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**VESICO-VAGINAL FISTULA AND PSYCHO-SOCIAL WELL-BEING OF
WOMEN IN NIGERIA**

Masters Thesis (2007)

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ABSTRACT

The problem of vesico-vagina fistula still remains a ravaging scourge in resource-poor countries of which Nigeria is visibly prominent. A majority of the cases are attributed to prolonged complicated labour due to inaccessibility of adequate and immediate obstetric health care. Complicated labour arises as a result of narrow pelvis bones of victims due to suffering from poor nutrition. While the above factors are noted as the direct cause to the prevalent of VVF, there are other socio-cultural conditions which predispose victims to this disease. Notable among them are the following: poverty; marital age; illiteracy; hazardous traditional practices, such as female circumcision. VVF victims often live an unworthy life. Many of them have been abandoned or divorced by their husbands and become ostracised by families and societies because of their repulsive smell and inability to engage in sexual activity and bear children. VVF victims suffer both physical and social consequences, many of them find it difficult to engage in any economic activity, surviving the hardship is very complicated and pathetic; some victims turn to street begging, while others survive through hawking of “bagged” water and selling firewood.

Most studies conducted on the problem of Vesico vaginal fistula are done from the medical perspectives, often neglecting the psycho-social consequences faced by the sufferers. This study, however, discusses the socio-cultural and the psychological consequences of the disease. Locally and internationally, attempts are being made to eradicate the problem of VVF, however, if the Nigerian government does not recognise the incidence of VVF as a major public health issue, it will continue to ravage lives of Nigerian women, hence increasing maternal mortality in the country. This study proffers recommendations to help eradicate or alleviate the problem in Nigeria.

CHAPTER 1.0 INTRODUCTION

"In Vast areas of the world, in South East Asia, in Burma, in India, in parts of central America, South America and Africa 50 million women will bring forth their children this year in sorrow, as in ancient Biblical times, and exposed to grave dangers. In Consequence, today as ever in the past, uncounted hundreds of thousand of young mothers annually suffer childbirth injuries; injuries which reduce them to the ultimate state of human wretchedness.

Consider these young women. Belonging generally to the age group of 15-23 yrs, and thus at the very beginning of their reproductive lives, they are more to be pitied even than the blind, for the blind can sometimes work and marry. Their desolation descends below that of the lepers, who though scarred, crippled and shunned, may still marry and find useful work to do. The blind, the crippled and the lepers with lesions obvious to the eye and therefore appealing to the heart, are all remembered and cared for by great charitable bodies, national and international.

Constantly in pain, incontinent of urine or faeces, bearing a heavy burden of sadness in discovering their child stillborn, ashamed of a rank personal offensiveness, abandoned therefore by their husbands, outcasts of society, unemployable except in the fields, they live, they exist, without friends and without hope.

Because their injuries are pudenda, affecting those parts of the body which must be hidden from the view and which a woman may not in modesty easily speak, they endure their injuries in silent shame. No charitable organisations become aware of them. Their misery is utter, lonely and complete."

RHJ Hamlin and E Catherine Nicholson

(Hamlin & Nicholson 1966)

The above quote gives a good grasp on the understanding of the miserable and gloomy life of young girls who are victims of VVF, a gynaecological condition which results from childbirth difficulties. The story illustrates the condition of women who go about during the day with big smelly and tattered clothes in between the upper cleavages of their legs. At night they go to sleep, albeit sleeplessness, and wake up in the morning in the middle of wet and stinky beddings. Getting up from the bed becomes so embarrassing and humiliating. Theirs is a story of young girls whose first child was born still, and who may

never have the opportunity of getting married or having babies again. This is a condition that is avoided in the public discussion because of the high level of stigma attached to it. Coping with this condition is done in isolation and loneliness!

It should be noted; however, that medical repair and treatment of fistula is possible. Whether treated or untreated, its effect on the psychological well-being of the victims can not be over emphasised.

1.1 BACKGROUND

In most societies of the third world, women are often seen as a vulnerable gender group, however, the attendant devastating and humiliating effects of ill health, e.g. *VVF* further make them more vulnerable in these societies, thus exposing their emotional instability. These women often see themselves as being different from other women in several areas, in spite of the fact that their sexual freedom has already been curtailed, they find it difficult to enjoy their sexuality; other infectious diseases may also arise; and they age more easily and quickly than their contemporaries who have not had their womanhood curtailed. This disrepairable and demoralizing condition thus destroys the psychological well-being of the victims. When someone loses confidence in enjoying a quality life, she often lives a miserable life throughout her life. This condition is typical of a Nigerian woman who is a victim of *VVF*.

The term “vesico” according to the medical profession is called urinary bladder. Vesico-vaginal fistula is thus the abnormal connection between the urinary tract and the vagina such that there is an uncontrollable leakage of urine into the vaginal tract. According to Villey VJ (2006), “*VVF* is an abnormal communication between the urinary bladder and the vagina that results in the continuous involuntary discharge of urine into the vaginal vault”.

Several literatures reveal that the condition has many causes with variation depending on the social and educational status of people. Undoubtedly, women from low and poor social and educational status are more often than not ravaged. Kabir et al (2003) observed the following to be possible causes of VVF: prolonged obstructed labour, trauma during operative delivery, infections and irradiation necrosis from treatment of cervical carcinoma. According to Villey, numerous factors contribute to the development of VVF in developing countries, among other cultures, which promotes marriage and conception at a young age, often before full pelvic growth has been reached.

Thus, an early child-bearing stage, poor physical growth and health of the mother coupled with poor medical facilities are all contributing to the prevalence of obstructed labour, hence VVF condition among women in low socio-economic status of Nigeria.

In spite of the medical consequences (diagnosis, treatment and so on) accorded the victims of VVF, the psycho-social consequences seem as more unbearable. In most Nigerian communities, affected women are ostracized from their local community, divorced, abandoned and remain childless. Since the urinary is uncontrollable, the affected women always remain wet and smelly, leading to discomfort and humiliation from people around. According to Sadik (2001), victims of VVF “often work alone, eat alone, and are not allowed to cook for anyone. They sleep in separate huts and often end up on the streets, begging for survival”.

The discrediting effect VVF is a stigma and this is a brutal punch to the psychological well-being of its victims. A stigmatized individual does not live a successful and happy life; this is the case of a woman living with VVF!

Overlooking the vast psycho-social consequences of VVF on its victims is not so easy to achieve unless social researchers observe her in her own social setting, thus World Health Organisation (2006) reports “the proper care of fistula victims requires a holistic approach that pays as much attention to healing the psycho-social wounds inflicted on these women as it does to curing their physical injuries.

1.2 AIM

Against the background of the preceding exposition, the *aim* of my thesis is to unravel the several factors responsible for the incidence of VVF and to look into the impact of this disease on the psychological well-being of its victims in Nigeria. With this, I intend to create an understanding and awareness of the socio-cultural consequences of the VVF condition among its victims in Nigeria.

1.3 RESEARCH QUESTIONS

The following shall constitute the foci of my study:

- What are those factors responsible for the incidence of VVF in Nigeria?
- What are the psycho-social conditions faced by the victims of VVF?
and
- What are the coping and survival strategies of victims living with VVF?

1.4 CHOICE AND MOTIVATION FOR THE STUDY

This study represents a part of my overall knowledge in the programme leading to a Master in Health and Society. And the purpose is to demonstrate my knowledge and a good understanding of the interaction between health and its people.

While DJP Barker's research work on *"Mothers, Babies and health in Later Life"* places emphasises on the importance of good health care delivery to women at both pre and post natal stage as being imperative in preventing some of the human diseases, such as coronary heart diseases and so on in later life (Barker, 1998:136), my own study, though not primarily about preventing diseases among women, focuses on the impact of diseases on the quality of life of women, vis a vis their psychological stability. Thus, my research interest lies in the quality of life of the vulnerable gender group in Nigerian society, i.e., the women whose diseased condition has both medical and psycho-social consequences.

VVF victims have traditionally been neglected in reproductive health. The victims are not getting the attention of programmes, research and donors, often in the context of interventions to reduce maternal mortality and disability. Sadik (2001) comments that "so much remains to be done for woman's health ...the frustration is that the area of maternal mortality and morbidity is a subject about which we know in the clinical sense, but so little in the social and cultural sense."

In a lot of literature on the prevalence of VVF, it becomes so obvious that the explanation and understanding of the phenomenon focus primarily on the epidemiological (quantitative) perspective; figures and data are mostly used to explain the prevalence. Maternal mortality and reproductive health are thus considered and diagnosed quantitatively. The focus on VVF is mostly on its medical consequences; hence, its social consequences on the victims are *neglected. Against this background, my own interest lies on the psycho-social consequences of VVF on its victims.*

Since the subject usually stems from the perspective of the so-called “objective” and hegemonic physicians, the voice and the “real” pains of the victims are unheard, and when heard, they are usually underestimated with figures.

My choice of research is thus to have a qualitative and phenomenological view of the patients as they present their everyday life.

This present investigation is motivated and justified in terms of the following:

There is an interest in victims of vesico vagina fistula which places them more and more in the focus of attention. Due to the dearth of research that principally explores the impact of the disease on the psychological well-being of its victims, this study is seen as an attempt to respond to this need.

Most of the research studies concerning vesico vagina fistula have been conducted quantitatively by practitioners in the medical field. This study is thus considered necessary in that it is being conducted by a qualitative researcher

CHAPTER 2.0 LITERATURE REVIEW

2.1 BRIEF HISTORY OF VESICO-VAGINAL FISTULA

The earliest and oldest evidence of obstructed labour was discovered in the remains of Queen Henhenit, who was a wife of King Mentuhotep II of Egypt sometime in 2050 BC. This observation was made when the Queen's mummy, on discovery by Edouard Naville was sent to the Metropolitan Museum of Art, New York in 1907. A thorough observation of the Queen's mummy indicated that the vaginal was normal while there was a mass of tissue 10 cm long, possibly intestine sticking out through the anus. In 1923, the mummy was returned to Cairo for detailed clinical examination by Professor D. E Derry, which showed that there was a tear in the bladder connecting to the vagina. A closer examination also indicated that the pelvic bone was abnormal in shape, approximating that of apes. Considering the width of the pelvis, the examiner believed it was too small or narrow to allow a passage of fetal head, and that the severe pain and damage done to the bladder and vagina could have been responsible for the death of Queen Henhenit (Zacharin,1988: 5).

Prior to the above discovery, an Arabo-Persian physician named Avicenna, who died in 1037 AD, was the first individual to observe that urinary incontinence in women may be as a result of fistula consequent upon obstructed labour (Zacharin, 1988:2). While linking difficult labour to fistula, he advised on

pregnancy prevention, especially among young girls, he thus said “in cases in which women are married young, and in patients who have weak bladders, the physician should instruct the patient in the ways of prevention of pregnancy. In these patients bulk of foetus may cause a tear in the bladder which results in incontinence of urine. The condition is incurable and remains so till death.” (p.2)

The end of 1600 BC however, became a remarkable period because that was when several clearer descriptions of fistula started coming up. In 1597, Felix Platter, Basle gave the following description of fistula: “ as a consequence of a first labour, the young country girl had the opening of the bladder rent to such a degree that there was a long gapping furrow in its place, and the open bladder could be seen. On account of this injury, there is a constant involuntary discharge of urine, and the surrounding parts become excoriated and inflamed” (Zacharin, 1988:3).

At the beginning of 19th century, major progress was made in the repair and treatment of Vesico-vaginal fistula. Notable among the physicians at the time were de Lmballe, Wutser, Simon, Sims, Emmet and Bozeman (Zacharin, 1988:11). Between 1845 and 1859 doctor Marion Sims has become famous for his aggressive discoveries of instruments and materials used in closing enormous fistula. Till date Sim has been praised for recognising that health problem faced by women required urgent medical and surgical attention (Medscape, 2003).

2.2 GLOBAL VIEW OF VVF

Historical understanding of VVF has shown to us that the condition is not a new phenomenon, as a matter of fact, this condition used to be a common scourge throughout the world. However, improved and advanced obstetric care in areas such as Europe and North America has made the scourge relatively unknown in these geographical regions of the world. Metro (2006) observed that fistula is

almost oblivion in countries where there is universal health care, which takes women's health more seriously. Metro further comments that VVF resulting in urinary incontinence in third world countries centres around obstetric difficulties, while 90% of such cases are caused by in advent bladder trauma during surgery with hysterectomy. A report by Wall et al (2003) observes that there are cases of VVF in industrialised countries, however, these are due to radiation therapy or surgery, thus distinguishing the aetiology from that of developing countries, which results mainly from neglect of obstetric complications which occur under very different circumstances (Wall et al 2003:1408). According to Villey (2006), the incidence of VVF in the United States is debated, "while most authors quote an incidence rate of VVF after total abdominal hysterectomy (TAH) of 0.5-2%, others suggest only a 0.05% incidence rate of injury to either the bladder or urethra, thus in approximately 10% of cases of VVF, obstetrical trauma was the associated aetiology. Radiotherapy and surgery for malignant gynaecologic disease each accounted for 5% of cases".

Most discussions about VVF center on Africa, this is however misleading because several other parts of the world also face this problem. To this end, a report by Wall et al brings out the fact that there has not been an up to date study around the world to actually determine the extent and the places where the scourge occur. According to them, "questions regarding the incidence and prevalence of obstetric fistulas have never been included on the standardised demographic and health surveys (DHS) that are carried out to evaluate population characteristics and overall health status in developing countries" (Wall et al (2003:1408).

Existing and accurate data on the problem of VVF are practically not available, although the incidence has been widely reported throughout Africa and the Indian subcontinent. However, a WHO report indicates that a cautious estimate of 2 million young women live with untreated VVF, and new cases of between 50,000 and 100,000 are reported every year (2006: 4). These figures above can be

argued to be highly underrepresented because of the stigma which is associated to the problem; hence, several other unknown and unreported victims of VVF live with the condition in fear and isolation. In spite of the stigma associated with VVF, it still records one of the commonest distressing conditions which bring women to hospital in many African countries (Kabir et al, 2003).

An isolated study of VVF in some selected parts of Africa undermines the true situation of the scourge in the third world specifically, and around the world in general. In order to come closer to the true incidence and prevalence of VVF around the world, Wall et al (2003:1408) suggests that the mapping of the entire world for a survey on VVF should include virtually all of Africa, South Asia, less developed parts of Oceania, Latin America, Middle East, some remote areas in central Asia, selected isolated areas of former Soviet Union and Soviet-dominated Eastern Europe.

However, high maternal mortality rate has been directly linked to the incidence of VVF. Poor countries with high maternal mortality have therefore been observed to have high prevalence of vesicovaginal fistula (WHO 2006:1407). These countries are undoubtedly located in the third world.

2.2.1 The Nigerian Situation

In the case of Nigeria alone, there is a vesico-vaginal fistula rate of 350 cases per 100,000 deliveries at a university teaching hospital. This condition is so enormous and thus ravages Nigerian women that the country's Federal Minister for Women Affairs and Youth Development, has estimated that the number of untreated VVFs in Nigeria stands between 800,000 and 1,000,000 (Villey, 2006). Going by this report, Nigerian women are under serious siege of VVF

Corroborating the above report, the Nigerian minister of health estimated that 800,000 women are plagued by the scourge of VVF, a majority of whom are living in the rural areas where there is inadequate or complete lack of primary health

facilities. The minister thus recalls that the country accounts for 40% of the global burden of VVF (The Guardian, 2007).

Some of the victims of VVF are very young and are not even privileged to have basic elementary school education. Magashi (2006) explains that when a woman in the rural part of the country is in labour, she usually stays at home for about 3 days trying to push, the family may decide to take her to the closest obstetric center which may be 70 kilometers away; lack of proper, easy and affordable transportation further worsens her traumatic experience. If she eventually gets to the clinic, there is no facility and skilled attendant to handle the emergency obstetric procedure. If the woman survives the labour, she hardly survives the waiting and gruesome grasp of VVF.

Magashi (2006) reports that Nigeria's maternal mortality ratio of 948 per 100,000 live births with a range of 339 to 1716 ranks among the highest in the world. For each maternal death that occurs, 15 to 20 other women suffer either short or long term maternal morbidities, and prominent among these morbidities is Obstetric Fistula which the major one is the VVF. Incidence of obstetric fistula is directly connected to maternal mortality (WHO, 2006:1407). Maternal mortality and morbidity is more likely in nations and cultures which give little priority to the needs, status and situation of girls; where girls and women are routinely discriminated against; where girls are married off as soon after puberty as possible; where education levels are low; and where the only role of women is seen as wives and mothers. In many of these cultures, maternal illness, suffering, and health are viewed as natural, inevitable, and part of what it means to be a woman (Sadik, 2001). Little wonder why scourge of VVF is not seen as a serious case of maternal mortality in such cultures.

2.3 TYPES OF FISTULA

At the moment, there is no universal or general procedure that has been adopted by medical practitioners to describe or classify fistula, this is due to the form and

extent of the injury on its victims. However, each author usually devises his own classification based on the anatomical structures of the injury or, the size of the fistula, or even the classification that is most convenient for him to use (Wall et al, 2003: 1429).

However, Sims (1852) identified the following classifications of vesico vaginal fistula based on its situation on the vagina: 1) urethra-vaginal fistula where the anomaly was restricted to the urethra 2) fistulas located “at the bladder neck or root of the urethra, destroying the trigone;” 3) fistulas which involves the body and the floor of the bladder and; 4) utero-vesical fistulas where the opening of the fistula communicated with the uterine cavity or cervical canal (Wall et al 2003: 1429).

Subsequent authors have also classified fistulas in various other ways. Moir (1967:17) claims that categorisation of fistulas can also be made according to their aetiology. Thus, the following typologies were adopted: obstetric injury, operative injury, ulceration from infection, radiation injury and congenital abnormality. All these typologies above are referred to as physical determinants of fistula because of their direct consequences on its victims. Bello (2006) observed the following as the physical factors that influence the incidence of VVF: obstructed labour, accidental surgical injury related to pregnancy, and crude attempts at induced abortion. Obstructed labour leads to VVF when prolonged and unrelieved pressure on the woman's pelvic wall causes a puncture in the bladder

2.4 CAUSES OF VVF

Just like the classification of fistula, it is also difficult to associate a particular cause to the scourge of VVF around the world. However, the study looks at the problem from both physical and socio-cultural perspective. The physical causes are referred to as the direct cause, while the socio-cultural causes are termed the underlying or the contributing factor to the problem of VVF.

2.4.1 Physical causes

This relates to particular situations which directly expose young women to the scourge of VVF. One important and predominant cause of VVF is a prolonged and difficult labour which sometimes last for days before a woman receives an obstetric care or dies. WHO (2006:4) reports that “if labour remains obstructed, the unrelenting pressure of the baby’s head against the pelvis can greatly reduce the flow of blood to the soft tissues surrounding the bladder, vagina and rectum”. This situation often leaves the pelvic tissue with injury which may rotten away, thus creating a hole or a fistula between the bladder and the urethra (ibid).

According to Moir (1967: 129) the common form of obstetric fistula is caused by pressure necrosis following a prolonged labour. Often, this situation may be unnoticed until many days after a woman delivers her child. The other form of fistula occurs as a result of improper use of obstetrical instruments. This is an accidental injury, which refers to injury caused to the bladder during obstetric operations performed within the formal/modern health care system, such as the hospital. Zacharin (1988:127) noted that destructive operative procedures during delivery of the child may cause trauma, hence fistulae. Poor instruments such as perforator or decapitation hook may slip and damage the vaginal wall and bladder. In some cases, incorrect application of obstetric substances into the urethra may cause the bladder to extend abnormally, thereby causing eruption, hence ureteric injury.

Several cases of VVF cases in developing nations have been observed to originate from obstetric complications such as prolonged and obstructed labour. Many times, this is due to inadequate or total lack of maternity care in such countries. Women from developed world on the other hand, who have proper access to maternity care have no worries over the incidence of VVF resulting from obstructed labour. Through adequate prenatal care and facilities in the

developed world, an endangered baby or mother can be saved through caesarean section, a method which is very new in developing countries. WHO reports that physical causes of fistula emanates from the following: Inaccessibility to basic maternity care and lack of knowledge about or facilities or facilities for fistula repair (2006:6)

A vast majority of pregnant women in developing nations lack access to basic obstetric care. As a matter of fact, many in the rural areas of the developing nations have their child birth at home. Traditional birth attendants are sometimes called upon in case of complications. Adequate obstetric care before, during and after labour goes a long way in preventing or correcting difficulties such as fistula or mortality for mother and child; and since the most women in the poor-resource setting of the world lack access to adequate obstetric care before, during and after delivery, it is expected that infant and maternal mortality would be very high in such regions of the world. United Nations Population Fund (2004) reports that if mothers are at high risk of maternal death or illness, their children are at risk, too. Neonatal and infant deaths can result from poor maternal health and inadequate care during pregnancy, delivery and the critical immediate postpartum period.

Another direct factor responsible for the incidence of VVF is complications of criminal abortion (Hilton, 2003). Most criminal abortions are clandestinely practiced by untrained individuals who claim to be knowledgeable in the act. Through the use of wrong instruments, some girls have had their birth canal unknowingly damaged. If not repaired on time and adequately, this may result in VVF.

2.4.2 Socio-cultural causes

The socio-cultural circumstances in which Nigerian women find themselves function as predisposing factors to their poor maternity conditions, hence incidence of VVF. These socio-cultural factors are mostly responsible as the

underlying behaviours and conditions that initiate and sustain the affliction of VVF on its victims. Important socio-cultural conditions include but are not limited to the following: early marriage; harmful traditional birth practices and poverty and illiteracy.

2.4.2.1 *Early marriage*

A woman who is given out in marriage as early as 10 to 16 years of age usually has a small and narrow pelvis. Early introduction to sexual activities as a result of this marriage leads to early pregnancy when the growth of pelvis is not complete, this situation causes cephalopelvic disproportion, a condition when the baby's head or body is too big to fit through the mother's pelvis (Ajuwon, 1997:27) Since the birth canal is too narrow for the baby to come out, a prolonged and obstructed labours occurs, threatening both the life of the mother and the child at the same time. The trauma experienced by the woman may damage her birth canal, thus giving way to reproductive tract infections; this in turn leads to the development of an opening or fistula between the vagina and the urethra, which allows urine to pass through the vagina uncontrollably (The safe Motherhood Newsletter, 2005). WHO reports that : "In Ethiopia and Nigeria, for example, over 25% of fistula patients had become pregnant before the age of 15, and over 50% had become pregnant before the age of 18" (2006:7). Age at marriage no doubt affects pregnancy and labour complications among Nigerian women, hence a likelihood of VVF.

2.4.2.2 *Female Genital Mutilation*

Another important underlying factor to the problem of VVF in Nigeria is the customary birth practices. Most prominent is the female genital mutilation or simply put; female circumcision. For instance, the gishiri cut which is very popular in the Northern part of Nigeria involves the incision of parts of the vagina with razor blade or a large curved knife, the cut is made against the pubic bone endangering both bladder and urethra. The cuts are often handled by traditional

healers or traditional birth attendants to prevent or treat numerous conditions including prolonged obstructed labour, infertility goiter, backaches, dysuria and coital difficulties (Ajuwon, 1997:30). Others are to prevent promiscuity and premarital pregnancy, to guarantee marriage with subsequent economic and social security for a daughter's future (Moir, 1967: 56)

Mutilation of the female genitals could come in various forms and this undoubtedly contributes to the problem of VVF in such countries where it is practiced. WHO reports that there is a version of circumcision which includes pricking, piercing or incision of the clitoris and or labia; stretching of the labia; cauterization by burning of clitoris and surrounding tissues; scrapping of the vagina orifice (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding; or to cause tightening or narrowing (1996:2001). While FGM is a dangerous practice on its own: considering the unhygienic condition and the dangerous instruments e.g. knife, razor blade or a piece of broken glass that are used to carry out the operation, its combination with early marriage can be more hazardous, especially when the young woman becomes pregnant and is about to go into labour.

Moir (1967:136) observed that about 10% of fistula seen at a particular hospital in Zaria region of Nigeria was directly attributed to the traditional practice of female circumcision, with a further 30% following a combination of genital cutting with obstructed labour. To corroborate this view, Tahzib (2003) reported while investigating the epidemiological determinants of VVF in Nigeria, that among the 80 % cases of VVF caused by obstructed labour, one-third of them all had undergone one form of genital mutilation or the other. WHO also reports that FGM may explain as many as 15% of fistula cases in some parts of Africa (2006)

A study of the traditional practice of female circumcision among people in eastern Nigeria reveals a terrible condition of the practice. According to Nnachi

(2007) the instrument used to circumcise Igbo women inspires much awe with its crudity and savage look. He further illustrates that “a hard metal carving knife known as “aguba” is usually used in cutting the clitoris, whereupon herbal concoctions are used to stop blood flow and reduce the excruciating pains. As the baby cries, the mother takes pleasure in the feeling that, at least, she has a normal woman made ready for her husband’s ecstasy. To further speed up the healing process, palm oil is applied to the wound intermittently using a feather to spread the oil along the cut edges of the former position occupied by the clitoris.” This traditional practice is necessary among the Igbos because of its alleged benefit that, circumcised women would not have an obstructed labour (ibid). Ironically, recent investigations on this practice indicate a connection between FGM and VVF; hence, infant and maternal mortality. Female circumcision and inserting of caustics into the postpartum vagina may lead to the damage of the birth canal which ultimately predisposes to prolonged labour and development of fistula (Moir, 1967:131)

Circumcised women often faced lots of health consequences. However, the consequences rely on the type of procedure performed, the extent of the cutting, the skill of the practitioner, the hygiene of the instruments, the environment of the operation, and more importantly, the physical condition of the girl to be circumcised (Chalmers & Omer-Hash, 2003:2).

2.4.2.3 *Poverty and illiteracy*

Poverty often plays an important role in predisposing Nigerian women to the problem of VVF. Poverty is linked to illiteracy, malnourishment, living condition, accessibility to good obstetric care and so on.

WHO reports that women suffering from fistulae come exclusively from poor families with subsistence farming background (1991). A subsequent study by WHO confirms this, i.e. that in sub-Sahara Africa the problem of Obstetric fistula

was estimated to be about 124 cases per 1,000 deliveries in rural areas, compared with virtually no cases in major cities (2006)

Two thirds of fistulae caused by difficult labour were due to contracted pelvis of the flat type which resulted from poor nutrition, with frequent childhood and adolescent infections (Zacharin, 1988: 124). Due to poverty, it is difficult for people especially in the rural areas to afford good nutrition; most times they live on nutritional diets that do not make them achieve full body growth. Many victims of VVF are malnourished resulting in abnormal growth of the pelvic bones. Balogun (1995:30) observed that because of high value placed on male children, they receive a larger quantity of food and on a more regular basis to the disadvantage of girls. Also when pregnant, women are prevented from eating some food which could enhance their body development and prepare them for the child delivery process. In addition the belief is that a large quantity of food will add to the weight of the baby, thus big baby would pose a complication for the mother at delivery. To this end, small food rations are encouraged for pregnant women.

As a result of poverty, some parents in Nigeria find it difficult to send their children to school. Some are even withdrawn from school so as to be given out in marriage to attract high bride prices, especially if they are still virgins (Balogun,1995: 29). When the girls become pregnant, they are usually sent home to deliver at their parents' house, and should there arise any complications, the cost of procuring immediate and good obstetric care might be too exorbitant for the parents. If and when VVF arise, victims equally find it impossible to afford medical services for repairs (1995:30). The cost of transporting VVF victims to the hospital, usually in major cities is also unaffordable by the family.

2.5 PSYCHO-SOCIAL CONSEQUENCES OF VVF ON ITS VICTIMS

Virtually all the studies into the case of VVF are conducted from the medical point of view. Treatment, correction, and repair of VVF is possible, however, due to

high cost involved, a majority of the victims are unable to afford the cost for the treatment, in this case, their physical, social and mental conditions are worsened. Victims of VVF suffer from urinary incontinence, which makes them stink of urine at all times, WHO reports that the uncontrollable passage of urine exposes their vulnerability to tract infection, vaginitis, and excoriation of vulva (i.e. injury to the surface of the skin or mucous membrane caused by physical abrasion, such as scratching). Stricture of the vagina which narrows the vagina, secondary amenorrhea, possible future of inability to carry a child even after repair of VVF, and a low child survival rate are also related to VVF (1991). Considering the nature of VVF, victims often find it very difficult to keep themselves clean and hygienic.

The devastating complication of VVF is the psycho-social consequences victims have to put up with, the major problems being incontinence, childlessness, divorce, poverty. Often times the victims become a social outcast with suicide sometime a terminal event (Moir, 1967:136). Because of the lower social status of women in Nigeria, the attitudes displayed by the society towards VVF victims are without sympathy, and this is further complicated by their husbands abandoning them. "Often a woman's role in family life centers around a strong obligation to satisfy the sexual needs of her husband and to provide him with offspring" (WHO, 2006). If a victim of VVF is fortunate enough to be in the same compound with her husband, they obviously do not share the same bed. This situation makes the sexual desire between the couple die out. Since victims can neither satisfy their husbands' sexual urge nor produce offspring, they become useless in the eyes of their husbands and even the society. Also because women in most African societies have accepted their low status role, the inability to produce children or satisfy their husband's sexual desire further destroy their own self esteem (WHO, 2006).

Large families are a source of pride and a symbol of affluence (WHO 2006). Having a large family in rural areas where a majority of VVF victims reside is very important in Nigerian societies, because large family is a source of social

security. More children enable a vast family land to be cultivated on time for planting, harvesting and produce sales. To this end, the more children a family has the more economic vibrant it is. Encroaching on family land, often rampant in rural areas is also prevented by a large family with male dominated children. In Nigeria, there is virtually no social welfare programme put in place by the government, thus the only hope parents have for coping at old age is their children. In traditional Nigerian society, any married woman who has no child for her husband has no contribution to the socio-economic and political development of her family, and the society in general. This is usually the case of a VVF victim with no child. In this case, the future becomes disastrous for both the wife and the husband. Because men still have the capacity to father many children, many men find it easier to rid themselves of their damaged wives and seek other, fertile, spouses. Women in this condition are left to live their lives in quietness and shame (WHO 2006).

Another view to the worthlessness of VVF victims in the society is seen from the perspective of their economic irrelevances. Since a majority of VVF victims comes from the rural areas where farming is the mainstay of economy and subsistence for each household, it is expected that women should contribute their labour in cultivating the family land. However, and due to the VVF condition, victims are no longer able to contribute to the economic productivity of their household, instead they become an economic burden. The inability of the victims to satisfy their husband's sexual desires, produce offspring and contribute to the economy of their household ultimately lead to the collapse of the marriage (WHO 2006).

Muslims, according to their Islamic belief consider cleanliness an important ritual while praying and during sexual intercourse, whoever is afflicted with VVF is considered unclean and therefore can not pray, however, she could be granted a permission to pray only when her condition is considered as incurable (Moir, 1967:137). Because of the magnanimity of the stigma involved and its

consequences, families and sufferers alike may decide not to reveal the existence of VVF, thus they are denied access to treatment.

Among the muslims in Nigeria, wives often live under a system of seclusion whereby their only social contact is their immediate family and female neighbours (Wall 1988). Women are also put in a system called *purdah*, they are provided with special clothing which covers their head to keep them away from public view, in some cases they are provided with separate rooms in the household to prevent them from intermingling with strangers or visitors. In a situation whereby a wife is afflicted with the VVF condition, the repulsive smell that accompanies total urinary incontinence usually curtails even the limited opportunity for social interaction. For the family to deal with this problem of offensive smell of the incontinence urine, the afflicted woman is often removed from the main household into a separate hut, though within the same compound, but as time goes on, they are often forced out of the family compound (WHO 2006).

The physical consequences of VVF are unbearable for victims; however, the attending psycho-social consequences seem to me as a more complicated situation for them to bear. Ostracising victims from the society by the families and societies alike removes the moral and physical support they need to cope with their miserable condition. This is rather a big blow to their psycho-social wellbeing.

2.6 STRATEGIES ADOPTED BY VVF VICTIMS TO MANAGE THEIR CONDITIONS

In as much as women live with the VVF condition, they are faced with the problem of stigma in the society. From the Greek origin, the term stigma was observed as a bodily sign designed to expose something unusual and bad about the moral status of the signifier (Goffman, 1963:11). *Stigma* is further explained as an attribute an individual possesses which makes her different from others in

the category of persons with a desirable kind. VVF victims are considered as “outsiders” or “abnormal” individuals which are not fit enough to live in the midst of “normal” individuals.

Goffman’s phenomenological theory gives us an insight into how individuals present their everyday life. More important is the way individual-self presentation is aided by the social categorisation of individuals into different social identities. The society constructs what should be a normative expectation from each member of the categorised group, these demands might be called demands ‘in effect’, i.e. *a virtual social identity*. On the other hand, the individual herself could possess some attributes which is indeed a relation to her real self, such is termed an *actual social identity* (Goffman,1963:12). VVF victims, due to their conditions have failed to meet the normal expectations of their family and society, therefore they are isolated into their own “abnormal” world.

Although stigmatised individuals do not live successful and happy life, they have developed different survival strategies in order to have a relative good life.

One important survival strategy adopted by victims is to associate more with people they share similar stigma with. Having been ostracised by their family and society, many victims of VVF derive great satisfaction from being with others who share their disability. UNFPA (2005) refers to this as “a sisterhood of suffering”. For instance, UNFPA (2005) reports that “at the Niamey National Hospital Fistula Pavilion in Niger, nearly 50 women with difficult cases lived for several years while waiting for treatment. At the Pavilion, they formed a community where they cooked for one another, sewed and braided each other’s hair- and lived without feeling ashamed”. This peculiar association is necessary for VVF victims because they can have solitude when they are within the circle of those with the same condition. This circle gives them a sense of belonging to deal with their life experiences. Another important method adopted by VVF victims to manage their problems is to hide themselves away from the so-called “normal” society because of humiliation. Some individuals who suffer from a particular stigma

would rather be alone until they are able to find treatment than to be around people that do not care about them.

Some girls living with fistula are very strong; they have resorted to fight the disease rather than losing hope. Some of them go into the forest to gather woods and fetch water to sell in order to survive. They may spend months or years saving money in order to pay for medical care and transportation to a facility providing treatment. It is rather unfortunate that, while being alone, some might go into deep physical and emotional decline and may resort into suicide (UNFPA, 2005).

A majority of indigenous people or patients in African usually have a way of explaining their distressing situations in order to reduce their psychological instability and pain suffered from their illnesses. For instance, some VVF victims believe they are bewitched by some wicked or spiritual forces. To this end, they have turned to some spiritual divinity as a source of coping with their unfortunate conditions (Balogun, 1997: 56). In the case of untreated diseases, some patients resort to the powers of fate, which controls their destiny. Those close to major cities have turned to religious organisations, like churches, which are sympathetic towards their condition. Some of these churches give them free accommodation and feeding, and they are being offered prayer for miraculous healings.

CHAPTER 3.0 METHODS

According to Chetty (1997: 61), “in any project, the researcher is responsible for his/ her “starting point, methods, findings and applications”. The methods and techniques used in the investigation are very important in order for the findings to be meaningful to readers and subsequent users of the work. This section explains the steps taken to arrive at the aims and objectives of this study.

3.1 PHENOMENOLOGY: A QUALITATIVE APPROACH

The in-depth knowledge and understanding of the psychological well-being of victims of *VVF* can best be obtained through the use of qualitative research techniques. The choice of this method becomes important because it best explains the experiences of people, how they interpret such experiences and how the world in which they live is structured. Since qualitative research always involves some kind of direct encounter with ‘the world’, whether it takes the form of ongoing daily life or interaction with a selected group (May, 2002: 199), qualitative researchers further make use of techniques such as participant observation, in-depth interviewing and personal documents to gather data.

There is a number of theoretical approaches that go along with the qualitative research technique, as noted above, and that is why it is chosen as the most

appropriate one to deal with issues such as the psycho-social conditions of victims of *VVF*. As a research technique, “qualitative” phenomenology concerns itself with the interpretation of everyday experience of individuals. This approach encourages researchers to look closely at the meanings and also at the way people interpret their interaction with others and how such meanings and interpretations influence the way they think about themselves and how they react.

One important assumption in hermeneutics is that meanings can be explained and understood only in the context from which they arise, that is through lived experience of those involved in particular situations (Nehls & Sallmann, 2005: 365). Thus, the systematic approaches used in interviewing and interpreting interview texts or other sources of data gave me the opportunity of understanding the everyday life of victims of *VVF*, and importantly from their own perspective, rather than from the so-called “objective” perspective of a quantitative researcher.

3.2 SAMPLING TECHNIQUE

Finding people living with *VVF* is not an easy task. To worsen the matter, not all clinics in Nigeria handle cases as serious as *VVF*. However, through the local government and local health centres, albeit was possible to identify those clinics and NGO's in Lagos that treat and assist (respectively) women having *VVF*. Lagos was selected purposefully for my sampling because of its ethnic and cultural diversity. Being the city with the largest population in Nigeria, Lagos is a home for people from all walks of life. However, for the sensitivity of this research topic and the difficulty in identifying victims of *VVF*, a snowball sampling technique was chosen, thus any victims of *VVF* in these clinics and NGOs willing to participate in the interview was approached, though with the assistance of the clinic management and staff. Willing respondents were also requested to suggest other victims they knew who could be willing to take part in this study. According to Rice & Ezzy (1999: 45) the snowball sampling method is significant when

people being studied are well networked and difficult to approach directly, or when the focus of the study is social networks. An example of this kind of network is the 'association of sisterhood' often created by victims of VVF. I visited three different government clinics, and two NGOs to gather my data, and a total number of seven victims of VVF were interviewed.

3.3 INTERVIEW SCHEDULE

The qualitative nature of this study presents to me the option of using an interview guide consisting of semi structured questions to gather my information. A semi structured questionnaire is used to collect data when the researcher is familiar with the terrain and issues bothering on the phenomenon or condition under study, but is not able to predict all the possible responses to a particular question, and thus can not structure the answer (Morse, 1992: 361). The significance of this interview guide is that it allows an informal setting between the researcher and the participant, therefore creating a relaxing atmosphere for the respondent to respond freely to the questions in language best understood. The unstructured questionnaire also enables the researcher to dig deep into a particular question that is of interest to him and to the respondent alike, this situation enables the researcher to gain adequate and rich information based on the direction of the interview guide. While the researcher has control over the way the interviews should go, the respondent on the other hand has control over the information provided (Morse, 1992: 361).

Being semi structured, the questions are mostly open-ended, such that the respondents have enough freedom to express their world experience. Since those interviewed were respondents that were awaiting discharge from the clinic admission, and those receiving "reintegration" assistance at the NGO's it became easy for the researcher to make repeated visits during the day time, when they were more relaxed to respond freely. This repeated and in-depth activity is very

effective because it availed the respondents and the researcher the opportunity to get to know one another very well, and since the interviews were not one off, I was able to gain an in-depth understanding of the lived experience of the victims of VVF.

Since a good data analysis depends greatly on how the information is gathered, I proceeded to aid myself with a tape recorder in order to capture data adequately. The researcher took one week day (average of one set of interviews per day) to finish the data gathering.

3.4 DATA ANALYSIS

The steps and guideline provided by qualitative researchers such as Onwuegbuzie & Leech (2004) were utilized for the data analysis. According to them there are three steps involved in the analysis of meaning. These steps include: (a) noting possible meanings in field notes, (b) reconstructing normative factors involves taking first-, second-, and third-person positions with respect to an act and this can be done only with reference to certain norms assumed to be in play” and (c) subjective states of the individuals must be reconstructed. (Onwuegbuzie & Leech 2004:774). Analyzing the meanings in the data involves looking out for, and building around those important and recurrent issues that are relevant to both the respondents and the research questions, thus validating them with the theoretical framework of other scientific researches. In order to achieve the above three steps of analyzing meaning, a meaning condensation method of phenomenology by carefully writing a summary of each transcribed interview was utilised, including all the events and experiences which were recurring and common to all the respondents. The results are subsequently discussed and presented in Chapter 4 of this study.

3.5 STRENGTHS

Qualitative approach has the advantage of being able to directly observe the behaviour of those who the researcher is interested in studying. In other words, the method allows the data to be analysed at the same time that it is being gathered, since there is a face to face in depth interaction between the researcher and the participant (respondent).

The conceptual density enables a qualitative researcher to go back and forth assessing extensively and adequately the utmost connections between the collected data and the problems stated. According to Strauss & Corbin (1994:274), this kind of hypothesis verification through the conceptual density is done throughout the course of a research work. Other important features which makes qualitative researches stand out include “the systematic asking of generative and concept-relating questions, theoretical sampling, systematic coding procedures, suggested guidelines for attaining conceptual density, variation and conceptual integration” (Strauss & Corbin, 1994: 275)

This approach becomes important and interesting because it enables the researcher to expand on the explanation of the impact of VVF on the psycho-social well-being of its victims by first identifying the cogent elements about the respondents’ experiences, and then proceed to categorise the relationships of those cogent elements to the context and process of my interviews.

3.6 LIMITATIONS

The qualitative technique involves direct contact and in-depth interviews with the respondents. With the sensitivity of the study, including: gender differences; cultural differences and so on, there is a challenge in the use of this approach. Also too many interview questions were problematic for the data analysis, however, those issues bothering on the research questions were purposely selected. The challenge of gender difference did not permit me to interview as many women as I originally wanted. I had to train my wife on qualitative interviewing to enable me gather sensitive data from some of the respondents. While researching other literatures, it was so obvious that much has not been

done about the socio-psychological aspects of VVF. Most studies on VVF were done by medical professionals, thus they concentrate on the medical aspects full of medical jargons. In order for me to understand these medical issues, I resorted to frequent use of medical dictionary. Another limitation in the choice of this approach is insufficient of fund and time to carry out a research finding which requires a huge number of respondents.

Time and funding are no doubt a limitation to the study. Thus a cost and time reasonable number of respondents were used in the study to generate required information for me to achieve the aim and objective of my study. In addition, the cassette used to record the first two set of interviews was not audible enough for transcription, so the use of tape recorder was discontinued. Because the questions were many, and in order not to tire out the respondents, the researcher decided to modify questions slightly, but the basic structure and format of the interview schedule was not altered. Another important limitation encountered on the field was local language barrier. Some of the respondents were Hausa speaking, and since I do not speak Hausa language, an interpreter who had to translate the response to me in English was used. There may have been a distortion, underestimation or exaggeration of issues described by the interviews, however, the information gathered were juxtaposed against literature earlier reviewed for guideline purpose. One important limitation of this study is what Onwuegbuzie & Leech (2004:777) refer to as “observer effect”. While interviewing the participants, I was almost sure of what their responses would be, however, this situation made the lived world experiences of the participants more meaningful to me.

3.7 ETHICAL IMPLICATIONS

For ethical consideration, I had earlier discussed the aim and objective of the study with the management of the clinics, thus permission was sought to be able to carry out the interview. The interview guide was also presented to the

respective clinic managements to ensure all questions are in line with the study objectives. This is done with the assistance of clinic staffs and the NGO's concerned.

According to Munhall and Boyd (1993: 403) "fieldwork that is existential and authentic involves the negotiation of trust between the researcher and the participants". Entry into the life world of an individual is a big privilege, thus negotiating for trust should be validated with informed consent. Informed consent is very important in the study, thus before conducting the interview, the respondents were all giving both written and or oral orientation to ensure their understanding and awareness of the procedure of the interview; this includes communicating the aim and objectives of hte study for them to give me their consent. Before using a tape recorder, respondents' permissions were sought, and there was no pressure on those who declined the use of tape recorder to gather their information.

To ensure confidentiality of those participated in the study, all the names used are not the real names of the participants.

4.0 RESULTS.

The findings of my study are based on variables including the following: socio economic conditions of informants; accessibility to maternal health care and treatment; attribution of causes; psycho-social reactions and consequences of VVF; and coping with the scourge of VVF.

4.1 RESPONDENTS

4.1.1 Areas of origin

The respondents in this study came from a great many areas. The highest number (five) of respondents were from rural areas, the remaining two came from urban area of Lagos and Ibadan. The findings of this study are in accordance with previous studies that majority of the women afflicted with VVF come from rural areas where there is a high level of illiteracy, poverty, inadequate health care and obstetric facilities. Rural areas also face the problems of strong hold to traditional practices.

4.1.2 Socio-economic background

The findings indicated that all the respondents came from educationally and socio-economically disadvantaged background. A majority of the respondents are from extremely poor families and did not complete their elementary school education. This finding is corroborated by the WHO report that pervasive poverty is an important underlying cause of VVF. Women who suffer from obstetric fistula tend to be impoverished, malnourished, lack basic education and live in remote

or rural areas (WHO, 2006:6). Incidence of abject poverty makes it difficult for parents to send their children to school, therefore, illiteracy prevents victims from having knowledge about their health condition and it also blinds them to understand the basic treatment and management involved in the condition VVF. Once VVF occur it is difficult to heal on its own, therefore surgical repair is necessary. However, due to the extreme poverty, parents and victims alike face the difficulty of raising fund for the treatment. Condition of poverty has a direct effect on the quality and quantity of food intake of most of the patients afflicted with VVF. Balogun, in his study observed that many victims of VVF are malnourished, anaemic, highly disease infected and rickety. “Evidences of inadequate growth are reflected in their statures, gaunt looks, and small pelvic bones (1995:30). A majority of my respondent are very small in stature. In the words of Hafsat, she is quoted as saying: “Don’t be deceived by my stature. I am older than what you think I look. A lot of people still think I am 13 years, but I am 22 this year” Illiteracy and poverty thus play an important role in predisposing victims to VVF.

4.1.3 Marital age of respondents

The findings in this present study concerning age at marriage agree considerably with those of other researchers on VVF. WHO reports that “in parts of sub-Saharan Africa and South Asia, where obstetric fistula is most common, women often marry as adolescents, sometimes as young as ten years of age, and may become pregnant immediately thereafter, before their pelvises are fully developed for childbearing (2006:7). Balogun (1995:24) wrote that “most literature reported that age at marriage of significant percentage of VF victims ranged between 9 and 15 years. A report by National Taskforce on VVF (1995) also showed that about 80% of VVF cases in Nigeria occur in girls who have been given out in marriage between ages 10 and 14 years (Ejembi, 1995:24). It should be noted however, that it is not every woman that married at early age are victims of VVF, but all the VVF victims, especially in this study married at early

age. Thus, there seems to be a correlation between developing fistula and age at marriage.

In this present study, the age at which victims developed fistula range from 12 to 16 years. All the respondents were of the opinion that if they had delayed marriage until when they were old and matured enough to carry pregnancy, they probably would not have been in their condition. One of the respondents, Juma, is quoted as saying *“pregnancy is for those who are old enough to carry it, if I did not marry at age 13, I would not engage in sex, and I would not be pregnant, look at me I still look like a girl who should not think about getting pregnant until the next 10 years. Marrying at early age is not a good practice”*.

Another respondent, Tawa, corroborated the above opinion of Juma. In her words, she said, *“how can a little child get pregnant and give birth to another little child? I was just 10 years old when my uncle arranged my marriage to one of his friends. My body was not ready for sexual activities. When I got pregnant, the pregnancy was almost bigger than my whole body. My pelvic bones and “private part” were still very small. I could not push the baby out for 3 days. When the baby came out the third day, it already died. After some weeks, I could not hold my urine. I became isolated and humiliated by everybody. If I was mature and old enough before getting pregnant, my pelvic bones and “private part” would have been big enough and I would be able push the baby out without difficulty. I would not be facing any embarrassment. The government should please put a stop to the practice”*.

In Nigeria, poverty has a direct consequence on the nutritional diets of adolescent girls, hence their physical appearances; however, their early marriage situation further complicates their risk towards the development of VF

4.2 Responses on accessibility to maternal health care and treatment

World Health Organisation reports that skilled care before and after birth, and particularly during labour can make the difference between life and death for women and their babies, and can help to prevent obstetric fistula (2006:5). In this present study, majority of the respondents reported they did not visit ante-natal clinic. One of the respondents commented.

“I could not visit the clinic when I was pregnant because, there is no clinic in my village. I can not afford transportation to the city, and since I was not sick during my pregnancy, there is no point to visit the clinic. We have traditional midwives around, and there is no charge for their services”.

Another respondent corroborated this by saying:

“The cost of transportation to the clinic is too much. I can use the money to buy food to eat, besides, one can spend the whole day at the clinic and the doctor will only test your urine and ask you to go back home, this to me is a waste of time and money, so I did not attend the clinic”.

Lack of access to obstetric care by pregnant women in Nigeria often contributes to the prevalence of VVF. If they had had access to basic maternity care, difficult and complicated labour would have been identified at ante-natal and rectified immediately before the child delivery period. As discussed earlier, the poor condition of victims would not allow them to afford cost of transportation to the clinic, usually in the urban towns; rather, they would use the money to buy food. Illiteracy on the other hand does not make them understand the importance of ante-natal care. Thus, in Nigeria, most cases of maternal mortality or condition of VVF arise because pregnant women fail to receive the health care they require;

this may be as a result of basic health-care provision or through inability to access the local health-care services (WHO, 2006: 5).

It is also observed that there is a prolonged lag between onset of fistula and first visit to the hospital (Mabeya, 2004), when asked about the time waited before seeking medical treatment, Five of the participants responded they did not seek medical intervention immediately.

One of the participants, Fatimah said *“I did not know where and who to inform when I started wetting my pant. It was very embarrassing and shameful. May be if there is a clinic around, I would have gone”*.

Another respondent, Marufa said *“When I realised I could not hold my urine, I secretly visited a traditional healer. I have confidence in her because she treated me like her child, she did not laugh at me. If I visit the clinic, everyone would see me, may be some people will even laugh at my condition”*.

The reason for not seeking medical attention immediately may be attributed to the fact that fistula repair facilities are inaccessible to victims, also VVF patients are stigmatized and ostracized by the society, therefore, they would rather bear the shame and pain in isolation. Another crucial reason may be that rural people often repose confidence in their traditional healers who handle their cases with empathy.

4.3 Attribution to causes of VVF

It is hard to attribute a particular cause to the prevalence of VVF among Nigerian women. Four of the respondents attributed the prevalence to prolonged and complicated labour. According to Tawa, *“my pelvic bones and “private part” were still very small. I could not push the baby out for three days. When the baby came out the third day, it already died”*. Another respondent, Fatimah corroborated this by saying *“since all parts of my body are very small, it was expected that there will be difficulty in the child delivery, the head of the baby*

was very big that it will not come out easily, it took about two days before I could eventually deliver the baby, I almost died". However, further probing questions indicated that there are other predisposing factors. For example, early marriage with early pregnancy, narrow pelvic bones to accommodate the baby, infection resulting from circumcision. As reported earlier in this study, all participants were married out when they were very young. When asked what to highlight the possible cause of her condition, one of the respondents, Ajuwa said *"if I was not pregnant at that early age, I would not probably be in this condition. I was not ready for sex or pregnancy, but my arranged marriage forced me to get pregnant, the doctor said my hip bones were too small to allow the baby to come out"*. Another respondent, Hafsat, corroborated the views of Ajuwa, in her words, *"the culture of early marriage is not a good thing, how can a 13 year old girl carry pregnancy, I was not happy when I got married, and when I became pregnant, I was very unhappy. I had wanted to go to school, now there is no hope for me. If I did not get married at that age, I would not be pregnant, I would be able to go to school, and I would not be in this condition"*. They all also reported that they were circumcised. The story told by one of the respondents, Marufa undoubtedly linked circumcision to her developing fistula. According to her story *"I was circumcised when I was 11 years. I can still remember the pains and the crude instruments used. After one month of the circumcision, I was still feeling the pains; I could not walk very well, so I was brought to the local clinic where they informed me there was an infection due to the deep cut. They gave me some antibiotics and I think it healed. 4 years later I got married and was pregnant. When I delivered my baby, everything was OK. 6 months after the delivery, my problem started. I could not stop my urine"*.

4.4 Psycho-social reactions and consequences of VVF

Development of fistula has a devastating effect and severe consequences on the victims. The findings of this study indicate that apart from the physical pains and consequences of continuous passage of urine and smell, victims often face

socio-psychological consequences which make their conditions more burdensome and unbearable. These conditions further complicate their physical problems. One of the respondents, Kahdijat, said *“I am very sad because my husband asked me to go back to my parents’ house because I am useless to him sexually and also because my body smelt of urine all the time, everybody is running away from me the moment they know about my condition. You see I am very religious, but with this condition I can not go to mosque to pray, it is an abomination”!*

Hafsat was very emotional when she said *“apart from my uncontrollable passage of urine, I faced a lot of rejection from everybody around me. When my husband realised, this sickness will not go away, he took me back to my father’s house and asked me not to come back until when I am cured. Most of the time I locked myself up in the room without talking to anybody”.*

In Juma’s words *“if people accept you with your condition, it can help to solve the problem. As for me, I have nobody to turn to. My husband died when I was pregnant, I already lost my parents when I was very little. My uncle who gave me out in marriage also abandoned me. Everybody who knows my condition treats me like I have leprosy. Life is very hard for me”.*

However, one of the participants who is not sent away by the husband because of a successful repair of the fistula, told that *“although I am still in my husband’s house, but because I will not be able to get pregnant again, my husband has taken in another woman. I am now being relegated in my house as if I was the cause of the fistula. My husband does not have sexual intercourse with me again”.* The findings in this study about the abandonment of VVF victims by their husbands are further corroborated by findings of various studies. For instance, the study carried out by INFO project on 899 fistula cases in Nigeria, India and Pakistan reported that between 70% and 90% of VVF patients were either divorced or separated from their husbands (2006). Also WHO (2006) reports that *“since the obstructed labour usually results in stillbirth, the victim will not be able*

to have a child of her own. The future thus becomes disastrous for both the wife and the husband. Faced with this situation, many men find it easier to rid themselves of their damaged wives and seek other, fertile, spouses”.

All the respondents in this present study reported that they developed fistula after their first pregnancy, this report is in line with that of WHO that most fistula formation is more likely to follow a first labour (2006:7) In Nigerian culture, cultural values such as marriage and child bearing add spice to people’s life. Victims whose baby died as a result of the labour complication may find it very difficult to raise a child again, these victims are then noted to experience a more lasting and devastating psychological instability than those whose baby survived. In Nigeria, especially the traditional parts of the country, childless women are often seen as social outcasts. They are treated with disregard and disrespect by both old and young ones, the attending condition of VVF thus makes their life more unbearable. With no husband, family, friends and children, they live a miserable life till they die. Many of these victims end up taking their own lives.

In this present study, only one of the respondents had a child, the others had still births and are unsure whether or not they will be able to raise a child again in future. One respondent said *“how can I ever be happy again in my life, with no child or husband”*? Another declared that *“I should be able to see another man who wants to marry me with my condition before talking about having a child”*. The childless situation of women in Nigeria is more felt by those who are in a polygamous marriage, and whose other wives have their own children. Such childless women are often taunted and treated with no respect. There is a Nigerian saying that, *“a woman with children owns the husband”*. Childlessness is thus used as one of the measurements for psychological well-being and stability among married or adult women in Nigeria. The only respondent whose baby survived is quoted said *“I don’t know what my life will be if my baby did not survive. I hear women who develop this disease can never have a child again”*. The fact that this respondent has a baby she can call her own is a source of joy to her, thus she no doubt has a better relative psychological well-being than those victims whose babies did not survive.

Another psycho-social consequence observed in this study is the inability of the victims to make a living. While financial prowess could help in adjusting to basic demands of daily lives, many women living with VVF find it difficult to meet their daily financial demands. This is due to the fact that, they are not fit enough to get a sustainable job. Since many jobs require physical contact with other people, victims of VVF are excluded from getting a meaningful job. All the respondents reported they were not economically productive as they would have wanted due to their conditions. They reported that no one will be willing to give them any job. One of the respondents, Tawa, responded on her state of economic production *“Before my sickness, I was buying fruits on the farm and selling in the market, but due to my condition, I don’t even have the money to buy the fruits. I don’t think anyone would want to buy fruits from me with my condition. This is so painful”*. Apart from the social isolation from both husband and the society alike, INFO project observed that many women with VVF live for years without financial or social support. Many fall into extreme poverty (2006), the true situation of women afflicted with the disease.

Depression and loss of self esteem are major psychological problems faced by victims of VVF. According to Balogun (1995:36), psychological depression involves mood swing, anger, anxiety, distress, hypochondriasis and withdrawal. This sometimes affects people who suffer from a devastating damage or loss of a valuable possession. This is exactly the case of a VVF victim, thus their state of depression leading to withdrawal should not be surprising. Fatimah said, *“sometimes, I wish I were not born... to die is even better than to be in this condition because no one wants to be with someone with this disease, I can’t attend school, I can’t get a meaningful job. I can’t play like others. What is the point living? When I am alone and depressed, I sometimes think of committing suicide”*!

Self esteem is the degree of self evaluation an individual places on him or herself at any given time. It is often learned from others and becomes a reflection of how others regard us or more accurately, the value we think others attach to us as

persons (Balogun, 1995:37). An Individual who reports a low level of confidence, enthusiasm and evaluation of herself is said to have a low or poor self esteem. Attitude meted out to VVF victims by their husbands often makes them perceive themselves as worthless or useless as an individual and martially. The attitude of the larger society further confirms this status of depression to them, thus low esteem impacts negatively on their activities and the way they relate to others.

Whether sick or healthy, normal or abnormal, Nigerian people are known for developing various strategies to manage whatever unfortunate situations they find themselves. It is though, not surprising that Victims of VVF in Nigeria also develop survival strategies in the face of their calamity. About four of the VVF victims in this present study have almost similar survival strategies. These among others include: Street begging, being religious, accepting fate, finding friendship with people of similar condition, working to raise money for treatment and survival.

4.5.1 Street begging

Four of the seven respondents indicated that they begged on the streets in order to make money. According to these respondents, this activity was the easiest and most common for people with any form of stigma or disability in Nigeria.

One of the respondents recounted:

"I used to sit at a corner usually frequented by people asking them form money. Every Sunday I sit at the corner of the church because Church people are very nice and merciful."

Another participant recalled that *"every Friday, I would go and sit at the corner of a mosque. I am a Muslim, and I know Muslims give "saka" every Friday of the week. The money I make on a Friday may be enough for me to eat the whole week"*. To corroborate the views of other victims who beg for alms in order to survive the hardship of VVF, one of the respondents recounted that *"since I can*

not get a reasonable job and am not ready to die, I have to survive, so I beg for money at a busy market. Begging is easy for my condition because I don't have to walk up and down. I just sit at a junction and those who are kind enough drop me some coins". The remaining three respondents who did not do street begging however, had other forms of generating money. Two of them sell firewood or bagged water, the remaining one does not do any paid work but receives a meagre support from her husband.

4.5.2 Hawking “pure” water or selling fire wood

Two out of the seven respondents survived their financial hardship by hawking the popular “pure” water on the busy streets of Lagos. One of the respondents tells that *“everyone buys pure water in Lagos, so what I do is to buy two bags of pure water and ice block everyday. So I just sit at a corner of the busy market and people come and buy from me. I don't have to stand up because they might see my leaking urine; the money I make is what I manage to eat. Sometimes, I have a little saving”*. The other respondent looked the difficulty in the face and thus muscled up strength by finding other ways to support herself. According to this respondent, *“I have customers whom I supply firewood daily. What I used to do is to wake up very early in the morning, say 4:30 am, since it is hard for me to enjoy sleeping, and head for the forest. By 5: 30 am, I am already in the bush picking and sometimes cutting woods, when I gather a heap that I can carry on my head, I stop. It takes me two to three hours to gather a stack of firewood, then I spend another one and a half hours to haul them to the city on my head. Sometimes I get lucky with plenty of firewood, so I make my journey to the forest twice on that day. This type of business is good for me because I have customers and I can make money and still save part of it”*.

4.5.3 Accepting fate

Apart from the financial hardship of finding food to eat, most victims of VVF in Nigeria have resorted to fate. All the seven respondents in this study came from an Islamic background, and since Islam's doctrine is based on a total submission to the will of Allah, whatever Allah wills, you can not query. Balogun (1995:42) observed that a total submission to the will of Allah is the way of life among the Muslims, thus victims from this religious background often alleviate their condition with this Islamic injunction or thought. All of the seven respondents corroborate this observation of Balogun. One of them concurred by saying *"I did not create myself; I believe it is the will of Allah that I am in this condition"*. Another respondent said *"I am not alone in this condition; Allah is with me because he allowed this to happen to me"*. Whether religion or fate, a majority of Africans have the culture of attributing their misfortunes to divinity, by so doing, their pains and suffering are spiritually alleviated. One of the respondents, Tawa said *"if I don't accept my condition the way it is, what would I do? The best thing I can do is to accept this as the will of my creator"*. Another victim, Hafsat was emotional when she said *"out of all the women that I know, why is it that I am the only one with this sickness? That is my own fate!"*

4.5.4 Network of friendship with people of same conditions

Victims of VVF often cope with their condition in secrecy; they rather hide themselves away from the so called "normal" people. One of the respondents, said that, *"most of the time I locked myself up in the room without talking to anybody for days"*. However, if they want to associate with other people, they often do this by either associating more with people they share similar stigma with or by being 'wise', according to Goffman (1963:41) wise persons are those who are normal, but whose special situation has made them intimately privy to

the secret life of the stigmatised individual and sympathetic with it. These are marginal persons before whom the individual with a fault need feel no shame nor exert self control, knowing that in spite of her failing she will be seen as an ordinary other (ibid). All the respondents in this present study reported that social isolation has “helped” them to cope with their condition. One of the respondent recalled *“It’s better to be on your own than to be among people that will constantly remind you of your problem”*. Another respondent recounted *“if I need to be with anyone, it would rather be with people who understand how I feel, since I came to this centre, I am less unhappy because we are all the same, we have the same thing in common”*. Corroborating the above views, Ajuwa said *“when I am with women with this same condition, I feel relaxed to discuss anything because they do not remind me of my condition, but when I am with people who do not have this condition, I feel very sad because they remind me that I am sick and abnormal”*. Organising themselves into a ‘sisterhood of suffering’ enables victims of VVF to survive the unwelcoming and the anti-social attitude of the “normal” people toward them.

4.5.5 Involving in religious activities.

Two of the respondents in this study reported that they cope with their disease by associating with church activities and believing in miracle from God. These victims that are previously Muslims claim that they are “born again” and that God will heal them of their disease. One of these respondents said *“I learnt that when you go to this church, they would be able to help you. Fortunately, the church I attended sent me to this clinic for my treatment. If not for them I would not be able to receive treatment”*. The view of this respondent is corroborated by a Christian journal in Nigeria which says “victims of VVF are unreachable group of people, hidden in the back of rooms of thousands of compounds in Nigeria. Suffering rejection and loneliness, they risk leaving their families and come to a Christian hospital where they are surrounded by love and concern. Those who meet the savior and return to their homes are brave messengers to every dark

corners of God's unharvested vineyard" (ECWA, 2005). Another VVF victim, who copes emotionally with the help of church activities, reported that *"when I am in the church, they show me love and pray with me. Some of them give me clothes, money and other gifts. Above all, the church people don't make me feel like I have a disease. They don't run away from me even when they learn of my problem. To be honest with you I feel very sad whenever the service in the church is coming to an end."*

While religion serves as a source of joy, strength and refuge for members to cope with their respective living conditions in Nigeria, there seems to be differences as this applies to Muslims and Christians. For instance, all the seven respondents in this study are Muslims originally, two of them converted to Christians in order to receive spiritual care from the churches. According to one of them, *"it makes a lot of sense to convert to Christianity because Christians believe in miracles, rather than Islamic fate. The spiritual faith has given me hope to be strong and happy"*. The second respondent said, *"Christians don't discriminate against you because of your diseases, they accept you for who you are. They accept you to worship with them in the church. As a Muslim, you can not enter the mosque with this kind of disease, you have to stand or sit outside the mosque because you are considered unclean"*.

According to one of the Muslim respondents, *"since my condition does not allow me to enter the mosque, I have no option but to sit at the corner of the mosque in order to beg for alms from those who are going in for prayers, mostly on Fridays"*.

Among all the religious groups in Nigeria, Christianity seems to play more important roles in the lives of individuals facing difficulties in coping with their day to day living conditions. Christians seem to accept these individuals as victims of spiritual circumstances, and thus seek to help them get out of these problems. Acceptability is an important factor for victims of VVF to cope with their conditions, and this is often found in Christianity.

5.0 SUMMARY OF FINDINGS

Reports by previous studies conducted on VVF are in line with some of the characteristics observed in the findings of this study. While it is difficult to attribute VVF to a particular factor, respondents in this study reported the following as possible causes: prolonged and complicated labour, early marriage, female genital mutilation, illiteracy, poverty and poor obstetric care. The group I studied in the areas above gave a representation of studies previously conducted by other researchers.

Age at marriage seems to be an important factor responsible for predisposing women to victims in Nigeria. The average age of marriage and conception of respondents in this study was 12 and 14 respectively. All seven VVF victims interviewed at this period were of frail stature with narrow pelvic bones. By the time of child delivery, they usually face a prolonged and complicated labour often resulting in the death of the baby and subsequent incidence of VVF. Their situation is more pathetic when the woman has previously had an internal organ infection due to harmful traditional practices such as circumcision or genital mutilation.

Other contributory factors include poverty and illiteracy. This study points to a fact that VVF victims in Nigeria are often from rural, poor and illiterate backgrounds. As a matter of fact, all the respondents in this study came from a social and economic disadvantaged background. Poor people often live in rural areas where there is inaccessibility to basic social amenities, like good water, quality food, and education and so on. Poverty has an impact on the quality and quantity of food intake; hence VVF victims often suffer from malnutrition leading to disproportionate and slow body development. Due to poverty also, some parents like to shift the financial responsibility of their female daughters to able bodied men who are willing to marry them. This situation saves them the hassles of fending for their female children.

Lack of skilled and obstetric care has also been identified in this study as a contributory factor to the prevalence of VVF in Nigeria. Since a vast majority of the victims are rural dwellers, it becomes difficult for them to access health care while pregnant and at delivery period. Even when women develop fistula, it takes them a long time before receiving medical attention, usually present in the urban areas. While rural areas in Nigeria lack adequate maternity care, poverty prevents VVF victims from affording transportation and cost of treatment in the cities.

The plight of VVF victims, a majority of whom have been in this condition for years, is sorrowful. Severe pains and bleeding, injury and infection to related organs e.g, vagina, urethra, bladder, involuntary passage of urine, fracture or dislocation of the pelvic bones and maternal mortality, these individuals are faced with lots of social isolation, divorced, prevented from touching other people's personal effects, barred from cooking food for others. With little or no social support, their state of poverty is further complicated. Malnutrition is visibly written all over them, with a poor quality of life, their days on the surface of earth are numbered.

A majority of the respondents in this present study have indicated virtually all the aforementioned physical and psycho-social conditions; however, the psycho-social conditions were reported to be greatly significant in destroying their emotional well-being. Women suffering from the scourge of VVF are victims of their social-cultural circumstances; however, the same societal conditions which pre-expose them to this disease are not offering them the required social and emotional support to deal with their trauma. The moment victims report their VVF conditions, they are rejected, ostracised and treated as if they are not fit to remain in the "normal" society. With this situation, many of the victims are left to take care of themselves. The findings in this study reveal that all interviewees were married at the period of child delivery, but abandoned when they developed fistula. This is an indication that a majority of women suffering from VVF are only

victims of their socio-cultural circumstances. It is thus demoralising to them that they suffer the pains of crimes they never committed.

Depression and low self esteem have been identified in this study as a major psychological effect often experienced by VVF victims. If not adequately and urgently attended to, many victims would end up committing suicide.

However, VVF victims often take the bull by the horn, rather than wallowing in life-long misery, many of them have developed several ways to manage and survive their embarrassing and humiliating conditions. In this study, management strategies developed by victims include begging alms for survival, selling water or fire wood to raise money for food and treatment. Many women suffering from this disease would rather suffer in isolation than parade themselves in the midst of the “normal” people. This situation according to them is like adding insult upon injury. If and when afflicted women required association, they would rather associate with people of similar condition, thus a “suffering of sisterhood” is likely to be of interest to them. A good number of VVF victims also alleviate their pains and suffering by attributing their condition to the will of Allah or the will of fate, by so doing, they excuse themselves for being the cause of their problems; rather, they shift the blame on divinity or fate. Other strategies developed by respondents in this study include engaging in Christian religious activities. Some of these Christian organisations have been able to offer victims respite of love and treatments, thus by associating with organisations that give moral support, stigmatised individuals have been able to use these avenues to cope with their unfortunate situations.

5.1 RECOMMENDATION

It's been established that the scourge of VVF is not a new phenomenon worldwide. The fact that the condition is a thing of the past in the developed world is an indication that the scourge is preventable. As much as it is a preventable condition, it is only possible if the Nigerian government is sensitive and serious enough to help in the control and prevention campaign.

The identified physical and social-cultural causes of VVF in this present study point to the fact that the scourge can be controlled and prevented in Nigeria.

5.1.1 Illiteracy

Illiteracy is more common in the rural areas where there is still a very strong hold on some cultural practices which are harmful to the dignity of human beings. Although, basic education in Nigeria is universal, it is made unreachable by some cultures in traditional parts of the country, where girls are excluded from going to school. It should be an offence in Nigeria for parents who prevent their female children from benefiting from the universal education. Further to this is a recommendation for free education. Payment of school fees is usually an excuse for some parents to choose a boy child ahead of girl child when considering who to send to school. If every child is educated in Nigeria, the problem of illiteracy will be a thing of the past; hence the ignorance of the repercussion of some harmful cultural practices such as early marriage, female genital mutilation would be a thing of the past. Illiteracy is also responsible for unawareness of the importance of ante and neo-natal care. With a good education, pregnant girls would be able to realise the importance of visiting their local clinics.

5.1.2 Obstetric facilities

It is no doubt that lack of accessibility to maternity facilities predisposes pregnant women to prefer traditional midwives over the orthodox midwives. If adequate health care facilities and skilled health care workers are available in the rural areas, most cases of VVF would have been prevented. Since most cases of VVF occur among the rural dwellers, it is imperative that Nigerian government, through the Ministry of Health should make accessibility to obstetric care in rural areas a paramount.

5.1.3 Social counselling

It is also equally important that victims of VVF be counselled and rehabilitated. While surgical repair helps victims to get on with a normal life, it is not enough to deal with the effect the scourge has had on their psychological well-being. Social workers and nurses should assist victims in talking about their ordeal. Victims of VVF need people to give them the confidence to relate their experience. With this opportunity, bottled up emotions are let out and victims would be able to gradually gain a good confidence level.

5.1.4 Economic empowerment.

There are various NGOs in Nigeria which help people with peculiar medical and social issues. The Nigerian government should encourage these institutions by funding them to provide training to VVF victims so as to generate income for themselves. Crafts, sewing, basket making and so on are examples of skills these individuals can be trained on to empower themselves. This type of venture would help reduce their poverty level and they might be able to gain confidence which would reduce the effect of the stigma (WHO, 2006:71).

5.1.5 Free repair or treatment

Since it is difficult to raise money for the treatment of fistula, the Nigerian government can help reduce the burden of the disease on these poor victims by making the treatment free and accessible to them. Victims should then be encouraged to visit these facilities as soon as the problem arises.

5.1.6 Family reintegration

Local communities should be enlightened on the problems faced by VVF victims. Afflicted women are only victims of their socio-cultural circumstances; therefore the society should be enlightened to accept them. There should be an assistance for reconciliation and reintegration to ensure that victims are able to return to their communities and families without difficulty, especially when they have been repaired (WHO, 2006: 72)

5.1.7 Network of people suffering from VVF

Victims often tend to relate with one another, this form of association helps them to discuss their problems freely, thus they are able to alleviate the stigma associated with their condition. This type of network can be strengthened and empowered by the local authority to mount campaign against the incidence of VVF.

5.2 CONCLUSION

The information gathered in this study should be regarded as a complement to other information collected by other researchers with respect to the circumstances surrounding the prevalence of VVF and its impact on the psychological well-being of Nigerian women. It is a complement in the sense that it gives the victims voices of their own, a situation which is lacking in several other reports, a majority of which are quantitative.

My study has been able to establish that the incidence of VVF cannot be explained from just one perspective alone. While there are physical causes, there are other socio-cultural explanations to this condition. The socio-cultural factors, which predispose victims to the scourge of VVF, are issues worthy of serious attention by both local and Federal government of Nigeria. It should be noted that the pains and suffering endured by VVF victims is the result of the social isolation and abandonment and subsequent loss of self-esteem coupled with economic deprivation that results from this social isolation (Wall et al, 2003:1431). To this end, serious efforts should be made vis a vis the expositions and recommendations in this study so that the health of women in Nigeria becomes a paramount issue.

In the global terrain, motherhood is a highly revered term, for instance we hear of the term “mother earth”. In Nigeria, we refer to the country as a “mother land”, and the language is called “mother tongue”, it is however paradoxical that the same motherhood epitomised is suffering from the hard grip of maternal mortality due to some of our cultural inventions in Nigeria. Since the whole world is changing positively regarding gender and health issues, Nigeria should make serious attempts at addressing those gender issues which put women’s health in jeopardy.

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APPENDIX

My interview guide includes the following:

Respondents' areas of origin

Socio economic background of respondents

Age at marriage of respondents

Marital status of respondents

At which pregnancy did your fistula occur?

How will you describe your accessibility to obstetric care

Where and how did you deliver you child?

What is the duration of your labour complication which prompts fistula

What will you say is the possible cause of your condition?

How will you describe the effect of traditional birth practices on VVF condition?

What is your social and marital status before and after developing VVF

How will you describe your accessibility to treatment

How will you describe the effect of VVF on your psycho-social well-being?

What survival strategies did you develop to manage your condition?