital of Plateau state which is in the middle belt of Nigeria. It is located on 9°86' N and 8°90' E high on the Jos Plateau. The city is divided into three local government areas namely Jos-North, Jos-South, and Jos-East with an altitude of 4,062 feet (1,217m) above sea level. It enjoys a moderate climate with a monthly average temperature range of 20° – 25°C and is covered by grassland (Anon, 2011a). Plateau State is bordered by Bauchi State – to the north east, Kaduna State – to the north-west, Nasarawa State – to the south west and Taraba State – to the south east. The State is further subdivided into seventeen Local Government Areas with over forty ethno-linguistic groups. These ethnic groups are predominantly farmers and have similar cultural and traditional ways of life. People from other parts of country have come to settle in the State; these include the Igbo, Yoruba, Ijaw, Bini and Hausa predominating in Jos North as well as Fulani/Kanuri in Wase (Anon, 2011b).

Research design

The research design employed in this study is a social survey as recommended by Major and Savin-Baden (2010), for managing information about a large group using a representative portion of the study population in social science research, while seeking to understand people with severe intellectual disabilities, including those with little or no spoken language as adapted (Hubert and Hollins, 2007).

Study population

The target population for this study was those women victims of VVF admitted in the VVF ward of the ECWA Evangel Hospital whom are referred to as case, while other women admitted in the hospital for various ailments other than VVF were referred to as a control. The total number of cases for the year 2011 as at the time of this study was one hundred and fifty-two cases (152).

Sampling technique and sample size

The sample technique used in this study was a systematic sampling method where every one in three cases were considered and selected for this survey. This gave the sample size of 50 (fifty cases).



Data presentation and statistical analysis

The personal characteristics and responses to the questionnaire in this study were analyzed using descriptive statistics such as frequency and percentages (Ijaiya and Aboyeji, 2004)

RESULTS AND DISCUSSION

Out of the 50 respondents, (Table 1) indicating the demographic distribution of the victims shows that 76.0% were married women between the ages of 14-20 years (50.0%) who were experiencing their first delivery as at the time of this ailment. Other victims were in the age range of 21-25 years (20.0%) and 26-30 years (12.0%). This agrees with the reports of Ijaiya and Adebeyeji (2004) that states VVF occurs in both young and older women. In addition, most of the victims were housewives (48.0%) with just primary school education training while majority (60.0%) of them was practicing Muslims. This connotes the reports of Tanko and Sambo (2006), which earlier stated VVF affected largely uneducated female folks with only 10% having secondary or above education and 8.1% having completed primary school. A reason that emerged for this, from their focus Group discussion, was the insignificance of female education because of their subsequent withdrawal from school for marriage as western education was said to be un-Islamic. As a result of this, females were mainly engaged in petty trading (54.9%) relying on their children, due to the practice of purdah which is inconsonance with high occurrence of ailment amongst the Muslims (81.8%) and Hausa (60.8%) communities. However, (38.0%) of these victims were Christians and a few (2.0%) traditionalist in this study. The respondents' opinion on the causes of VVF indicated that early marriage (46.0%), prolonged labour (24.0%) and poverty (14.0%) were the most common causes of this ailment. This connotes similar works of Braddock and Mohammad (1996) which indicates that 'VVF is as a result of poverty and gender discrimination, under-development, harmful traditional practices, low status and educational level of women, lack of primary health networks and maternal and child health (MCH) care, and lack of accessible Caesarean services. Wall, (1988) reported early marriage, prolonged labour and cultural practices, while lack of girl child parental care, early unsafe sex life, marriage and child birth irrespective of physical and emotional maturity were suggested as causes by Sambo, (2003). Sambo, (2008) stated low status of women, poverty, ignorance, access and use of available health care services as well as cultural practise that mitigates safe motherhood as causes of VVF. However, Ijaiya, (2002) stated that the principal cause of VVF is prolonged labour. The respondents' opinion to the administered questionnaires as indicated in Table 2 showed that most of respondents (92.0%) agreed that they were perceived negatively in an unpleasant manner by the society while (8.0%) felt positively accepted by their neighborhood. The attitude of hospital staff towards these patients during course of treatment was characterized by reluctance (46.0%). However, some staff showed some level of sympathy (24.0%) and care (26.0%) but in extreme situations avoidance, as highlighted by a few (4.0%) of the respondents. These findings are similar to reports of Wall, (1998) which

reported victims were rejected by their husbands, families and friends. As a result they become outcast, being unable to participate in social activities such as commuting public transportation with negative effect on daily livelihood as emphasized by Mohammed, (2002). Most respondents (96.0%) agreed that consequences of untreated VVF is dangerous and would become unfavorable. This agrees with earlier reports on the harsh consequences such as loss of self esteem (Sambo, 1994), Amenorrhoea (Harrison, 1998), Vaginal necrosis (destruction) and scar formation making sexual activity nearly impossible following healing (Saifuddin and Holtz, 2005) and Foot-drop which limits the woman's mobility and ability to perform her day-to-day activities thus becoming economically unproductive (Mohammed, 2002). These effects of VVF is a consequence of delay in deciding to seek help; delay in gaining access to where help can be given and delay in getting help when the facility has been reached. The delay in decision may be cultural, social or educational; delay in accessing help may be geographical, topographical, psychological or economic and lastly delay in getting help is a problem of the health services delivery system e.g. inadequate facility, attitude to workers or bureaucracy as reported by Sambo (2003). Child birth complications, death of the baby, women divorce, and socio-economic hardship were documented by Sambo, (2008) as other consequences of this ailment. The respondents' suggestion on possible methods of preventing VVF reveals that most (48.0%) advocated for an adequate age of marriage while others (28.0%) and (24.0%) felt early medical and proper health education respectively will greatly aid the control of this ailment. This connotes earlier suggestions of Mohammed (2002) that stated counselling should form part of a whole package of rehabilitation which ideally should start with the treatment but should not end with it as social re-integration should take different forms according to different cultural norms in specific areas (Alubo, 2010). Other suggestions, such as prevention of behavioral patterns that are dangerous to the society particularly those that affect women's health in modern societies using laws against child labour and early and forced marriages can be used to foster the development of women and the society as stated by Ozo-Eson, (2008) also connotes respondents opinion in this study. These victims (76.0%) proffered solutions as to the possibility of re-integrating victims by giving job opportunities to those rejected by their husbands. Some (18.0%) suggested rehabilitation in designated centres and others (6.0%) felt that affected women should be reconciled with their divorced husbands. All these suggestions were earlier proffered by Mohammed, (2002), who also reported efforts of FORWARD (NGO) that implemented VVF surgery and rehabilitation project in Kano State – Nigeria for 6 years with funding from the UK as well as help from local Philanthropists and volunteers. Further discussion with these women during the course of this study revealed that the VVF women victims were willing to learn more about this ailment and to share their experiences with other women in their communities if they are encouraged and accepted back into the society.



They also reiterated the fact that poverty and lack of access to health services aggravates the occurrence of VVF, which affects women's status psychologically, socially, physically and economically.

CONCLUSION

In conclusion, VVF is an issue of growing concern amongst young early child bearing, low income generating, married women with little or no formal education in the Muslim communities in Jos-North and its environs with associated serious social, economic, and religious implications which requires urgent attention to save the lives of young women and enhance their participation in nation building and sustainable development.

RECOMMENDATIONS

It is therefore suggested that Mass awareness and sex education campaign using mass media publicity as well as Gender base adult literacy classes in collaboration with faith based organization in both urban and rural

communities which will emphasize the adverse effects of early pregnancy and marriage be executed. NGOs, CBOs and Government should design and implement programmes that emphasize avoidance of early marriage and the need for proper and regulate ante natal care that will prevent the occurrence of this fistula and other related complications of obstructed labour. This should be re-enforced by training of health and social welfare officers on the subject of VVF who in turn educate their target groups. Finally, creation of multipurpose rehabilitation centers (by government and or in collaboration with NGOs, local philanthropists, and international donor partners) in the society for victims instead of roaming the streets to facilitate quick recovery from the presumed socio-psychological trauma associate with the ailment in the end becoming economically empowered. As seen in the case of the Dambatta initiative implemented by FORWARD - Nigeria based in Kano (FORWARD, 2002).

Table: 1 Demographic distribution of respondents by personal characteristics

Age (years)	Frequency	Percentage (%)
Below 14	5	10.0
14-20	25	50.0
21-25	10	20.0
26-30	6	12.0
31-35	4	8.0
Total	50	100
Marital status	Frequency	Percentage (%)
Single	5	10.0
Married	38	76.0
Separated	3	6.0
Divorced	4	8.0
Age at first pregnancy (years)	Frequency	Percentage (%)
14-20	35	70.0
21-25	12	24.0
26-35	3	6.0
Religion	Frequency	Percentage (%)
Christian	19	38.0
Muslims	30	60.0
Traditionalist	1	2.0
Educational Qualification	Frequency	Percentage (%)
Non-formal	13	26.0
Primary	21	42.0
Secondary	10	20.0
Tertiary	6	12.0
Occupation	Frequency	Percentage (%)
Farmer	12	24.0
Civil servant	4	8.0
Trader	6	12.0
House wife	24	48.0
Unemployed	4	8.0
Total	50	100



Table 2: Respondents' opinion to the administered questionnaire

Respondent opinion to causes of VVF	Frequency	Percentage (%)
Early marriage	23	46.0
Height	3	6.0
Prolonged labour	12	24.0
Poverty	7	14.0
Ritual cleansing	4	8.0
Ignorance	1	2.0
Total	50	100
Respondent opinion on societal attitude to VVF victims	Frequency	Percentage (%)
Negative (Unpleasant)	46	92.0
Positive (pleasant)	4	8.0
Respondent opinion on Health personnel attitude to VVF victims	Frequency	Percentage (%)
Sympathetic	12	24.0
Caring	13	26.0
Reluctant	23	46.0
Avoidance	2	4.0
Respondent opinion on the consequences of untreated VVF victims	Frequency	Percentage (%)
Unfavorable	48	96.0
Favorable	2	4.0
Respondent opinion on VVF preventive methods	Frequency	Percentage (%)
Health education	12	24.0
Marriage at maturity age	24	48.0
Early medical intervention	14	28.0
Respondent opinion on re-integration of VVF victims into the society	Frequency	Percentage (%)
Provision of job opportunities to those neglected by their spouse	38	76.0
Rehabilitation by designated centers	9	18.0
Reconciliation of divorced victims with their spouses	3	6.0
Total	50	100

APPENDIX I

Questionnaire for the research survey on the socio-economic impact of Vesico-Vaginal Fistula in women in Jos- North communities in Plateau State, Nigeria

Dear respondent

Below is a questionnaire to determine the socio-economic impact of Vesico Vaginal Fistula in women in Jos North, Plateau State, Nigeria. The usefulness of this survey is to contribute to the knowledge on prevalence and socio-economic burden of Vesico Vaginal Fistula in women in the state. I appeal to you to give honest and accurate answers to each question. Please, your cooperation is highly needed as all information provided will be treated with utmost confidentiality.

Thank you

Please tick as appropriate

- Marital status:
Single () Married () Separated () Divorced ()
- Age:
Below 14year () 14-20 () 21-25 () 26-30 () 35and above ()
- Educational Qualification:
Non-Formal () Primary () Secondary () Tertiary ()
- Occupation: Farming () Civil Servant () Trading () Student () Housewife () Unemployed ()
- Religion: Christianity () Islam () Traditionalist () None of the above
- Age at first pregnancy _____
- To what extent do you agree that Vesico vaginal fistula is caused by the following?

Cause of VVF	Strongly agree	Agree	Disagree	Strongly disagree	No idea
Early marriage					
Prolonged labour					
Ritual cleansing					
Ignorance					

8. To what extent do you think your present condition has greatly affected your marriage and relationship with your loved ones
A great extent () some extent () Not at all ()
- 9a. How many wives does your husband have?
Only One () Two () Three () Four () more than four ()
- b. When did he marry you and or the others?
10. What is the staff attitude towards your condition in the course of discharging their duties?
Sympathetic () Caring () Reluctant () Try to avoid us ()
11. Does untreated cases of VVF affects a woman's psycho-social function?
Strongly Agree () Agree () Disagree () strongly disagree ()
12. Normally (Physiologically) how do you feel with this condition?
13. What is the peoples' reaction towards you when you get close to them?
14. How do you think this problem of VVF should be managed?
15. Give any useful suggestion as to how this problem can be prevented or eradicated in Jos
16. In your own opinion what are the possible ways women suffering VVF could be assisted or re-integrated back into the society

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