

CHAPTER IV

RESULTS

A total of 380 married women of reproductive age (15-49 year old) voluntarily participated in the study. The study was carried out in 15 political wards of Birnin Kebbi Local Government area of Kebbi State Nigeria namely: Ambursa, Dangaladima, Gawasu, Gulumbe, Gwadangaji, Kardi, Kola/Tarasa, Lagga/Randali, Makera, Marafa, Maurida/Karyo, Nassarawa I, Nassarawa II, Ujariyo and Zauro. The respondents have been selected in proportion to the total population of the respective 15 wards within the randomly selected 30 settlements.

4.1 Socio demographic and socio cultural characteristics

Table 1 shows the frequency distribution of basic demographic information of all the respondents such as age, religion, education, occupation, marital status, age at first marriage and number of parity.

Age:

The range of women was divided into seven categories. Majority of the subjects fall under the age group of 25-29 (23.9%) followed by 20 – 24 (17.9%). Age group 30-34 (14.7%) and 15-19 (14.2%) had almost getting the same percentage of respondents. The lowest age group in the study is 45-49 years which had 4.2%. The mean age was 28.82 and SD was 8.34.

Religion:

The religion system in Kebbi State prevails that, majority of the respondents belong to Islamic group (99.5%) while Christianity counted for (0.5%) respectively.

Education:

Most of the half of the total study respondents (45.8%) has Quranic education, (36.1%) lacks any formal education followed by (10.3%) that had basic Education of primary school. About (6.3%) had secondary education and only (1.6%) had received education till tertiary institution.

Occupation:

Almost three quarter (39.5%) of the respondents were housewives and did not have any work to do within their matrimonial house, followed by (30.9%) are daily employee either in their houses or outside. Only (21.3%) are petty traders, while (5.5%) had animal husbandry/poultry and the rest (2.9%) has little income activities.

Marital Status:

Most of the respondents of the study were married (72.6%) with (16.8%) of them being separated and (9.2%) were divorce. Only (1.3%) of them being widowed.

Age at first marriage and Birth of first child:

The age range of women at their first marriage was found to be 12-24 years Majority of women (63.7%) had their first marriage between the age of 12-15 years and the least was 24 years at (5.5%). The mean and standard deviation was 15.48 and 1.96. Also (56.3%) of women had their first baby between the ages of 14-17 years while only (3.1%) had their first baby between the ages of 22-25. The mean and Standard deviation was 16.53 and 4.54 respectively.

Total number of Pregnancy and Children:

Most of the respondent were found to have between 0-3 children (59.7%) and 36.1% of them had 4-7 children. The percentage of women that had between 8-11 children was 4.2. The total number of pregnancies which includes (live birth, still birth, abortion and dead children), women who had two or three pregnancies found to be the highest with 26.3% and those with four to five were 24.5%. While 21.9% of the women had 0-1 pregnancies and the least women (1.8%) had between 12 to 13 pregnancies.

Table 1 Socio Demographic and Socio-cultural Characteristics

Characteristics	Frequency	Percentage
Observation (n=380)	380	100
Age		
15-19	54	14.2
20-24	68	17.9
25-29	91	23.9

30-34	56	14.7
35-39	59	15.5
40-44	36	9.5
45-49	16	4.2
Mean±SD	28.82±8.34	
Religion		
Islam	378	99.5
Christainity	2	0.5
Educational Status		
Quranic School	174	45.8
Primary School	39	10.3
Secondary School	24	6.3
Tertiary Institution	6	1.6
None	137	36
Occupation		
Housewife	150	39.5
Daily employment	117	30.8
Petty trading	81	21.3
Animal husbandary/Poultry	21	5.5
Others	11	2.9
Marital Status		
Married	276	72.6
Widow	5	1.3
Divorce	35	9.2
Separated	64	16.8

Table 1 (continued) Socio Demographic and Socio-cultural Characteristics

Characteristics	Frequency	Percentage
Age at first Marriage		
12 to 15	242	63.7
16-19	117	30.8
20-24	21	5.5
Mean ± SD	15.48±1.96	

Characteristics	Frequency	Percentage
Age at birth of first child		
14-17	201	56.3
18-21	145	40.6
22-25	11	3.1
Mean ± SD	16.53± 4.54	
Total number of pregnancy		
0-1	83	21.9
2-3	100	26.3
4-5	93	24.5
6-7	57	15
8-9	24	6.3
10-11	16	4.2
12-13	7	1.8
Total number of living children		
0-3	227	59.7
4 to 7	137	36.1
8 to 11	16	4.2

4.2 Utilization of maternal health services

Table 2 describes the utilization of various types of health services by the respondent at their settlement. They were permitted to respond to more than one type of health services they demanded when they had health problems. Most of the respondent prefers to visit Public health facility (77.4%). Women seeking for traditional healers are (13.4%) while (8.7%) are not going anywhere for health services. Only (0.5%) of the respondents visited the private health institution.

Table 2 Utilization of maternal health services by the women

Items	Frequency	Percent
Public Health Facility	288	77.4
Private Health Facility	7	0.5
Traditional healers	51	13.4
Others	32	8.7

Among the respondents that did not seek for health services at the health facility (44%) cited due to financial constraint in Table 3. Most of the women 31.7% not having husband support as their reason followed by (13.4%) who cited due to lack of interest, while (8.5%) of the women could not visit the health facility due to poor road network. The remaining (2.4%) were not able to visit the health facility due to lack of transportation.

Table 3 Reasons for not visiting health facility

Reasons (n=82)	Frequency	Percent
Poor road network	7	8.5
Financial constraint	36	44.0
Lack of transport	2	2.4
No husband support	26	31.7
Others	11	13.4

For the mode of financing health services, majority of the respondent (72.6%) were getting support for health services from their husband while (14.2%) of the women paid for their health services by themselves. Others obtain support by their parent and free government services.

Table 4 Mode of financing health services

Items	Frequency	Percent
Out of pocket	54	14.2
Husband support	276	72.6
Parent support	46	12.1
Free government services	4	1.1
Total	380	100.0

In terms of availability of female health care provider at the health facility, (52.1%) of the respondents stated not having female health worker in the health facility at their settlement in (Table 5). Only (43.4%) indicated having female health worker in the health facility of their settlement while, 4.5% of the respondents would not respond to the question as they are not visiting the health facility.

Table 5 Availability of Female Health Workers at Health Facility

Items	Frequency	Percent
Yes	165	43.4
No	198	52.1
Not responded	17	4.5

Majority of the respondent (66.9%) did not go for ante- natal care when they are pregnant and also post natal care after delivery (76.9%) as shown in Table 6. Those that had more than 4 times ante natal care were 12.3% and the rest had 4 to one time of ante natal visit. However, very few of the respondents had received post natal care after their delivery.

Table 6 Ante natal and Post natal Care visit

Observation (n=366)	Frequency	Percent
Number of Ante natal care visit		
>4 times	45	12.3
4 times	16	4.4
3 times	26	7.1
2 times	21	5.7
Once	13	3.6
None	245	66.9
Number of Post natal care visit		
None	277	76.9
Once	44	12.2
Many times	39	10.8

Table 6 shows the type and mode of delivery practice by the respondent. Their responses refer to the last delivery of the child. Most of the deliveries by the respondent took place at home (77.1%) out of 358 participants who answer the questionnaire (48.6%) were assisted by untrained birth attendants, while (24.6%) delivered their babies with the help of trained birth attendants and (23.2%) were assisted by trained health worker. The rest (3.6%) had delivered alone or assisted by their relatives.

Table 7 Mode of Child birth by Women

Observation (n=358)	Frequency	Percentage
Place of delivery		
Home	276	77.1
Public hospital	70	19.6
Private hospital	9	2.5
Others	3	0.8
Total	358	100
Assistance during child birth		
Trained TBA	88	24.6
Untrained TBA	174	48.6
Trained health worker	83	23.2
Others	13	3.6
Total	358	100

Occurrence vesico vaginal fistula:

Age of onset and Causes of VVF: The age of the onset of fistula during the study recorded was found that (66.7%) of the women were the highest to be affected by fistula followed by (11.1%) who are between the ages of 19-20 years. The least of age group 23-24 (5.5%). The minimum age of women at the time VVF occur was 15 while the maximum was 24.

Table 8 Age of Onset of Fistula

Observation (n=36)	Frequency	Percentage
Age		
15-16	24	66.7
17-18	5	14
19-20	4	11.1
21-22	1	2.7
23-24	2	5.5
Total	36	100

Majority of the affected women (86%) answered that obstructed labour were the cause of their VVF while (14%) of them answered that delays in seeking medical care were the cause.

Table 9 Causes of Vesico vaginal fistula for the women

Observation (n=36)	Frequency	Percentage
Causes		
Prolonged/ Obstructed labour	31	86.0
Delay in seeking medical care	5	14.0
Total	380	100

Table 10 describes the frequency distribution as well as the different symptoms of women suffering with VVF. The result showed all women experience a continuous leaking of urine and foul smelling discharge from vagina. Around 80 percent of women suffering with VVF reported the itching of their vagina.

Table 10 Symptoms of VVF

Symptoms (n=36)	Yes	No
Experience continuous leaking of urine	36 (100.0%)	344 (0.0%)
Foul smelling discharge from vagina	36 (100.0%)	344 (0.0%)
Having itching of the vagina	29 (80.6%)	7 (19.4%)

Table 11 shows the average women with VVF have been suffering for. This shows that (61.1%) of the respondents had been suffering from VVF for 5-8 years followed by those that had been living with it for 1-4 years. Women that had been with VVF for more than 13 years were (13.9%). The minimum and maximum years of living with VVF was found to be 1 year and 25 years respectively.

Table 11 Years of Living with VVF

Years(n=36)	Frequency	Percentage
1-4	6	16.7
5-8	22	61.1
9-12	5	13.9

Years(n=36)	Frequency	Percentage
>13	3	8.3
Mean ±SD	7.36±4.21	
Minimum	1 Year	
Maximum	25 Years	

Table 12 describes the frequency of (24) VVF cases of self-reported and also diagnose by medical doctor during the study in the sampled areas. In this study diagnose and self –reported are those women that found themselves with the symptoms of VVF and visited the health institution for medical check- up based on hearing other women experiences from the media or family/friends. The remaining 12 of VVF cases that answer no during the study means they did not report or diagnose by Medical doctor at the health institution but still have all the sign and symptoms of VVF. Their reasons for not reported is ignorance and lack of knowledge.

Table 12 VVF Cases diagnose by medical doctor

Diagnose by medical doctor (n=36)	Frequency	Percentage
Yes	24	66.7
No	12	33.3
Total	36	100

4.3 Knowledge about Vesico Vaginal Fistula

Around 37% of the respondents 141 never get any information on preventive measures of VVF (Table 18). Among the respondents who never get any information, most of them (21.6% and 20.3%) got the information from family/friends and radio respectively. Health care center was another source of information, 15.3% of the respondents received this information from there. Small amount of respondents got information from television (5.5%) and pamphlet (0.3%).

Table 13 Source of information regarding knowledge and preventive measures of VVF

Items (n=380)	Frequency	Percent
Health centre	58	15.3
Family or friend	82	21.6

Radio	77	20.3
TV	21	5.5
Pamphlet	1	0.3
Never get any information	141	37.0

Table 14 explain the number and percentage of married women of reproductive age that gives a correct answer from each question regarding knowledge of risk factors, sign and symptoms and preventive measures. Majority of the respondents had the knowledge that staying for long period during labor (77.9%) and delay for seeking medical care (66.3%) cause vesico vaginal fistula. For the knowledge regarding signs and symptoms (72.9%) of the respondents stated that women with VVF experience foul smelling, (63.2%) of women knows that women with VVF experience continuous leaking of urine. For the preventive measures (56.8%) of them thought that VVF can be prevented by avoiding early marriage, while 41.1% and 34.5% of them thought that warly referral to obstetric care and delivery by health worker can reduce the chances of having VVF.

Among all risk factors, delivery by untrained birth attendance, early pregnancy caused delivery complication and delays for referral were less aware.

Table 14 Frequency of respondents that correctly answered to the knowledge questions

Items	Correct answers	
	Number	Percent
Risk factors		
1. Does home delivery by untrained birth attendant cause vesico vaginal fistula?	44	11.6
2. Does early pregnancy cause delivery Complication resulting vesico vaginal fistula?	138	36.3
3. Does staying for long period during labour Cause vesico vaginal fistula?	296	77.9
4. Does delay for seeking medical care cause vesico vaginal fistula?	252	66.3
5. Does lack of transportation or delay for referral causes delivery complications?	102	26.8
Signs and Symptoms		
6. Does woman with vesico vaginal fistula experience continous leaking of urine?	240	63.2

Items	Correct answers	
	Number	Percent
7. Does a woman with vesico vaginal fistula have painful ulceration and wetness from the vagina?	42	11.1
8. Does woman with vesico vaginal fistula experience foul smelling?	277	72.9
9. Does vesico vaginal fistula causes paralysis or foot drop?	36	9.5
Preventive measures		
10. Can vesico vaginal fistula be prevented by avoiding early marriage?	216	56.8
11. Does early referral to obstetric care reduces the cause of vesico vaginal fistula?	156	41.1
12. Can delivery by health worker minimize the chances of having vesico vaginal fistula?	131	34.5

When assessing the knowledge level, majority of the respondents (65.8%) had low knowledge level, 29.5% had moderate knowledge level and only 4.7% of the respondents had high knowledge level.

Table 15 Knowledge Level amongst respondents

Items (=380)	Frequency	Percent
Low Knowledge level (<60%)	250	65.8
Moderate Knowledge level (60-80%)	112	29.5
High Knowledge level (>80%)	18	4.7

4.4 Attitude towards vesico-vaginal fistula

Table 16 describes the percentage of women's attitude towards each question together with the mean and standard deviation. Almost (60%) of the respondents agreed when asked whether VVF is an embarrassing disease (59.7%) and mean score at (2.34), faces many changes of behavior from their husband (46.9%) and mean score was (2.28) and that VVF lowers the quality of life of women (33.9% and mean score (1.93). Most of women answered uncertain for many questions especially VVF women should be invited to community functions, there were 90.0% that feel uncertain follow by be friend with VVF women (75.5%), take the relative who suffer from VVF to the health center (53.7%), VVF is an incurable disease (55.5% and feel

shy to talk about VVF with husband 941.3%). Interestingly 27.6% of women thought that VVF is an incurable disease.

Table 16 Percentage of women's attitude towards each question

Items	Percentage			Mean (Score)	S.D
	agree	disagree	uncertain		
1. Vesico vaginal fistula is incurable disease	27.6	16.9	55.5	1.72	0.86
2. Vesicio vaginal fistula is an embarrassing disease	59.7	15	25.3	2.34	0.85
3. Do you feel shy to talk about vesico vaginal fistula with your husband or relatives?	21.3	37.4	41.3	1.80	0.76
4. Do you think women with vesico vaginal fistula have faces many changes of behaviour from their husband?	46.9	34.7	18.4	2.28	0.75
5. Will you take your relative to the health centre for treatment if they suffer from VVF	16.6	29.7	53.7	1.63	0.75
6. Should women with vesico vaginal fistula be invited to community function?	1.8	8.2	90	1.12	0.37
7. If there is a woman with VVF, could you like to be friend with the woman?	4.2	20.3	75.5	1.29	0.53
8. Do you think vesico vaginal fistula lowers the quality life of women?	33.9	25	41.1	1.93	0.86

For level of attitude towards vesico vaginal fistula, respondents were asked to give their opinions whether they agreed or disagreed with the questions provided to them regarding to vesico vaginal fistula.

Table 17 present the level of attitude towards vesico vaginal fistula. The score was ranged from 8-24. The mean score recorded at .692 and standard deviation is .545. Majority of the respondents (60.8%) had moderate attitude towards vesico vaginal fistula while (35.0%) had negative attitude, only (4.2%) had positive attitude.

Table 17 Attitude level towards vesico vaginal fistula

Items	Frequency	Percent
Negative Attitude	133	35.0
Moderate Attitude	231	60.0
Positive Attitude	16	4.2
Mean± SD	17.86±3.04	

4.5 Relationship between socio demographic characteristics, utilization of maternal health services, knowledge, attitude and VVF occurrence of the women

Bivariate Analysis

The relationship between socio demographic characteristics, utilization of maternal health services, knowledge and attitude with the occurrence of vesico vaginal fistula was tested using Chi-square test. The level of significant for the relationship was set at p-value=0.05

Table 18 showed the relationship between socio demographic/socio -cultural characteristics which are age, religion, education level, occupation, and marital status, age at first marriage, age at first delivery, number of pregnancy and number of children.

Age:

The respondent's age was range into 7 categories and was compared with the occurrence of vesico vaginal fistula. It was found that there is relationship between the age of marriage women and the occurrence of VVF (p <0.001). Women without

VVF found to be much higher under the age group 27-38 years (43.2% followed by 15-26 years (40.2%) compared with VVF women who were mostly seen to be among the age group of 15-26 years at (77.8%) respectively.

Religion:

The study revealed that, there was no significant difference between the religion (Islam and Christianity) and the occurrence of VVF ($p = 0.646$). All of the VVF respondents were Muslims (Islam). From the proportion of VVF women in the none formal education

Education:

Education was ranged in two groups, formal and none formal education. Study showed the relationship between education and occurrence of VVF ($p < 0.001$). From the proportion of VVF women in the none formal education and formal education group was little difference but in the women without VVF, the proportion of educated people were more than twice when compared with the uneducated people.

Occupation:

Occupation was categorized into 3 groups, Housewife, daily employment and others to facilitate the analysis. Study showed that, there is relationship between the occupation and the occurrence of VVF ($p < 0.001$). Majority of women with VVF were in the others category (informal sector/employment). Out of 41.71% were engaged into daily employment and only 8.3% were in the category of housewife.

Marital status:

Majority of the respondents with VVF were divorced (86.1%) and only (13.9%) were married. The marital status was found to be highly significant with occurrence of VVF ($p < 0.001$).

Table 18 Relationship between socio demographic/socio-cultural characteristics and occurrence of VVF

Variables	With VVF n (%)	Without VVF n (%)	χ^2	<i>p-value</i>
Age (n=380)				
15-26	287(7.8%)	139(40.4%)	18.86	<0.001*
27-38	7(19.4%)	148(43.0%)		
>39	1(2.8%)	57(16.6%)		
Religion				
Islam	36(100%)	342(99.4%)	210	0.646
Christianity	0(0.0%)	2(0.6%)		
Educational level				
None Formal Education	19(52.8%)	118(34.3%)	4.825	<0.001*
Formal Education	17(47.2%)	226(65.71%)		
Occupation				
Others	18(50.0%)	95(27.6%)	16.789	<0.001*
Housewife	3(8.3%)	147(42.7%)		
Daily Employment	15(41.7%)	102(29.7%)		
Marital status				
Married	5(13.9%)	271(78.8%)	69.03	<0.001*
Divorce	31(86.1%)	73(21.2%)		

Table 18 (continue) Relationship between socio demographic/socio-cultural characteristics and occurrence of VVF

Variables	With VVF n (%)	Without VVF n (%)	χ^2	<i>P-value</i>
Age at first marriage				
12 - 15	35(97.2%)	207(60.1%)	19.356	<0.001*
16-19	1(2.8%)	116(33.8%)		
20-24	0(0.0%)	21(6.1%)		
Number of pregnancy				
0-4	36 (100.0%)	199(58.0%)	24.537	<0.001*
5 to 9	0 (.0%)	122 (35.4%)		
≥10	0 (.0%)	23 (6.6%)		
Age of first delivery				
14- 17	34 (94.4%)	167 (52.0%)		

Variables	With VVF n (%)	Without VVF n (%)	χ^2	P-value
18-21	2 (5.6%)	143 (44.6%)	23.696	<0.001*
22-25	0 (0.0%)	11 (3.4%)		
Number of Living Children				
0-3	36 (100.0%)	191 (55.5%)	26.804	<0.001*
4 - 7	0 (.0%)	137 (39.8%)		
8 - 11	0 (.0%)	16 (4.7%)		

Age at first marriage:

There is strong relationship between the age at first marriage and the occurrence of vesico vaginal fistula, the result showed that (97.2%) of women with VVF at the time of their first marriage were at the age range between 12-15 years. Only (2.8%) had married at the age of 16-19 years ($p < 0.001$).

Number of pregnancy:

There was significant different between the occurrence of VVF and the number of total pregnancies among the VVF women ($p < 0.001$). All VVF women had 0-4 pregnancies unlike women without VVF; they could have up to more than 10 pregnancies.

Age at first delivery:

There is relationship between the age at first delivery and occurrence of VVF ($p < 0.001$). Majority of women with VVF had first delivery in the age range between 14-17 years (94.4%), only (5.6%) of them had first delivery in the range of 18-21 years. The study also revealed that the age range at first delivery among the respondents were between the age of 14-25 years. About 22 respondents were not delivered.

Number of living children:

There is a relationship between the total number of living children and occurrence of VVF and also found to be significant ($p < 0.001$). All VVF women who had 0-3 children. The study shows that women with VVF were not having more than 0-3 children compared with women without VVF. The percentage of women who had

no VVF having 0-3 children is higher at 55.5% and the rest had between 4-11 children.

Table 19 Relationship between utilization of maternal health services and occurrence of vesico vaginal fistula

Variables	With VVF n (%)	Without VVF n (%)	χ^2	<i>P-value</i>
Place of delivery				
Home	10 (27.8%)	269 (83.6%)	55.128	<0.001*
Health center	26 (72.2%)	53 (16.4%)		
Delivery Practice				
Trained TBA	0 (0.0%)	88 (27.3%)	68.194	<0.001*
Untrained TBA	8 (22.2%)	179 (55.6%)		
Health worker	28 (77.8%)	55 (27.2%)		
Number of Antenatal Visit				
None	36 (100.0%)	209 (73.3%)	12.578	0.002
1-3 times	0 (.0%)	26 (9.2%)		
>4-4 times	0 (.0%)	50 (17.5%)		
Number of Postnatal visit				
None	36 (100.0%)	241 (74.4%)	11.986	<0.001*
Once-Many times	0 (.0%)	83 (25.6%)		

4.6 Relationship between utilization of maternal health services and occurrence of vesico vaginal fistula

Place of delivery:

There is relationship between place of delivery and the occurrence of VVF which also found to be significant ($p < 0.001$) Majority of VVF women (72.2%) had their delivery in the health center, this is mainly due to their delivery complications, unlike women without VVF (83.6%) had delivered their babies at home. Only 27.8% of VVF women delivered at home.

Delivery practice:

The relationship between delivery practice and the occurrence of VVF women was found to be highly significant ($p < 0.001$). Majority of women with VVF (77.8%) had their babies delivered with the help of health worker, this was due to obstetric complication (prolong period during labor). Out of (22.27%) were assisted

by untrained birth attendant, none of the VVF women delivered by trained birth attendant.

Number of Antenatal visit:

There is a relationship between the number of antenatal visit and the occurrence of VVF ($p < 0.002$). All VVF women found not been attending antenatal checkup. However, only (26.7%) of the women without VVF found to have gone for antenatal visit at least 1 or more than 4 times.

Number of Postnatal visit:

The number of postnatal visit was categorized in into two groups, none or once to many times. There is a relationship between the number of postnatal visit and occurrence of VVF ($p < 0.001$). None of women with VVF found to have gone for post natal visit even one time.

4.7 Relationship between knowledge, attitude and the occurrence of VVF

The relationship between the knowledge level and the occurrence of VVF was found to be significant ($p < 0.001$). Thirty –five women with VVF were found to have low knowledge level; only 1 woman had moderate knowledge level. No relationship between attitude levels was not found to be significant with the occurrence of VVF ($p .432$). Only 3 women with VVF were found to have positive attitude level and 210 have moderate attitude level while 121 have low attitude level.

Table 20 Relationship between knowledge, attitude and the occurrence of VVF

Variables	With VVF n(%)	Without VVF n(%)	χ^2	p-value
Knowledge Level				
Low	35(97.2%)	215(62.5%)	17.472	<0.001
Moderate	1(2.8%)	111(32.3%)		
High	0(0.0%)	18 (5.2%)		
Attitude Levels				
Negative	12(33.4%)	121(35.2%)	1.676	.432
Moderate	21(58.8%)	210(61.0%)		
Positive	3(8.3%)	13(3.8%)		

4.8 Focus Group Discussion

The study on knowledge about VVF indicates that, women had moderate knowledge about the risk factors, sign and symptoms but had low knowledge about preventive measures. The main objective of the discussion was to assess their knowledge and attitude towards vesico vaginal fistula and occurrence of vesico vaginal fistula.

FGD discussion revealed that women had moderate knowledge about the risk factors of VVF but they were not been able to make any effort on the preventive measures due to lack of decision making, poverty and gender discrimination was the main underlying factor for women to be able to take any preventive measures.

Women with vesico- vaginal fistula

The discussion was conducted amongst women with VVF who are between 25 to 35 years old because they are the most vulnerable for acquiring the disease.

Vesico Vaginal Fistula

The respondents had little knowledge about VVF. Four of them describe it as a disease caused by spiritual act who enters the woman's body during pregnancy while three of them said it is due to the size of the baby that tears the woman's private part (vagina) during delivery and the last respondent said it is due to circumstance (God making).

Knowledge towards contributing risk factors for VVF

Maternal mortality caused by pregnancy and child birth is the most common factors affecting women leading to the cause of VVF in the state. The major cause of fistula among the respondents is prolonged obstructed labour which is also due to teenage pregnancy as one of the risk for acquiring VVF. This was as a result where the pelvis of young woman is narrow for the passage of the baby through the birth canal because the growth of the pelvis is not completed at the time of her pregnancy.

Malnutrition and infection also affect the development of the pelvis which is common in the state.

Most of the respondents stated that, Staying for a longer period during labour causes VVF, Others said that, Traditional birth attendance administer traditional substances or forcing a woman to push frequently in order to aid the baby coming out easily, these contribute in having tears of the vagina and followed by continuous leaking of urine. Some of the key responses by the participants are stated below

“Delay for husband or his relatives consent in seeking for medical care when delivery complication occurred facilitates in developing the disease” (FGD VVF participant 001).

“I am forced to marry when I am a teen to an old man, i become pregnant immediately, I was in pains for almost 3 days without knowing my situation. My mother in-law abandons me without any assistance until I become restless and weak.

I end up with cesarean section without having alive baby and the worse part of it is incontinence of urine” (FGD VVF participant 005).

“Socio-cultural believes and ignorance makes women to be discriminated” (FGD VVF participant 002).

Generally, the common saying by women in this area is that, “when a woman is pregnant, she has her one leg in heaven and the other in the world”. This was mention by a participant during discussion (FGD VVF participant 001).

Women status

As part of the customary and religion practices in the society, purdah (women seclusion) is being practice among the muslims communities, where women’s movement is strictly in control of her husband. She has to secure permission before going out even if it affect to her own health, they are also being sideline in decision making and in the absent of her husband (father in law) will act on his behalf and if none, then no one can guarantee for that until he is around. Generally, this mainly causes the development of VVF among the participants.

Women were asked if they take part in decision making especially issues that affect them and their children. Most of them stated that, this is the most difficult way especially if an issue involves the whole stakeholders because in their culture a woman has no role to play in terms of decision making. They are much worried when certain issues were raised especially;

“Defined age at first marriage”

“Child spacing or birth control”

“Eating good food at early age and during pregnancy”

“Frequent antenatal care visit”

“Avoiding home delivery”

“Girl child education”

Some of the participants cited that:

“Women are in the control of men, they are being restriction to movement without the consent of her husband” (FGD VVF participant 004).

“Also a women’s paradise is in her husband house” (FGD VVF participants 004).

“Most of the women are ignorant towards their health, they prepare home practice than modern concept” (FGD VVF participant 006).

“Many women lack autonomy to make decision about their own health care” (FGD VVF participant 008).

Most of the women gave their own contribution for giving their reasons for the contributing factors towards the cause of their fistula as lack of knowledge on the warning signs of difficult labour or pregnancy related complications, gender discrimination, poverty, illiteracy are the main cause. Some of the women stated that, women in the rural setting encounter a lot of hardship when it comes to the utilization of maternal health services because they are not involve in decision making even if it involve their own health care.

“Women in the rural areas are not taken to hospital for delivery until there situation become hopeless or about to die” (FGD VVF participant 002)

“If a woman is in hardship during labour normally decision comes from mother in-laws and they always have to decide because of the hospital cost her son will spend” (FGD VVF participant 007).

“Most men don’t know what going through labour is, and things can go wrong at any time” (FGD VVF participant 006).

“None availability of female health worker in our health center makes me not going for ANC check –up and culture and religion did not allow male health worker to oversee a woman especially married woman” (FGD VVF participant 004).

Attitude of community towards VVF women

Due to the low status of women in our societies, women suffering with VVF are facing many challenges by the communities. In the first place this arises from the husband down to the families and the societies these attitudes placed by the society towards the victims showed no sympathy to them. They are being deprived to so many conditions that will make them part of the society such as sexual intercourse, cooking for the husband and his families, eating together with husband or families, social gathering, friendship, because of the magnitude of the stigma involved in the disease and its consequences victims suffered, they tend to isolate or hidden to a different environment. There is a lot of consequences arises towards the negative reaction of the society. This makes the victims to develop a lots of psychological problems that affect their physical situation. As stated by the participants below:

“This is a disturbing condition that leads to isolate myself in such a way that it causes a lot of social and psychological consequences”

“I so feel so much annoyed and unbelievable with the reaction of my husband and his relatives. Everybody is running away from me, they thought I am useless because I am not sexually active and I don’t have any child” (FGD VVF participant 007).

“My husband sends me a way when he notices me of having continuous leaking of urine and foul smelling, In reaching my parent house because of I don’t have alive parents my family members also rejected me. These situations push me to be on the street begging for my livelihood” (FGD VVF participant 008).

“This is a lesson to me; I will use myself as an example to other teenagers” (FGD VVF participant 002).

“If treated I will never allow this condition to re-occur to me again”(FGD VVF participant 004)

A woman stated that, “majority of women develop VVF through men but, men abandon women when they develop VVF”. Now our husbands are no more, they shy away from us (FGD VVF participant 003).

During discussion, one women stated that, “VVF is a social disaster to the highest level, due to continuous leaking of urine with offensive smell, many people ran away from me it loses all my dignity as a woman and as human being” (FGD VVF participant 005).

All the participants have the same voice, we are now being abandon by our husband, families and the whole society, no child no money to take care for our self- neither nowhere to go even after we are treated because people will not belief we are cured. “The world is different to us” (All FGD VVF participants).

Practice of preventive measures:

Women were asked during discussion if they have been doing something that will prevent them from re-occurring the disease? Most of them have negative response because they don’t have any role in the family. Even if they have the intention to make a move culture does not warrant them to do so.

Majority of women faces a lot of socio-cultural challenges, where a woman has to bear the practice of home delivery assisted by trained or un-trained birth attendance. Because they lack knowledge and education, they didn’t consider antenatal visit, delivery by skilled birth attendance, postnatal care and child spacing are important aspect towards woman’s health.

Women without vesico vaginal fistula:

Focus group discussion was carried out amongst 8 women without vesico vaginal fistula and to who are less than 35 years. The session was for 45 minutes, it was observe that some women in the group are having knowledge in the practice of preventive measures because majority of them leaves in the urban area.

Knowledge towards vesico vaginal fistula:

Most of the women in the group are more aware of the disease because of the information they gain from the media. Their responses are cited below:

“VVF is drilling of urine when a woman did not have proper care during delivery” (FGD without VVF participant 003).

“One woman said is a disease of the poor where they are neglected during delivery” (FGD without VVF participant 001).

“VVF is known to be a disease for young women who mostly have stayed long in labour and most of them delivered their babies at home without any support by the health worker”(FGD without VVF participant 004).

Reasons for developing vesico vaginal fistula:

It was indicated from the study that, most of the women during discussion session stated the reasons for developing VVF in a correct way as mention below:

“Early marriage or pregnancy, prolong period during labour without quick medical attention, or home delivery by untrained birth attendant makes women to developed VVF” (FGD without VVF participant 008).

“My daughter getting to start her menses I don’t wanted to avoid unwanted pregnancy, so is better to engage her to someone else” (FGD without VVF participant 004).

“Financial constrain prevent them for hospital delivery” (FGD without VVF participant 007).

“Majority of our health facilities are running out of female health workers where women will seek for care during pregnancy and delivery” (FGD without VVF participant 005).

Majority of women in the northern part of Nigeria consider that when a girl start menstruation in her father’s house she is likely to have sexual intercourse with someone outside, which will resulted to unwanted pregnancy. Some stated that, boys should eat heavy food than girls because they need more energy than girls. And they also went ahead in saying it is a taboo for a pregnant woman to be eating eggs because of the fair of her child to become a thief when he grows-up. Their key responses are stated below:

“Most of women don’t want to deliver in the hospital because of two reasons, attitude of health workers and exposing herself to someone else (Male health worker)” (FGD without VVF participant 006)

“Traditional birth attendant are always available and cost less, so I don’t have to spend much for delivery in the hospital”(FGD without VVF participant 002).

Attitude of community towards VVF women:

Women suffering from VVF are also suffering from socio-cultural problems. Most of the societal issues that attributed to the development of the VVF are not giving them the required social and emotional support/caring that will clampdown their trauma/injury sustained. When a VVF victim reported her situation to public she might be rejected by the society, ostracized and maltreated as if she will not be cured forever.

During discussion, majority of participants showed their reaction towards VVF women as stated below:

“VVF is an embarrassing disease, though it is sympathetic but it is difficult to associate with them due to foul smelling from the urine” (FGD without VVF participant 001).

“Once a woman is affected with VVF majority of the society denied her including her parents which sometime makes miserable” (FGD without VVF participant 003).

“I think it is an incurable disease and that staying with such people can be contacted on the disease” (FGD without VVF participant 006).

“So much has to be done for these poor young women to secure them from this difficulty of life” (FGD without VVF participant 007).

Preventive measures to towards occurrence of VVF:

Majority of the participants have said that, we have been hearing and seeing from the media on the effect of pregnancy complications to women but because of ignorance we seem to neglect certain issues especially- Antenatal care, delivery practice and postnatal care

“I have a healthy pregnancy, I see no reason for roaming about to the hospital” I have a good Traditional birth attendance who is in practice for many years why should I waste my time to deliver somewhere else” (FGD without VVF participant 002)

Women without fistula indicate their reasons for preventive measures as:

“Girls have to get enough education before marriage” (FGD without VVF participant 008).

“Women empowerment on income generating activities, attending antenatal care and always have hospital delivery” (FGD without VVF participant 004).

The last participant round the topic by saying that:

“Seeking for medical attention whenever there is any signal of complication is the best” (FGD without VVF participant 003).

A lot of women have got the concept of developing VVF but some time they fail to practice the preventive measures until when they found themselves into faulty.

“In some cases VVF has nothing to do with age or early marriage but practicing for the prevention is the solution to occurrence”.