# CHAPTER V

# DISCUSSION, CONCLUSION AND RECOMMENDATIONS

## 5.1 Discussion

The main purpose of this study was to determine the prevalence of vesico vaginal fistula in the studied sample area; knowledge about vesico vaginal fistula (contributing risk factors, signs and symptoms and preventive measures) and attitude towards vesico vaginal fistula. The study was a cross sectional carried out amongst 380 married women of reproductive age in Birnin Kebbi Local Government of Kebbi State, Nigeria.

The study describes the relationship between socio demographic and socio cultural characteristics, utilization of maternal health services, knowledge, attitude and occurrence of vesico vaginal fistula. The result of the survey will be used to promote the level of awareness regarding the disease to all stakeholders responsible for the empowerment of women and strengthening the reproductive health activities that will improve the women's right.

**Socio demographic and Socio-cultural characteristics:**

Regarding the age group in this study, majority of the respondents (23.9%) were aged between 25-29 years. The prevalence of age in vesico vaginal fistula in Birnin Kebbi LGA is between 15-26 years (16.8%) which is showed that, it is almost the same as the article (Kabir et al., 2004; Ibrahim et al., 2000) where VVF affect mostly young girls who are under 16 years.

Three quarters (72.6%) of the respondents are married while 27.4% were either divorce or separated where as women with VVF 31 out of 36 respondents in the study were divorce. Education is one of the basic factors as it determines the level of awareness amongst the women. The educational status of the VVF women in the study presented was as low as 52.8% not had any form of education, only 47.2% had formal education. For women without fistula 34.3% of them had no formal education. This was also indicated from the previous studies carried out in the northern part of Nigeria where most of the women with VVF (88.6%) are illiterate (Ijaiya et al., 2010).

A report by (NDHS, 2008) also indicates that, 36% of women of reproductive age 15-49 years in the Northwest of Nigeria had no formal education. Majority of the women (39.5%) are not involve into any form of income generating activities, 30.8% had been involve in daily employment, while 21.3% engage in petty trading. The findings of the study showed that nearly 50% of women with VVF are not engage in any form of income generating activities which was similar with other studies conducted in the region 61% of women are full time housewives only 39% were home-based petty traders (Ibrahim. et al., 2000).

**Age and Marriage:**

The average age at first marriage in the Kebbi State is 15-18 years (NDHS, 2008). However, the findings of the study shows that, 63.7% of the respondents had their first married at the age of 12-15 years while, 30.8% married between the ages of 16-24 years. The result is similar with other studies carried out by UNFPA/Nigeria (2005) where young girls got marriage at the age of 12-13 years. Another studies also cited that, young girls were given out in marriage before or immediately they see their menstruation (Ijaiya et al., 2010). Also because of poverty some parents prepare to give out their daughters in marriage as early as possible rather than sending them to school as reported by (Ibrahim et al., 2000). Majority of these girls were either been forced into marriage or were married off at the age where they cannot have decision to accept it as a normal process and their physical structure (pelvis is not mature); (UNICEF, 2001). Significantly, the important aspect of this is that girls should be delayed until such girls are mature. Age at marriage no doubt affects pregnancy and labour complications amongst women hence likelihood of having VVF.

Also the percentage of women (56.3%) is those who had their first delivery at the age between 14-17 years while, 40.6% of the respondents had their first babies at 18-21 years. This was also similar with the previous study by (UNFPA, 2005) which stated that most of young girls that married early become pregnant by13-14 years. Ajuwon, 1997 reported that as a result of this early marriage it also leads to early pregnancy when the growth of the pelvis is not completely developed, this resulted to a condition where the baby's head or body is too big to fit through the mother's pelvis that leads to the development of fistula.

**Utilization of maternal health services:**

The study revealed that, 77.4% of the women are seeking or going for health service in the public health institutions only 13.4% seek for traditional healers. Mode of payment for health services of the majority women depend by their husband support (72.6%) while 14.2% paid out of their pocket. Majority of the VVF women encounter a lot of problems in terms of financing their health services because they are being deprived by their husband and families. Forty-four percent do not visit the health facility their reasons are due to financial constraint. The findings also showed that, there is a lot of health facilities around the study area but some of them; their services are limited to only minor ailments.

**Availability of female health workers**

The findings of the current study showed that, 52.1% of the respondents were not having female health worker at their facilities only 43.4% indicate of availability of female health workers. This has been explained in the other studies (Wall et al., 2004; Ibrahim et al., 2000) where they indicated that, there is shortage of female health workers at the rural health facilities (Mal-distribution of staff).

No female health worker is an obstacle in accessing the health facility. Majority of the respondents (99.5%) are predominantly Muslims and more than 50% of the health facilities in the studied area are managed by male health workers. Though the religion did not permit a male to examine a woman, these debar them from attending the right health facility even when they are in critical health challenges especially those that are related to pregnancy complications (Ibrahim et al., 2000).

**Place of delivery:**

Almost three third of the respondents (77.1%) had their delivery at home without the support of trained health assistance only 19.6% had their babies delivered in the health facility. The findings are close to the studies conducted in northern Nigeria by (Lindros and Lukkainen, 2004) where 69% of women in the rural areas have their deliveries at home by untrained skilled attendance. Another study with a slight lower figures with the current findings carried out by (WHO, 2006) stated that, 65% of Nigerian deliveries take place outside the health facilities.

**Delivery practice:**

The study presented that 48.6% of the women deliver their babies with the assistant of untrained birth attendant or relatives while 24.6% had their deliveries at the health facility. Most the women in northern Nigerian had home deliveries through untrained birth attendant and if attempted to seek for medical care eventually presented late labour that had already been obstructed as indicated by( Shittu and colleagues, 2009). The unskilled birth attendant or Traditional birth attendants had great recognition and are widely patronized in the rural communities because they are easy to access and cost less than government institutions. A study carried out by (Wall et al., 2004) stated that, in the northern Nigeria women lack of power in decision making and their movement is strictly under the control of their husband and permission has to be obtained before financing for health care or any other spending. This could be the common cause of her delay in seeking for medical attention at early stage especially in cases of obstructed labour. However, in most cases these circumstances increase the risk of maternal deaths/ disability (such as fistula) and still birth.

**Antenatal care visit:**

The study shows that, 66.9% of women have not made any attempt in visiting antenatal clinic during their pregnancy; only 12.3% had visited more than four times. (NDHS, 2008) found that 55% of the women had not any visit of antenatal care. This could have been due to the shortage of female health workers in the rural health facility and lack of power in decision making. In the focus group discussion, when asked on practice of preventive measures, one of the participants cited that "I am much healthier during my pregnancies so there is no need to go for any check-up". Her statement could be due to lack of knowledge on the importance of antenatal care. According to WHO, 2006 report, skilled care before and after birth and particularly during labour can make the difference between life and death for women and their babies and help to prevent obstetric fistula. Lack of access to obstetric care by pregnant women in the study area is among the contributing factor to the prevalence of VVF. If they had access to basic antenatal care, difficult and complicated labour

would have been identified at the antenatal clinic immediately before the child delivery period.

**Postnatal visit:**

The study revealed that 76.9% of the respondents had not visited the health facility after their delivery. This is consistent with the findings of NDHS (2008) indicated that only 17% of women from the northwest zone in Nigeria received postnatal care within 2 days after their deliveries which Kebbi State is within the zone. WHO defined post natal care: as a care given to the mother and baby at the first six weeks after birth which is the most vulnerable time for both mother and the child during the hours and days after birth. Thus lack of care at this time period may result in death or disability as well as missed opportunities to promote healthy behavior, affecting mother and newborn as well.

**Overall prevalence of vesico vaginal fistula:**

The study found the prevalence of vesico vaginal fistula amongst the total women of 380 is 9.5%. The scope of this study is on knowledge; attitude and preventive measures so could not be comparable to the previous studies conducted on the subject (VVF) since they were clinically based. This is the first time to conduct a community –based study in the state. Fistula care project a USAID project based in Nigeria is now also conducting a community-based study for reporting the minimum estimate of prevalence and incidence of fistula in two LGAs of the state. The result of the study will be available before the end of the year. In 2012, data obtained from the VVF center in the state shows that almost 310 women who self –reported VVF in the center affecting mostly women of 15-50 years of age and nearly 60 women reported for treatment from January to March, 2013. Birnin Kebbi LGA has 30 cases reported to the center last year but this year at the time of the study only 2 cases were so far reported (VVF Kebbi Centre, 2012). These indicate that the prevalence of VVF is still high in the state and a lot are still hidden.

Other studies were carried out in Sokoto state that shares common boundary with Kebbi State, where 241 cases were reported in two years (Wall et al., 2004). Waaldijk, 2004 stated in his report that, 1,716 fresh obstetric fistula cases were

recorded in less than three months duration in Katsina and Kano fistula center that are also part of Northwestern zone (Waaldijk, 2004). Similar study carried out in Nigeria and Asia as well as some part of Europe, globally, the prevalence of vesico vaginal fistula is estimated to be two million women and majority of them are from sub-saharan Africa and South-Asia (Kelly and Kwast, 1993). Another study conducted by Tsui and others (2004) stated that the annual incidence of vesico vaginal fistula in Nigeria is estimated at 2.11 per 1000 births and (Wall, 1998) indicate that almost 100,000-1,000,000 Nigerian women live with obstetric fistula. UNFPA/Engender Health report, (2003) indicate that, Nigeria recorded almost 20,000 new cases of fistula every year and the situation is being more evidence in northern part of the country. A country assessment on obstetric fistula carried out by (Duysburg et al., 2009) findings revealed that, Nigeria counts 40% of the worldwide fistula prevalence.

**Years of living with Fistula:**

The study shows the average duration for a woman suffering from fistula is 7 years (± 4.21 years). The minimum years were 1 year and the maximum was 25 years. This was indicated during the focus group discussion by one of the participant who cited that she has been with the disease for almost 20 years without knowing where to go for medical attention. Majority of women with fistula do not access to medical care or to any social services this was stated by (Ahmed and Holtz, 2007).

**Age of Onset of fistula:**

The mean age of onset of fistula in this study is 16 and the minimum age of onset of fistula was found to be 15. Many studies conducted have their different figures. UNFPA, (2005) statistics showed that most of the VVF cases are below 20 years old. Study by Kabir and others (2004) revealed that the youngest age of VVF in his study was 13 years and the average age in his study was 16 years old. Prevalence rate in a study carried out by (Ibrahim et al., 2000) in Sokoto stated that the peak age of occurrence of vesico vaginal fistula in Sokoto was 10-18 (90%) among his respondents. where as in another studies carried out by Waaldijk (2004) who stated that in northern Nigeria, women younger than 16 years accounted for 42.4%. This shows that the prevalent of vesico vaginal fistula amongst the younger women is very high in northern Nigeria. But, in some cases fistula has nothing to do with age or early

marriage. (Kess, 1994) included that, the causes and prevalence of the disease is due to lack of medical facilities and ignorance of women on the need to seek for medical attention.

**Knowledge regarding vesico vaginal fistula:**

The result of study revealed that there was 65.8% of women have low level of knowledge about vesico vaginal fistula while only 29.5% women have moderate level. The proportion is lower as compared with the result of study conducted in Sokoto State by (Hassan and Ekele, 2009) where the proportion of women with VVF 70% had moderate knowledge and 32% had lower knowledge of causes of their fistula during health talk while on admission, but the researcher's fair is whether their knowledge can be put into practice during subsequent pregnancy. However, another study carried out by (Kazaura et al., 2011), mentioned that 60% of the women identified have the knowledge on the perceived cause of obstetric fistula where they identified prolong labour, delivery by operation through doctor/nurses but eventually they made a mistake in perforating their bladder and also young or old age of expecting mother in having sex early of at late age.

This indicates that women have poor knowledge when it comes to the emergency obstetric care during labour, they also had good knowledge level regarding to the risk factor by staying for long period during labour (77.9%) and delay for seeking medical care (66.6%). The respondents had fair knowledge level regarding to the sign and symptoms of vesico vaginal fistula as most of them had a moderate knowledge level (72.9%) among the women answered questions for the signs and symptoms which they stated that women with VVF experience foul smelling. Among the respondents 63.2% of them mention that women with VVF experience continuous leaking of urine. This shows that they still have fair knowledge on the sign and symptoms because leaking of urine is the first sign for VVF women to notice which is found significant with vesico vaginal fistula (Murphy, 1981; Harrison, 1983). We also have to consider that, due to the fact, the study combine with women with fistula and women without fistula. So it is likely that the negative responses are made by those without fistula.

When compared with the risk factor and sign and symptoms, the knowledge level on preventive measures is very low (56.8%) of women stated that VVF can be prevented by avoiding early marriage. Only 34.5% of women stated that delivery assisted by health worker can minimize the chances of having vesico vaginal fistula while, 41.1% mentioned that VVF can be reduced if there is quick early referral for medical care. The result is also similar with (Hassan MA, 2009) where she doubts whether the women can put the knowledge gained into practice. When we look at previous studies and this study, it shows that majority of the women have low knowledge level considering the fact that many donor agencies and government are doing their best in creating awareness on the prevention of fistula but still there is wide gap in the knowledge level amongst women. When women were asked whether home delivery by untrained birth attendant cause VVF, only 11.6% answered correctly, which means they doesn't consider delivery assisted by untrained birth attendant is part of the contributing factors of fistula among women. Transportation or delay for referral causes delivery complications which are very sensitive and important question but only 26.8% among the women answered correctly. Educational level and economic status of both women and the society also contributes to lack of transportation or delay in referral for emergency care. This study is also similar with the previous study conducted by Ibrahim and others (2000) where he reported that, 28% of the VVF cases caused by obstructed labour are due to delay in seeking permission from husband/ family to seek for emergency obstetric care while 25% are due to lack of transportation and 7.4% attempted for traditional remedies.

**Attitude towards vesico vaginal fistula:**

The study revealed that 60.8% of women had moderate attitude level towards vesico vaginal fistula. Due to the negative reaction of the societies towards women with VVF which is quite high, (Harrison, 1993) stated that women with VVF are often ostracized by their husband, families and communities. However, the result of this study shows that 46.8% of women face many changes of behaviors from their husband. A study in Africa reported that 28% of women were divorced and only 11% were allowed to stay (Murphy, 1981). Another study by (Ojanuga, 1991) revealed that in Niger republic, 63% of married women with fistula were sent back to their parents'

home where they are deprived not to cook, participate social event and the worst part is they are not allowed to perform religious rituals. The societal reaction towards women with fistula in Nigeria is the same with the previous studies, where 53% of these women found to be rejected (Kabir et al., 2004).

Due to the fact that, vesico vaginal fistula is associated with medical and psychological complications. Harrison, (1993) stated that fistula is consider to be a ''social calamity''. Also (Robert, 1957) stated that it is one of the most frightful afflictions of human kind due to continuous leaking of urine and offensive smelling. During focus group discussion one of the participants stated her experience in having fistula as "loss of child, incontinent of urine, ashamed of having offensive odor, separation from the husband and families, unemployment, enduring the exist without friends and without hope of her future". This could be the reasons that majority of the respondents 59.7% thought that VVF is an embarrassing disease, while 33.95 thought that VVF lowers the quality life of women and 27.6% think it is incurable disease.

**Focus Group Discussion:**

Focus group discussion explains the qualitative results on the maternal health status of women. The discussion revealed that women had knowledge on the risk factors of VVF but could not guarantee in practicing the preventive measures even though they stated the existence of VVF within their communities. The presence of low maternal health status among the women indicate their limited power/decision in seeking health care especially during pregnancy and delivery as stated by Kabir and others (2004).

## 5.2 Conclusion

Form the findings; it can be summarized by saying that, most of the women have poor access to maternal health. They also have moderate knowledge level regarding the risk factors of vesico vaginal fistula with low knowledge level about the preventive measures and moderate attitude towards it. These indicate that there is poor practice on maternal health issues which will result to increase of prevalence of vesico vaginal fistula.

The result of chi-square shows that there is significant relationship between the age of marriage women and the occurrence of vesico vaginal fistula (p-<001) and there is also relationship between the three variables and the occurrence of vesico vaginal fistula such as education (p 0.025), occupation (p<001) and marital status (p<001). There is no significant relationship between religion and occurrence of vesico vaginal fistula (p=0.646).

The relationship between the Knowledge level and occurrence of vesico vaginal fistula was found to be highly significant (p <001) compared to knowledge level, attitude level was not found to be significant (p=0.432).

Lastly, we can say that, having a fistula changes a woman's life forever. So there is need for wider research on community-based study in order to determine the actual incidence and prevalence the condition of the community and the need to develop concrete strategies toward prevention and eradication of the disease.

## 5.3 Recommendations

The result of the study found that there is an indication of prevalence of vesico vaginal fistula and also a gap in the knowledge level. Due to the fact that the maternal health status of the women is poor which is the common factors for the occurrence of vesico vaginal fistula. These indicate that there is inadequate awareness amongst women regarding to maternal health issues.

- The following strategies need to be adopted and implemented in order to prevent the occurrence of vesico vaginal fistula:
- There is need to define the management and delivery structure by the government especially with regard to obstetric fistula intervention.
- To develop a consolidated strategy that will sustain the awareness creation of the community.
- Government and legislators should adopt a policy on mandatory formal education for girls up to high institution.
- More female personnel to be train in order to bring maternal health services closer to the community.

- Special attention should be given to the socio cultural barriers to good reproductive health amongst women by legislating against the practice of early pregnancy and child birth in very young women which is a direct consequence of early marriage.
- There is need to empowered women through income generating activities
- Through the initiative of midwives service scheme (MSS), Government needs to increase and sustain skilled attendance at delivery point.