# ASSESSING PSYCHO-SOCIAL CHALLENGES OF WOMEN WITH VESICO-VAGINA FISTULA AT NATIONAL OBSTETRIC FISTULA CENTRE, ABAKALIKI, EBONYI STATE

**BY**

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**DEPARTMENT OF NURSING SCIENCE**
**FACULTY OF HEALTH SCIENCES AND TECHNOLOGY**
**UNIVERSITY OF NIGERIA**
**ENUGU CAMPUS**

**NOVEMBER, 2015**

**TITLE PAGE**

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**M.Sc DISSERTATION**

**PRESENTED TO THE DEPARTMENT OF NURSING SCIENCE**
**FACULTY OF HEALTH SCIENCES AND TECHNOLOGY**
**UNIVERSITY OF NIGERIA, ENUGU CAMPUS**

**IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF SCIENCE (M.Sc) DEGREE IN NURSING SCIENCE**

**SUPERVISOR: PROF. (MRS.) C. B OKAFOR**

**NOVEMBER, 2015**

## APPROVAL

This dissertation, ñPsycho-social Challenges of women with Vesico-Vagina Fistula at National Obstetric Fistula Centre, Abakaliki, Ebonyi Stateò, has been approved for the award of Master of Science Degree in Nursing (Maternal and Child Health Nursing) for the Department of Nursing Science, Faculty of Health Sciences and Technology, University of Nigeria Enugu Campus.

**BY**

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## CERTIFICATION

This is to certify that this M.Sc dissertation is the original research work of *Kanikwu Nwamaka Phoebe*, with registration Number *PG/M.Sc/12/64134*, a Post Graduate Student in the Department of Nursing Sciences, and that neither the dissertation work nor the original work contained therein has been submitted to this University or any other institution for the award of degree.

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## DEDICATION

To my amiable parents, Mr. and Mrs. Emmanuel Ahueze Kanikwu, and to all VVF patients all over the world.

## ACKNOWLEDGEMENT

From the depth of my heart, I appreciate God Almighty whose faithfulness has seen me through this Master of science (M.Sc) in Maternal and Child Health Nursing degree. I am also sincerely grateful to my seasoned supervisor Prof. (Mrs.) C.B Okafor who patiently mentored me throughout this research. My heartfelt thanks go to the Head of Department Dr. A.C Nwaneri, my content readers, the PG Co-ordinator Prof. (Mrs.) I.O. Ehiemere, my specialty Co-ordinators Dr. E.I Nwonu and Dr. (Mrs.) A.U Chinweuba as well as the entire academic and non-academic staff of the Department for their help.

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I also thank my laudable friends who for want of space I cannot list, the VVF patients who participated in this study for their cooperation and Miss Nnamani Judith for typesetting the work.

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## ABSTRACT

This study was on the Assessing Psychosocial Challenges of women with Vesico-Vagina Fistula at National Obstetric Fistula Centre, Abakaliki, Ebonyi State. Specifically, the three objectives of the study were to; assess how VVF affect the emotional health of patients, determine how the attitude of significant others affect their social health and determine some correlates of VVF among the patients. Descriptive survey research design was adopted for the study. Reliability coefficient of 0.73 was obtained using Spearman Brownôs prophesy formula. Thirty-five participants who met the inclusion criteria were studied using convenience sampling method. Instruments for data collection were a researcher developed focused group discussion guide and questionnaire. Data obtained with the questionnaire and FGD were analyzed from a descriptive perspective. Results obtained from the questionnaire were presented in Tables while FGD excerpts were reported as quotation or paraphrases with narrative summaries presented in bar charts. The correlation studies done using Pearsonôs Product Moment Correlation were reported in Tables. The study showed that VVF affected patients emotional health because it led to unhappiness, worries and shame, while the attitude of their significant others which most of them reported as avoidance affected their social health because it led to avoidance of social functions, separation from husband, deprivation of sex and lack of physical attention. Moreso, there was a direct positive relationship between the avoidance attitude of significant others and the social health of participants, as well as, a positive correlation between the patients feeling of unhappiness and their avoidance of social cum religious functions. The researcher recommended that more doctors and nurses should be encouraged to specialize in VVF repair to speed up rehabilitation of patients, while more health campaigns, community outreaches and health education through the mass media should be organized to facilitate the support of VVF patients by their significant others.

# CHAPTER ONE

# INTRODUCTION

## Background to the Study

Frajznygier, Ruminjo & Barone (2012), described vesico-vagina fistula (VVF) as an abnormal opening between the vagina and bladder, resulting from prolonged obstructed labour and resulting in urinary incontinence. At present, Africa has recorded approximately 3 million cases of vesico-vagina fistula (Maggi, Rogers, Scanlon, Koroma & Mends, 2011; Egender Health Organization and the United Nations Population Fund, 2013). Meanwhile, a research by the National Demographic Health Survey (2012) showed that no fewer than 12,000 women develop VVF in Nigeria yearly. The study further indicated that more than 150,000 registered patientswas recorded at present in Nigeria (The News Agency of Nigeria, 2013). However, many researchers consider these figures to be grossly underestimated as they are based on women seeking treatment, whereas the condition most widely and severely affects women who are unable to reach, seek or afford treatment (Donnay & Weil, 2004).

In the words of Sambo (2008), Nigeria has the highest prevalence rate of VVF in Africa, with wide regional variations. The regional variation is as a result of the difference in the distribution of risk factors like, unavailability or under-utilization of obstetric health facilities and other cultural practices inimical to safe motherhood. Such cultural practices include: Female Genital Cutting (FGM); early marriage, with consequent pregnancy when the pelvic muscles and bones are not matured; traditional type of episiotomy (cutting through the vagina to create a passage for the baby); home delivery and patronage of unskilled traditional birth attendants (TBAs) (Donnay & Weil, 2004). In addition, VVF could also occur due to urological and lower gastro- intestinal or pelvic surgeries (Yamin, Tayyaba, Naeem, Shafia & Hussain, 2009). During these surgeries, an accidental and unrecognized injury to the bladder causes urine to drain through

the vaginal cuff suture line. This results from pressure necrosis, hematoma formation and the occurrence of infection from incorrectly placed sutures between the vaginal cuff and posterior bladder wall, bringing about VVF (Garthwaite & Neil, 2010).

Gbola (2007) penned that, victims of VVF suffer from urinary incontinence, which makes them smell of urine at all times and expose them to infections such as; vaginitis, and excoriation of the vulva (injury to the surface of the skin or mucous membrane caused by physical abrasion, such as scratching). Also, they suffer vagina stricture, secondary amenorrhea, possible secondary infertility even after repair of VVF, and a low child survival rate.

VVF is considered one of the most dehumanizing conditions to afflict women, because patients also suffer devastating emotional and social challenges in addition to the medical sequels of the condition. The emotional challenges include shame, depression, loss of self esteem, discrimination and anxiety, while the social challenges include unemployment, divorce or separation, rejection, social isolation and abandonment by significant others (Munir-Deen, 2007). Other social problems associated with vesico- vagina fistula include secondary infertility and childlessness, as well as elective caesarean section in subsequent pregnancies. Wall (2007) opined that these emotional and social challenges are jointly termed psychosocial challenges and result from the offensive/pungent smell of urine. This is in line with Onwunali (2012) who stated that these challenges affect the femininity, intimate/social relationships and the daily life functioning of victims, thus leading many to early death by suicide. Moreso, it is the psychosocial challenges experienced by VVF patients that hinders them from reporting for treatment, thus making the assessment of VVF incidence, prevalence and magnitude difficult to assess in Nigeria (Taylor, 2011) .

In addition, Onwunali (2012) noted that vesico vagina fistula leaves the women and girls incapacitated for several months, years or for a lifetime. Consequently, these women live a life of

destitution and often end up on the streets begging for survival (Onwunali, 2012). However, the condition is a preventable one with the key measure being prevention of obstructed labor. Other measures include: poverty alleviation and improvement in socio-economic conditions; prevention of childhood malnutrition and consequent osteomalacia and pelvic bone mal-development (Munir-Deen, 2007). Furthermore, formal education and women empowerment can prevent early marriage. This is because, it will allow the women to better appreciate and utilizethe available health facilities for antenatal care, hospital delivery and family planning services. Incorporation of sex education into post-primary education curricula, to sensitize people on sexual health from an early age, is another preventive measure. However, it is pertinent to state that VVF prevention can only be achieved through comprehensive strategies and with the combined efforts of the government, health and community organizations (Munir-Deen, 2007).One of these strategies is assessing the psychosocial challenges that the victims of VVF have, as a means of strategizing and giving evidence based care. Therefore this study addressed the psycho-social challenges of women with vesico-vagina fistula.

**Statement of Problem**

VVF is a serious disability experienced by some women after childbirth. According to The News Agency of Nigeria (2013), there are more than 150,000 registered vesico- vagina fistula patients in Nigeria. This represents about 40 percent of the cases in the world (United States Agency for International Development, 2013).Vesico vagina fistula is an injury often secondary to an obstetric manipulation, gynaecologic surgery, radiation or invasive cancer of the cervix, and patients present with constant leakage of urine. This results in perineal wetness and excoriation, as well as ammoniacal urinary odour (Yola, 2012). In addition, VVF has been known to affect the activities of daily living of its victims (Onwunali, 2012).

Regardless of the etiopathology, the development of vesico-vagina fistula like any other chronic health condition has profound and devastating consequences on the patientôs physical, social and psychological health (Garthwaite & Neil, 2010). Moreover, previous studies and up-to-date information on VVF has often concentrated on the medical and surgical needs of these victims, leaving out the psychological and social challenges associated with this devastating condition, which has serious implications. Thus making it difficult to describe the psycho-social impact of Vesico-vagina fistula on its victims (Onwunali, 2012). Therefore, this study was selected by the researcher to assess the psycho-social challenges of women with VVF at the National Obstetric Fistula Centre, Abakaliki, Ebonyi State.

**Purpose of the Study**

The purpose of this study was to assess the psycho-social challenges experienced by patients with vesico-vaginal fistula (VVF) at the National Obstetric Fistula Centre (NOFIC), Abakaliki, Ebonyi State, and the effect of such challenges on their emotional and social health.

**Objectives**

Specifically, the objectives for this study were to assess;

- How VVF affects the emotional health of patients at the National Obstetric Fistula Centre, Abakaliki.
- How the attitude of significant others affect the social health of VVF patients at the National Obstetric Fistula Centre, Abakaliki.
- The relationship between the psychological challenges and social health of VVF patients at the National Obstetric Fistula Centre, Abakaliki.

**Research Questions**

- How does VVF affect the emotional health of patients at the National Obstetric Fistula Centre, Abakaliki?
- How does the attitude of significant others affect the social health of VVF patients at the National Obstetric Fistula Centre, Abakaliki?
- What is the relationship between the psychological challenges and social health of VVF patients at the National Obstetric Fistula Centre, Abakaliki?

**Significance of the Study**

The findings of this study would be relevant to VVF patients, healthcare providers, counselors, community health workers, philanthropists, non-governmental organizations, religious organizations, policy makers and researchers.

To VVF patients, it would help them to understand how VVF affects their emotional healthand how the attitude of significant others affect the social health. This would enable them gain insight to their psycho-social deficiency and thus seek, accept and appreciate psycho-social support programmes planned or provided for them.

To health care providers at different levels, it will help themto understand the psychological and social problems of VVF patients and thus plan holistic care that will address the social and psychological needs of VVF patients as much as their physical needs. This is important because often times, health care providers focus more on the physical aspects of the patients care with little or no concern about their psycho-social health.

To counselors, it would help them to design and organize counseling sections that aim at identifying and handling patients psycho-social needs.

To community health workers, it would help them to carryout public enlightenment programmes that will prepare the public to accept and support VVF patients in their communities. This will consequently aid the adaptation of VVF patients to their communities even after treatment, thus improving their overall psychosocial health.

To philanthropists, non-governmental organizations and religious organizations, it will help them to realize that their material, financial and spiritual support is needed in the eradication of this health menace and its consequent psycho-social challenges.

To policy makers, it will enable them to understand the psycho-social challenges of patients and formulate policies that will enforce the rehabilitation and support of victims, to aid their reintegration into their families and communities.

To researchers, this study would contribute to the existing body of knowledge on the psycho-social challenges of VVF patients and serve as a reference material for subsequent related studies on this issue.

**Scope of the Study**

The study was delimited to VVF patients admitted in the National Obstetric Fistula Centre, Abakaliki. The study investigated the psychosocial challenges of these patients, through the identification of their social and obstetric characteristics as well as the assessment of the impact of VVF on their emotional and social health.

**Operational Definition of Terms**

- Psycho-social Challenges in this study refer to personal and interpersonal problems that confront VVF patients as a result of their health condition. They include; low self esteem, depression, shame, isolation, economic deprivation, public embarrassment, attitude of

rejection, including; abandonment, neglect and deprivation of intimacy by their husbands and significant others as a result of the condition.

- Emotional health of a VVF patient refers to the aspect of the individual which affects her mood, bringing about emotional changes such as shame, depression, loss of self esteem, and anxiety in a VVF patient.
- Social health of a VVF patient refers to the aspect of the individual that relates to her social functioning as she interacts with significant others at home, work and the community. VVF patients suffer social challenges such as threat to occupation, divorce or separation, rejection, social isolation, religious isolation and abandonment by significant others.
- Women with vesico-vagina fistula are those patients who present with urinary incontinence as a result of an abnormal communication between their vagina and bladder, at the National Obstetric Fistula Centre, Abakaliki.
- Significant others of VVF patients refer to the husband, children, parents, siblings, in-laws, other extended family members, church and social meeting associates of VVF patients.

# CHAPTER TWO

# LITERATURE REVIEW

## Vesico-Vagina Fistula

Vesico-vaginal fistula (VVF) is an abnormal communication between the mucosa of the urinary bladder and that of the vagina. It is characterized by persistent leakage of urine, resulting in perineal wetness, excoriation and ammonical urinary odour. As a result, the women develop low self-esteem, depression and become socially withdrawn. If this condition is not treated promptly, the affected woman may be abandoned by her husband and close relatives (Yola, 2012).

## History of Vesico-Vagina Fistula

The oldest evidence of vesico-vaginal fistula (VVF) was found in the remains of Queen Henhenit (Egyptian Queenôs mummy), the wife of Egyptôs ruler; King Mentuhotep II around 2050 BC. The Queenôs body was originally sent to the metropolitan museum of Art in 1909 but was returned to Cairo in 1923, where an extensive anatomical review by Edouard Naville revealed a defect in her bladder communicating directly with the vagina (Gbola, 2007). It was then hypothesized that, severe damage to Queen Henhenitôs bladder and vagina occurred at the time of parturition, likely resulting in her death. As it has been noted and documented, ñto Queen Henhenit belong the dubious honour of having suffered the most antique vesico- vaginal fistulaò (Cron, 2003).

The first reference to fistula dates back to 1550 BC and in 1030 AD, a Persian physician; Avicenna linked VVF to obstructed labour (Rahmat, 2008). Noting that, ñin cases where women got married too young, and in patients who have weak bladder, the physician should instruct the

patient on ways of preventing pregnancy, otherwise, the fetus may cause a tear in the bladder and result in incontinence of urine; which is incurable till deathò (Cron, 2003).

In 1663, a Dutch physician; Hendrik Van Roonhuyse proposed a method of repair using stitching needles made of stiff swansô quill in his book titled; operative gynecology. Although , the first vesico-vaginal fistula was closed in the year 1838 by Dr. John Peter Mettauer in the United States, the honour of being the first American surgeon to close a vesico-vaginal fistula is most often erroneously given to, Dr. James Marion Sims who was born in 1813. This is because, Sims significantly improved the surgical techniques of fistula repair and his techniques have remained the standard (Cron, 2003).

Sims encountered his first vesico-vaginal fistula when a colleague introduced him to Anarcha, a 17-year-old slave who had been in labour for 3 days. However, he completely closed the enormous fistula of Anarcha on June 21, 1849, after discovering silver wire suture; this was his $30^{th}$ surgery (Cron, 2003).

On May 4, 1855, the first fistula hospital was opened in New York as a result of Simsô determination. However, the hospital shortly became too small to accommodate the growing patient population and therefore, was moved to the prestigious Park Avenue location in the year 1857. With improvements in obstetric care and the surgical advances of Dr. Sims and his colleagues, the problems of obstructed labour and vesico-vaginal fistula became rare occurrences in the developed world, during the 20th century. But this was not so in the developing world (Cron, 2003).

On May 24, 1975, the second fistula hospital was opened in Addis Ababa, the capital of Ethiopia with the efforts of Catherine and Reginald Hamlin, in response to the prevalence of VVF in the developing world. According to Zacharin (1988) in Cron (2003), ñIt is the wish of Catherine and Reginald Hamlin that, like the first VVF hospital in New York functioned until it

was no longer required about 100 years ago, the second VVF hospital in Addis Ababa would function until the time when obstetric fistula vanishedò.

**Global view on VVF**

Historical understanding of VVF has shown that the condition is not a new phenomenon. As a matter of fact, this condition used to be a common scourge throughout the world. But, 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 (Gbola, 2007). Metro (2006) observed that fistula is almost oblivion in countries where there is universal health care, which takes womenôs health very seriously (Gbola, 2007). According to Bello (2006), 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 worldwide every year (Gbola, 2007).

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 (Gbola, 2007). According to the countryôs Federal Minister for Women Affairs and Youth Development (2006), untreated VVF cases stands between 800,000 and 1,000,000 (Gbola, 2007). Corroborating the above report, the Nigerian minister of health estimated that about 800,000 women are presently plagued by the scourge of VVF. A majority of whom live in the rural areas where there is inadequate or complete lack of primary health facilities. The minister also added that this population accounts for 40% of the global burden of VVF (The Guardian, 2007). In addition, a Nigerian doctor; Yola (2012), stated that, no fewer than 12,000 women develop vesico-vagina fistula (VVF) in Nigeria yearly.

According to Magashi (2006), 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. When the family may decide to take her to the closest obstetric center which may be up to 70 kilometers away, lack of proper easily

available and affordable means of transportation further worsens her traumatic experience. However, if she eventually gets to the clinic, there may be no available skilled attendant to handle the emergency obstetric procedure. Therefore, if the woman survives the labour, she hardly survives the waiting and gruesome grasp of VVF.

**Pathophysiology of VVF**

Vesico-vagina fistulas often result from vaginal tissue damage. This occurs when the presenting fetal head is unable to pass through the bony pelvis and impacts against an edematous distended anterior vaginal wall, resulting in necrosis. The above induces inflammation at the injury site, which stimulates the process of cell regeneration. However, any disruption in the sequence of cell regeneration, which may result from infection, hypoxia, ischemia, malnutrition, radiation or chemotherapy, affects the healing environment and results in the formation of a fistula. Subsequently, a chronic fistula tract is created when the edges of the injury eventually epithelializes (Marissa, 2011).

In addition, introital stenosis secondary to female genital cutting, cephalopelvic disproportion secondary to reduced pelvic dimensions or early child bearing, an android pelvis, malnutrition, orthopedic disorders including rickets, and hydrocephalus contribute to dystocia and consequently VVF (Rhamat, 2008). Others are caused by forceps or destructive instruments used to deliver stillborn infants or surgical abortion. While, symphysiotomy, the use of post-partum vaginal caustic agents and ñGishiri cutsò also play a role (Meeks & Ghafar, 2012).

**Causes of Vesico-Vaginal Fistula**

Rahmat (2008) divided the causes of VVF into two (2), namely; direct and indirect.

**Direct causes**

1. Prolonged Obstructed Labour

This is the most common cause of VVF in developing countries. It occurs because the impacted fetal head compresses the anterior vaginal wall and urinary bladder (Marissa, 2011). Sometimes, the compression may involve the proximal part of the urethra against the symphysis pubis, leading to ischemia and necrosis. Thereafter, the necrotic area sloughs off and the patient starts leaking urine per vagina, between the third and tenth day post-partum. Teenagers and short-statured primigravid women are the most vulnerable groups because, their pelvis are under developed and small respectively, thus being inadequate for vaginal delivery. There may be associated recto-vaginal fistula and foot-drop. The foot-drop occurs when there is damage to the nerves of the lower limb (Munir- Deen, 2007) . In addition, other factors such as fetal malpresentation which could result from lax uterine muscles in grand multiparous women and cephalopelvic disproportion may cause VVF, by predisposing to prolonged labour.

2. Female Genital Cutting

This is the traditional and customary practice of cutting and removing part or all of the labia, clitoris and urethra, in the newborn girl child, teenagers, newly married bride or primigravida, to prevent promiscuity. This harmful practice is often carried out by untrained traditional birth attendants (TBAs) with a razor blade, knife, piece of glass or any unsterilized sharp instrument. The cut usually narrows the vaginal introitus and if made too deep, creates a hole between the bladder and vaginal, resulting in VVF. It is a common practice among the Hausaôs and is referred to as ôYankan Gishiriô or óAnguryaô cut (Onwunali, 2012; Rahmat, 2008; Waaldijk, 2008).

3. Traditional Type of Episiotomy

This is the traditional practice of cutting through the vagina to widen the birth canal during childbirth, by untrained traditional birth attendants (TBAs). This harmful traditional practice which endangers the vagina, urethra, bladder and even the levator ani muscles, causes VVF and increases the likelihood of recto-vaginal fistula (RVF) formation (Kabir, Iliyasu, Abubakar and Umar, 2004).

4. Forceful / Early Coitus

Forceful coitus or rape and early coitus before age 16 when the pelvis is under-developed with or without a disproportionate vagina and penis will result in VVF (Chase, Dalouya & Diasaia, 2008).

5. Accidental Surgical Injury due to Pregnancy

VVF can occur following urological, lower gastro-intestinal and pelvic surgeries such as; difficult forceps delivery, caesarean section and hysterectomy. According to Rahmat (2008), these surgical obstetric procedures are usually performed in a formal / modern healthcare system.

**Indirect Causes**

1. Low socio-economic status

According to Gbola (2007), this often plays an important role in predisposing Nigerian women to the problem of VVF. This is because it is linked with illiteracy, malnourishment, poor living conditions and poor access to good obstetric care. Two-third of fistulas which result from prolonged labour following contracted pelvis result from poor nutrition which is connected to low socio-economic status.

2. Limited access to health services

According to the National Foundation on vesico- vaginal fistulae (2005), access to good quality maternal health services for antenatal, delivery, preventive and obstetric services are limited in rural areas and for poor people (Onwunali, 2012). In many rural areas, such services are not available, so women in need of them will have to travel long distance to reach them. However, when these services are available, the cost is usually beyond what poor people can afford. This situation has worsened with the introduction of cost recovery policies, where patients have to pay for every care they receive at the point of delivery. The impact of such policy(s) is worse for people who are rushed to health facilities during life threatening situations like; complications during labour, with little or no resources. This is because, treatment may be delayed or denied (Onwunali, 2012).

3. Early Childbearing

Girls who are married at very early age are usually not fully matured for childbearing (Onwunali, 2012). According to Gbola (2007), these young girls have immature and narrow pelvis. Therefore, early involvement in coitus with the resultant pregnancy and labour becomes a problem. Since, the pelvis is usually inadequate for easy passage of the fetal head (cephalopelvic disproportion), resulting in obstructed labour and its concomitant vesico-vaginal fistula formation (Onwunali, 2012).

4. Lack of Education

Lack of education or low educational attainment of women is associated with early marriage and early pregnancy (Onwunali, 2012). Conversely, a formal education will delay marriage and allow for better appreciation and utilization of available health facilities for antenatal care, hospital confinement and family planning services (Munir-Deen, 2007). According to a study by Ventura, Abma, Mosher and Henshaw (2004) in Onwunali (2012), more women

who underwent educational training for seven years or less, became pregnant before age 18 unlike their counterparts, thereby increasing the risk of VVF.

5. Malnutrition

Good nutrition is a basic necessity for normal organ development and functioning (Onwunali, 2012). Furthermore, malnutrition causes stunted growth which makes potential mothers to have skeletons that are unequipped for birth, such as underdeveloped pelvis. This weak and underdeveloped bone structure increases the chances of the fetal head getting stuck in the pelvis during childbirth, cutting off circulation and rotting away of tissues, which culminates in VVF (Womenôs Health, 2012).

6. Role and Status of Women

In developing countries, a good number of women do not have full control over their bodies or households. On the other hand, some religious practices like ñpurdahò which is practiced in Muslim communities to confine women to their matrimonial homes, makes these women unable to take decisions concerning their health, even in emergencies like prolonged obstructed labour (The National foundation on vesico-vagina fistulae, 2005). Instead, their husbands and other family members have the control; determining when and the nature of healthcare the women should receive. Moreover, in some religions and societies where it is believed that women are supposed to suffer in childbirth, less support is inclined towards maternal health (Womenôs Health, 2012).

7. Pelvic Irradiation

Pelvic irradiation may be followed by vesico-vagina fistula formation after some years. This is because, it produces ôhot spotsô that involves the base of the bladder. The upper limit of tolerance for radiation to the bladder is about Centi Gray (cGy). When the trigone and the base of

the bladder receive a dosage in excess of this limit, the risk of VVF formation increases. However, the distal end of the ureters are more resistant to radiation therapy than the bladder (Sudha, 2011).

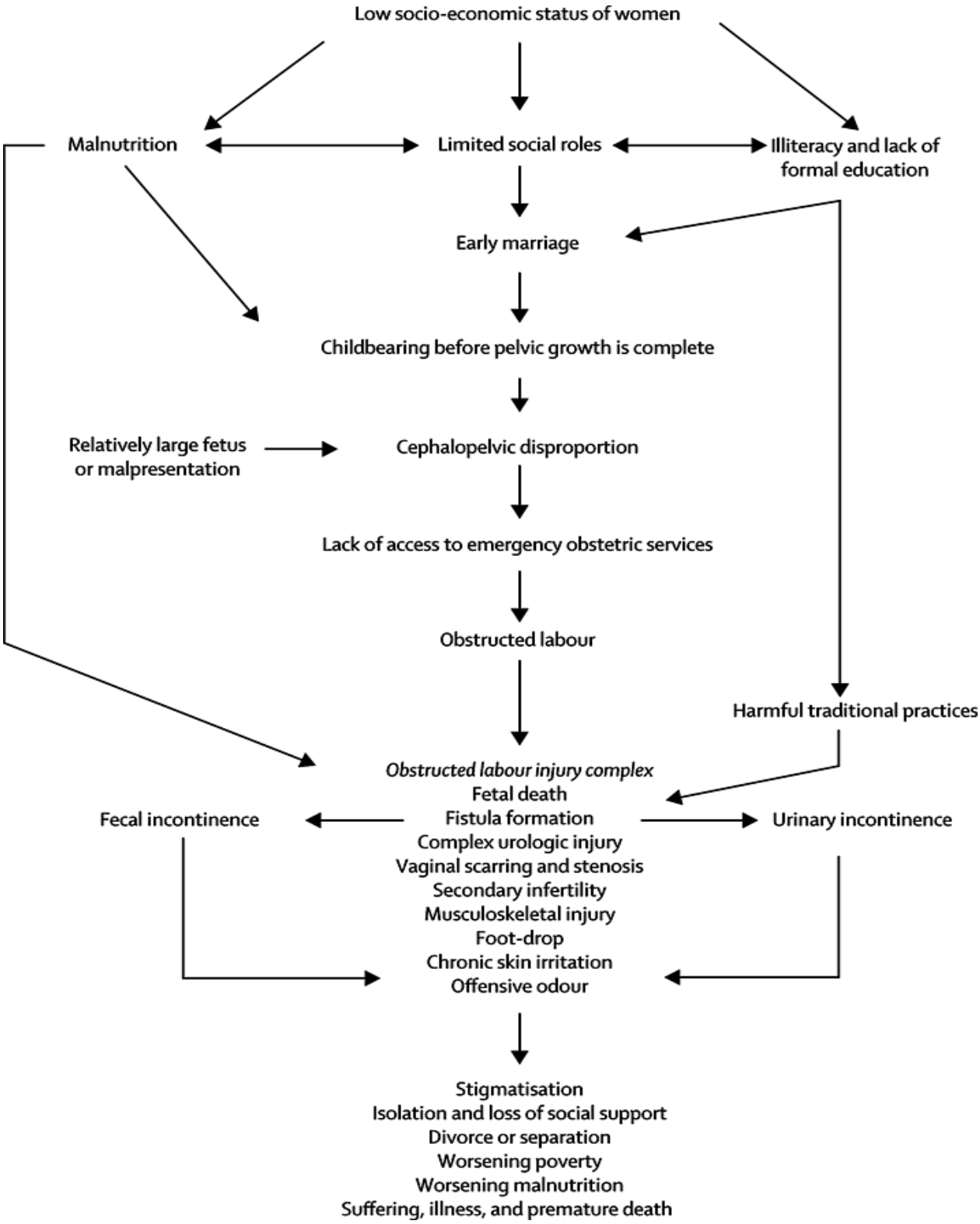
8. Malignancies

Excluding the effects of treatment, malignancies can cause VVF, if a tumour becomes necrotic or infected and invades the urinary bladder. Cervical cancer is more frequently a cause of VVF, than other cancers of the uterine fundus, urinary bladder or vagina (Sudha, 2011).

9. Ignorance

Ignorance is a major cause of maternal mortality and morbidity including VVF. It is ignorance that makes women indulge in risky behaviours like; female genital cutting and early childbearing which predisposes them to VVF formation (Onwunali, 2012).

**Diagram I: The Obstetric Fistula Pathway**




Source: Wall (2006). Adopted from: www.global-sisterhood-network.org/content/view/1310/76 on August 26,2013.

**Classification of VVF**

According to Sudha (2011), the classification of VVF is done according to the organ involved, etiology and size. However, for the purpose of treatment and prognosis, these three classifications are interrelated. It is also suggested that surgeons should further classify the fistulas as simple or complex.

- **Simple Fistula:** Is easily assessable with healthy tissue surrounding it.
- **Complex and difficult Fistula:** The associated lesions require additional urologic genital or gastrointestinal operations. This category of fistula follows several unsuccessful attempts of repair, difficult access to the fistula, loss of tissue or scarring and may involve ureteric opening.

**VVF Classification According to Organ Involvement**

Waaldijk (2008) classified VVF into 4; depending on the organs involved. They include:

**a.** **Juxta-urethra:** This type of VVF occurs between the bladder and the urethra (at the urethra-vesical junction)

**b.** **Mid-vaginal fistula:** This type of VVF occurs 4cm or more below the urethral orifice and is very easy to repair

**c.** **Juxta-Cervical Fistula:** This type of VVF occurs around the cervix. The defect may sometimes extend into the cervical canal, leaving the anterior cervical canal completely open. This type usually results from vertical tear in the lower uterine segment, with accidental injury to the bladder at the time of caesarean section.

**d.** **Intra-Cervical Fistula:** This type of VVF occurs between the bladder and the cervical canal.

**Etiological Classification of VVF**

- Congenital Anomalies
- Surgical: Ligation, Crushing, Puncture, Kinking

- Obstetrical: Ischemic necrosis (Obstructed labour) or direct injury (caesarean section, ruptured uterus, vaginal operative delivery).
- Malignant: For example, cervical cancer in fourth stage
- Radiation: It is a very slow avascularization and may manifest after years.
- Infection: Tuberculosis and lympho-granuloma venereum
- Foreign body:For example, long standing bladder stone and neglected vaginal pessarywhichcauses pathological pressure
- Traumatic accidents
- Spontaneous/idiopathic

**VVF Classification According to Size**

- Small: less than 2cm
- Medium: 2-3cm
- Large: 4-5cm
- Extensive: 6cm or more.

**Psychosocial Challenges associated with VVF**

Obstructed labour and its devastating consequence; vesico vaginal fistula are common among young primiparous adolescents who are likely to be illiterates, from impoverished rural areas and of low social status, who are usually among the most vulnerable members of the society. However, they also occur in women who belong to the middle or upper social class (Wall, 2006). Published works on vesico-vaginal fistula often focus exclusively on the hole in the bladder and pay less attention to the whole patient, thereby excluding the patientôs psychosocial experiences. Although, available detailed researches on the psychosocial challenges of VVF patients are very few, results of preliminary surveys suggest that divorce or separation, rejection,

abandonment, social isolation, unemployment, as well as shame, loss of self esteem, anxiety and depression are common forms of psychosocial challenges experienced by women with vesico-vagina fistula (Wall, 2006).

Often, husbands and other family members may initially be supportive and compassionate to VVF patients, but when it becomes clear that the constant leakage of urine is a chronic condition (viewed as incurable in the context of the local culture), the womanôs sexual life is hampered and shattered, so she is separated from or even divorced by her husband (Wall, 2006). This brings about childlessness which could make her husband/spouse on whom she is economically dependent on to abandon her. Childlessness therefore, becomes an obvious factor in marital breakdown (United States Agency for International Development, 2007). Also, significant others usually reject VVF patients and neither permit them to live together with, cook for, nor share utensils with them (Wall, 2006). While their communities usually blame, stigmatize and excommunicate them for their predicament which is viewed as a punishment from God for sexual misbehavior (Onwunali, 2012). All these contribute to the patientôs loss of self-esteem, depression and in few cases psychosis (Wall, 2006).

According to United Nations Population fund (2006) in Onwunali (2012), VVF affects womenôs ability to work or access jobs. In short, women with VVF experienced severe reduction in their source of independent income, thereby, increasing their dependence on others. According to Muhammedôs report, in a survey on VVF victims at Bugando Medical Centre, Tanzania, in 1998; one-third of the subjects reported that, VVF made it difficult for them to do work at all; one-third reported that their families and friends still cartered for their needs and; another one-third said they resorted to begging and other less productive jobs. Furthermore, as a result of their health condition, women with obstetric fistulas may lose their jobs or will not be able carry out economic tasks they used to do. That may result in these women being dependent on their

husbands and significant others which may lead to anxiety and loss of self esteem (UNFPA, 2006).These challenges put together, makes the psycho-social trauma of having VVF, worse than the physical injury (Onwunali, 2012).

**Prevention of VVF**

The first and most essential step in limiting the morbidity associated with VVF is prevention. The major strategy in prevention have been; improved obstetric management, including emergency obstetric care (EMOC), improved technique of delivery with concomitant decrease in the practice of difficult forceps maneuvers and improved management of labour. Other strategies include; the prevention of early marriage and early childbearing; the prevention of anaemia during pregnancy; and having good nutrition. Furthermore, pressure necrosis can be prevented by efficient obstetric care, anticipation of difficulties before labour begins for prompt intervention like caesarean section, if the labour is prolonged because of disproportion between the passage and the passenger and before the stage of obstruction is reached (Sudha, 2011). Moreover, catheterization will be required for at least 48hours after delivery following obstructed labour. Otherwise, the oedema and eachymosis round the neck of the urinary bladder will cause retention which will prevent healing and lead to VVF formation (Garthwaite & Neil, 2010).However, extensive electrocautery injuries of the bladder wall should be carefully avoided when securing homeostasis. In addition, permanent suture material(s) should not be allowed to penetrate the inner wall of the bladder. If it does, it becomes a nidus for stone formation which may predispose the patient to transmural infection and subsequent fistula formation (Sudha, 2011).

According to Garthwaite and Neil (2010) full thickness sloughing off of the bladder should be prevented by the continuous drainage of the bladder, when the patient is first seen in

obstructed labour. Also, sepsis should be controlled by the use of systemic broad spectrum antibiotics; gentle daily irrigation of the vagina with a mild antiseptic as well as improved nutrition to prevent VVF.However, if there in haematuria following obstructed labour, continuous drainage per urethra should be maintained for 10days or until speculum examination reveals no sign of necrosis in the anterior vaginal wall and the microscopic examination of the urine shows no haematuria (Garthwaite & Neil, 2010).Also, the effective use of parthograph to monitor labour is important. Consequently, any labour that crosses the alert line on the cardiogram should be referred early enough to prevent obstructed labour and its complications like VVF (Munir-Deen, 2007). Moreover, public enlightenment through mass campaigns, community sensitization and mobilization to promote healthy behaviours/practices and discourage harmful practices will prevent the formation of VVF (Munir-Deen, 2007).

**Treatment**

VVF can be treated with medical therapy or surgical therapy. Medical therapy involves bladder drainage using an indwelling urinary catheter which is followed by eventual spontaneous closure (Marissa, 2011). However, Spurlock (2011) noted that fibrin occlusion therapy is a more recently available choice in medical treatment.

Surgical therapy has recorded a cure rate of 90% for uncomplicated cases (UNFPA, 2011). The surgery is done via abdominal or vaginal approach (Meeks & Ghafar, 2012). It is done using any of the following techniques; trans-vaginal, latzko, classical, Trans-peritoneal or laparoscopic technique (Schorge, 2011). According to Meeks and Ghafar (2012), surgical repair should be water-tight and tested with the instillation of ethylene blue or indigo carmine into the bladder.A vaginal pack should be left in situ for 24 hours post operatively and the patient maintained on prophylatic antibiotics, while the catheter remains insitu. The bladder should be continuously

drained with a size 16 French Catheter for about 3 weeks. Thereafter, the catheter should be discontinued after the patient has successfully passed voiding trials. Although, surgical repair of VVF is the standard of care for any non-healing fistula, it carries the risk of; bleeding, infection, adhesions and possible damage to other tissues (Spurlock, 2011; Taylor, 2011).

Whether medical or surgical therapy is adopted for treatment, the patients must be counseled throughout treatment and for a long period after the treatment (Marissa, 2011).

**Theoretical Review**

The theory adopted for this study is ñMaslow's Hierarchy of Needsò propounded by Abraham Maslow in 1943. The theory is founded on the belief that once a need is fulfilled, a person seeks to fullfil the next one, and so on. Originally, the theory consisted of 5 stages, namely; Biological and Physiological needs, Safety needs, Love and belongingness needs, Esteem needs and Self-Actualization(McLeod, 2014).Furthermore, McLeod (2014) penned that one must satisfy lower level basic needs before progressing on to meet higher level needs. Once these needs have been reasonably satisfied, one may be able to reach the highest level called self-actualization. Unfortunately, progress is often disrupted by failure to meet lower level needs. Life experiences including divorce and loss of job may cause an individual to fluctuate between levels of the hierarchy. However, Maslow noted that motivation to reach the top of the pyramid is primarily based on esteem, love and other social needs (Huitt, 2007).The original theory is depicted as hierarchical levels within a pyramid (McLeod, 2014).

**Diagram II: Maslow's Hierarchy of Needs**


Source: (McLeod, 2014). Adopted from www.simplypsychology.org/maslow.html on December 4, 2014.

*Classification of the needs*

Maslowôs hierarchy of needs are classified into two (2), namely:

- Deficiency or basic needs

Out of the five (5) hierarchies of need, Maslow identified the first three needs (physiological, safety and social needs) as deficit or basic. This means that, if these needs are not

met, they make us uncomfortable. Hence, we are motivated or driven by these needs in as much as we are able to sufficiently fulfill them.

- Growth needs

The last two needs (esteem and self-actualization) are identified by Maslow as growth needs. This means that we never get enough of them and are constantly motivated by these needs as they pertain to our growth and development.

*Maslow's hierarchy of needs*

1. Physiological needs

The basic animal needs include; air, food, water, sleep, warmth, shelter, sex, and other body needs. If a person is hungry or thirsty or his body is chemically unbalanced, all of his energies turn toward remedying these deficiencies, and other needs remain inactive. If oneôs basic biological needs are not met, one would never be able to trust the environment and would be stuck with high neuroticism and anxiety.

2. Safety needs

With his physical needs relatively satisfied, the individualôs safety needs take over and dominate his behavior. These needs have to do with manôs yearning for a predictable, orderly world in which injustice and inconsistency are under control, the familiar frequent, and the unfamiliar rare. This need for consistency, if not satisfied leads to feelings of doubt and shame, as opposed to feelings of autonomy or being in control. Thus leading to high conscientiousness or need for discipline and orderliness. The Safety needs include; protection from elements, security, order, law and stability.

3. Social needs

After physiological and safety needs are fulfilled, the third layer of human needs is social. This psychological aspect of Maslowôs hierarchy involves emotionally-based relationships in general. Such include, friendship, sexual intimacy, affection and love from; work group; family; friends and romantic relationships. If one finds failure in having such close relationships, one is bedeviled with such negative social emotions like guilt and low extraversion values.

4. Esteem needs

All humans have a need to be respected, to have self-esteem, self-respect, and to respect others. People need to engage themselves to gain recognition and have an activity or activities that give the person a sense of contribution, to feel accepted and self-valued, be it in a profession or hobby. This need if not satisfied leads to feelings of inferiority. The needs include; self-esteem, achievement, mastery, independence, status, dominance, prestige and managerial responsibility.

5. Self-Actualization needs

Self-actualization is the instinctual need of humans to make the most of their abilities and to strive to be the best they can. This need includes; realizing personal potential, self-fulfillment, seeking personal growth and peak experiences. When fulfilled leads to feeling of generativity.

He also arranged them in a hierarchy such that we are motivated primarily by a need only if lower level needs have been met. Thus, before one is motivated by cognitive or self actualization needs, one should have taken care of basic deficit needs like physiological, security, belonging and esteem.

**Application of the Theory to this Study**

Vesico- vagina fistula patients have needs in hierarchical order and these needs are affected by their health condition.

1. Physiological needs

For VVF patients, they are in one way or the order denied physiological needs.For instance, they are denied sex because of the continuous wetness with urine and the resulting ammonical odour. They are also denied shelter by isolation and excommunication. Deprivation of these basic needs could lead to depression which is experienced by the VVF patients, thus affecting their ability to pursue the next level of needs.

2. Safety needs

VVF patients often lack the physical support and protection from their spouses, family members, close associates and even their communities. This bring a sense of insecurity and distrust for their environment, thus affecting their ability to pursue the next level of needs.

3. Social need

This is a psychological aspect of Maslowôs hierarchy of needs and VVF patients are unable to achieve these needs. As a result of the VVF condition, these patients often loose the required love and belongingness that friendships, sexual intimacy, affection and love from; work group; family; friends and even spouse offers. Thus failure at this level often results in the thought of ending their life (suicide)

4. Esteem needs

VVF patients are often rejected, leading to loss of self-respect and low self-esteem. This affects their ability to pursue the next level needs.

5. Self-Actualization needs

With inability to meet aesthetic needs, VVF patients will loose the zeal and strength to be the best they can. Hence, there is inability to realize personal potential and self-fulfillment.

Ascending the pyramid, needs become increasingly psychological and social. Initially, the need for love, friendship, and intimacy are important, but VVF patients often lack them. Higher up, the need for personal esteem and feelings of accomplishment take priority and become a prerequisite for self-actualization, as a process of growth and development in order to achieve individual potential. Yet VVF patients lack them , and are thus unable to attain the level of internal peace.

From the above discuss, it is obvious that the problem of VVF affects every level of the patients need, hence psychosocial care and support is critical to their care and survival.

**Empirical Review**

According to the study by Kabir, Iliyasu, Abubakar and Umar (2003) which examined the medico-social problems of patients with vesico-vaginal fistula in Murtala Mohammed Specialist hospital, Kano, a total of one hundred and twenty (120) patients with VVF admitted between November and December 2001 at the VVF centre of the hospital were investigated using convenience sampling technique. Structural questionnaire was used to collect data on their medical and social problems, while additional information on clinical features were obtained from patientôs case notes. Results were analysed using median, range and percentages for quantitative and qualitative data respectively. The study revealed that 72.5%, were between ages 10 and 20 years, and 81.6% of the patients were married between ages 10 and 15 years. Regarding VVF patients main medical problems, vulval dermatitis, foot drop, amenorrhoea, recurrent urinary tract infections and dysmenorrhoea were reported. Regarding VVF patients reaction to their

condition, 51% felt bitter, 8% resigned to fate, 33% felt depressed and 8% felt indifferent. Regarding VVF patients perception of societal reaction towards them, 28% received sympathy, 53% were rejected and 18% were treated indifferently.

In a similar study by Onwunali (2012) on the effect of vesico vaginal fistula on psychosocial well-being of victims in Nigeria, the aim of the study was to assess the effect of vesico vaginal fistula on the psychosocial well-being of victims in Nigeria. The study was carried out in 6 selected VVF Centers in the six geopolitical zones of Nigeria. A total of 506 subjects were purposively selected. Data was collected with the aid of a researcher designed structured questionnaire. Reliability obtained using Cronbach-alpha was a coefficient of 0.94. One sample Z-test was used to test the major hypothesis and several other descriptive statistics was used to test the other 8 sub-hypotheses at 0.05 level of significance. The result revealed that VVF has adverse significant effect on the psychosocial well-being of victims in Nigeria, especially on the emotional status and self esteem of victims. There was significant relationship between the family attitude and public attitude towards victims and the psychosocial well-being of victims. The researcher therefore recommended that government should employ more clinical psychologists at VVF Centres to provide psychotherapy to victims during hospitalization until they are finally discharged home.

In a related work, Alio, Merrelle, Roxbyrgh, Clayton, Marty, Bomboka, Traore and Salihu (2010) studied the psychosocial impact of veico-vaginal fistula in Niger. The purpose of the study was to explore the psychosocial impact of vesico-vaginal fistula or women in Niger. In the qualitative study, the researchers studied 21 women in convalescence who had undergone 1-3 fistula repair operations at DIMOL Reproductive Health Centre in Niamey, Niger between 2008 and 2009. According to the researchers, women reported the experience of psychological consequences of VVF which included; depression, feelings of shame and loneliness. Some others

reported feeling devalued as a woman and wanting to end their lives. Furthermore, the social consequences reported by all the women included rejection from society, isolation, rejection by husband and/or divorce. Almost half reported that they had lost their social network and support and were accused of being the architect of their condition. The researchers however concluded that VVF is a direct result of lack of access to skilled birth attendants and emergency obstetric care rather than being the womenôs fault.

In a phenomenological study by Gbola (2007) on the topic ñVesico-vaginal fistula and psychological well-being of women in Nigeriaò, the aim of the study was to identify the psycho-social conditions faced by the victims and their coping strategies. The study was purposively carried out in Lagos because Lagos had the largest population in the country with both ethnic and cultural diversity. A total of 7 participants were recruited for the study. Five were from rural areas and the other two from urban areas. The instrument for data collection was a researcher developed semi-structured interview guide and data was analysed from a descriptive perspective. The result revealed that majority of participants suffered divorce, social isolation, abandonment by husband, rejection by significant others at home and place of work, depression and low self esteem. However, the coping strategies for most of them was begging for alms, change of job to selling of firewood or pure water to raise money for treatment and participation in religious activities. The researcher therefore concluded that since the whole world is changing positively regarding gender and health issues, Nigeria should make serious attempts at addressing those gender issues which put womenôs health in jeopardy.

In a related study conducted by Okoye, Echiegu and Tanyi (2014) on living with vesico-vaginal fistula: experiences of women awaiting repairs in Ebonyi State, Nigeria, the objective of the study was to highlight how women living with VVF cope with the health problem in Ebonyi State. The study was carried out at the National Fistula Centre, Abakaliki. Indepth interview was

used to study 10 women, out of which 6 had lived with the problem for more than ten years. The findings showed that all women go through many physical and emotional problems which included unemployment, as well as rejection by husband and by significant others. However, some of the ways they devised to cope with the problem emotionally and financially was by attending religious gathering and having some form of income yielding businesses. The researchers concluded that VVF repairs should go hand in hand with vocational training, so that the women will be able to have some income yielding business after repair.

In a study conducted by Aboh, Nwankwo, Obi and Agu (2013) which examined the clinical features of patients diagnosed with vesico vaginal fistula in South East Nigeria on women between ages 17 and 65 years. The one hundred and twenty-five (125) participants were sampled using convenience sampling technique from National Obstetric Fistula centre, Abakaliki and Gynaecology department of Nnamdi Azikiwe University Teaching Hospital, Nnewi. Ex-post factor design was adopted while descriptive (Percentage) and quantitative (Chi Square) statistics were applied in testing the hypotheses. The result revealed that 64.29% suffered rejection and 73.81% suffered depression all at P<.001 level of significance. Based on the outcome, it was concluded that clinical features had a remarkable difference on the prevalence and incidence of VVF among diagnosed patients.

In another study by Mutambara, Maunganidze and Muchichwa (2013) on the topic ñtowards promotion of maternal health: the psychological impact of obstetric fistula on women in Zimbabweò. The study was quanlitative in nature and the phenomenological design was used. Purposive sampling was used to identify four (4) women with obstetric fistula in two hospitals in Zimbabwe and in-depth interviews using unstructured interview guides were done with these women. The data obtained from the interviews was grouped into themes and analysed using content analysis. The results of the study revealed that women with obstetric fistula faced the

following psychological problems: helplessness, sadness, suicidal thought, stigma and blame, feelings of worthlessness, fear, shame and social withdrawal. Based on the outcomes, the researchers concluded that women with obstetric fistula face a number of psychological problems hence issues to do with their mental health needed to be taken seriously.

In a descriptive research survey by Odu and Cleland (2013) on the psycho-social consequences of vesico vaginal fistula among women in Northern Nigeria, the sample consisted of two hundred and fifty two (252) VVF patients. The purposive sampling technique was used to select the sample. Data was collected with the aid of a self constructed questionnaire and analysed using percentage score and t-test analysis. The three (3) hypotheses generated were tested at 0.05 level of significance. The result revealed a significant relationship between VVF and stigmatization, positive relationship existed between VVF and self worth and significant relationship exist between VVF and rational ability of patients. Based on the findings, it was recommended that adequate support should be given to VVF patients by their family and friends, who should identify with their predicaments rather than denying and isolating them. The researchers also suggested that if adequate care is given; their hope would be restored, low self-worth will be eliminated and their rational ability will be restored.

**Summary of Literature Reviewed**

From all the related literatures reviewed in this chapter, vesico-vaginal fistula is a devastating, distressing and dehumanizing condition, which was once common in the western world, but now occurs almost exclusively in resource poor countries including Nigeria (Munir-Deen, 2007). The condition is one of the greatest tragedies that can befall a woman and poses medical aswell as psychological and social challenges to the patient. Its causes are classified as direct or indirect (Rahmat, 2008). While, the types have been classified based on the size, etiology

or the organs involved. VVF is an issue of public health concern whose mainstay of prevention in developing countries is the avoidance of obstructed labour, through improved obstetric care. However, its eradication requires the concerted efforts of individual(s), governmental and non-governmental organizations (Munir-Deen, 2007).

Drawing up on all the above discussions in this chapter, it is pertinent to state that, much of literatures on VVF concentrate on the incidence, prevalence and causes of VVF in different parts of the world. Although, several researches have been conducted by different groups of individuals on VVF, many of the researches focused on the medical and surgical aspects of the condition and pretty less about the psychosocial challenges of VVF patients. This is because, many of the studies were carried out by gynaecologists or surgeons who operate on these women, and sometimes based on hospital records. Therefore, this study is important to assess and document psychosocial challenges of VVF patients in Nigeria.

# CHAPTER THREE

# RESEARCH METHODS

This chapter describes the research design; area of study; population of study; subjects of study; instrument for data collection; validation and reliability of instrument; ethical consideration applied to the research; procedure for data collection and; method of data analysis.

## Research Design

The research design adopted for this study is the descriptive survey research design. A descriptive research is designed to describe the characteristics or behaviour of a particular population in a systematic and accurate fashion. While the survey research allows the use of instruments such as; questionnaires and interviews to collect information about peopleôs attitudes, beliefs, feelings, behaviours and life styles (Polit & Tetano-Beck, 2008). This design was successfully used by Mutambara et al., (2013) in their study of psychological impact of obstetric fistula on women in Zimbabwe.

## Area of Study

The survey was carried out in the National Obstetric Fistula Centre (NOFIC) Abakaliki, Ebonyi State. It is located in the South-East of Nigeria at 86 Abakaliki/Enugu express way, Abakaliki. The centre is bounded in the north and east by the Federal Teaching Hospital, in the south by the Coca-cola residential quarters and in the west by Odunukwe quarters.

This fistula centre was purposively selected because fistula cases from all the geo-political zones in Nigeria are referred there to receive free specialized treatment and fistula repair. It comprises one (1) operating theatre, nine (9) departments, one (1) clinical unit and two (2) wards and departments. The departments include the General Out-Patient, Nursing services,

Administrative, Laboratory, Pharmaceutical Services, Social works, Records, Audit and Accounts departments respectively. The clinical unit is cancer screening unit. The wards include, the pre-operative and post-operative wards. The pre-operative ward is a 46 bedded ward for surgical preparation, while the post-operative ward is a 41 bedded ward for post surgical care of VVF patients. Both the pre-operative and post-operative wards are staffed with Registered Nurses and Midwives.

**Population**

Population for this study consisted of VVF patients admitted for vesico-vagina fistula repair, within a period of eight (8) weeks in the National Obstetric Fistula Centre, Abakaliki. The long period was to enable the researcher get reasonable number of participants. The number of patients admitted at the centre within a period of eight (8) months is shown in the Table below.

**Table 1: The number of patients admitted at the NOFIC within a period of eight (8) months in 2014**

| Month | Number of admitted patients |
|---|---|
| May | 30 |
| June | 3 |
| July | 2 |
| August | 5 |
| September | 45 |
| October | 7 |
| November | 9 |
| December | 2 |

Source: Department of Social Works, National Obstetric Fistula Centre, Abakaliki.

**Selection of Subjects**

The researcher used a convenience (non-probability) sampling method to study all respondents/informants who met the inclusion criteria for the study. The inclusion criteria was;

- VVF patients admitted for repair at the VVF centre, Abakaliki, within the study period.
- Willingness to participate in the study.
- Consent to audio-tape during the focus group discussion sessions.

**Instrument for Data Collection**

The researcher used a triangulation of methods, that is; a focus group discussion method and the (survey) questionnaire. The aim was to get in-depth information from participants on the psycho-social challenges they faced with vesico-vagina fistula using focus group discussion. However, since the FGD alone will not offer the researcher quantitative data to do statistic comparism (correlation) between the most significant responses of participants, it was imperative to also use a survey (questionnaire) to substantiate the findings of FGD.

*Focus Group Discussion Guide*

The researcher developed a focus group discussion guide consisting of open ended questions. The questions were generated based on the objectives to elicit information on how VVF affects the emotional health of the patients, as well as how the attitude of significant others affect the social health of the VVF patients at the National Obstetric Fistula Centre, Abakaliki. The researcher probed participantsô response to get details of their psychosocial challenges in narrative format. Two research assistants were recruited to interpret the FGD questions in different local dialects of participants. The two research assistants were also instructed to assist in taking notes and making observations, while the researcher moderated and recorded the FGD sessions.

*Questionnaire*

The researcher developed a semi-structured questionnaire to elicit response on the social and obstetric characteristics of VVF patients and on the psychosocial challenges affecting the emotional and social health of the VVF patients at the National Obstetric Fistula Centre, Abakaliki. The questionnaire comprised twenty-two (22) questions with both open and closed-ended questions in four (4) sections. Section A contained six (6) questions to elicit response on the social characteristics of VVF patients, while section B contained five (5) questions to elicit response on the obstetric characteristics of VVF patients. Section C contained four (4) questions on a modified likert scale to elicit response on the psychosocial challenges affecting their emotional health, while section D contained seven (7) questions on a likert scale to elicit response on the psychosocial challenges affecting the social health of VVF patients at the National Obstetric Fistula Centre, Abakaliki. Two research assistants were recruited and instructed to assist the researcher in the administration and retrieval of the questionnaires. They also assisted in interpreting the survey questions in different local dialects of participants.

It was based on the significant statements of the participants in the FGD sessions and themes generated after the thematic analysis, that the researcher selected and did correlation between psychological challenges and social health of VVF patients with responses in the questionnaire. The aim was to determine the statistical relationship existing between these variates, using the quantitative data gathered with the questionnaire. Specifically, the correlation was between participants responses on;

i. Attitude of significant others and psychological challenges affecting the social health of participants

ii. Feeling of unhappiness and avoidance of social cum religious functions among VVF patients

**Validation of Instrument**

*Content validity*

In line with the objectives of this study, the draft copies of the researcher developed questionnaire and FGD guide were submitted to a total of three (3) research experts. Each expert was selected from the department of Psychology in Nnamdi Azikiwe University, Awka, the department of Statistics in Nnamdi Azikiwe University, Awka and the department of Nursing Science in the University of Nigeria, Enugu, to vet in order to check for accuracy and consistency of the instruments as well as establish the content validity of the instruments. The experts critiqued and modified the instruments by making comments and suggestions. Thereafter, the researcher modified the questions and statements before submitting the final draft of the questionnaire and FGD guide to the project supervisor for approval, before using it for pilot study.

*Reliability*

A pilot study was conducted at the Nnamdi Azikiwe University Teaching Hospital, Nnewi, Anambra State with five (5) VVF patients who met the inclusion criteria. The instruments were considered efficient as there was neither question ambiguity nor emotion provoking questions. The FGD results were also shown to the participants to confirm that the themes reflected what were discussed. The questionnaire was analysed using split half method and computed using Spearman Brownôs Prophesy formula which obtained a reliability coefficient of 0.73. The result of the reliability test using Statistical Package for Social Sciences (SPSS) version 20.0 is shown in appendix viii. This high reliability coefficient indicated that the instrument was reliable.

**Ethical Consideration**

A letter of introduction obtained from the Department of Nursing Science, University of Nigeria, Enugu campus, was submitted to the ethical review committee at the National Obstetric Fistula Centre, Abakaliki, Ebonyi State. The researcher received the committeeôs approval and permission to undertake the study at the National Obstetric Fistula Centre, Abakaliki, Ebonyi State. Also, permission to carry out the study was obtained from the Head of Nursing Services Department, and the Matrons in-charge of the pre and post-operative wards of the hospital. Informants/respondents were required to give signed informed consent and their confidentiality, anonymity and privacy was maintained.

**Procedure for Data Collection**

Data was collected during one of the quarterly VVF repair campaigns with the permission of the ethical review committee of the hospital and signed informed consent of the participants over a period of eight weeks. For the data collection, participants were engaged between 12noon and 2pm daily. The survey preceded the focus group discussion sessions. Two research assistants were recruited and instructed to assist the researcher in the administration, interpretation and retrieval of the questionnaires, as well as, in interpreting the FGD questions, taking notes, and making observations during the FGD sessions. The researcher participated in administering, recording and moderating of the FGD sessions. Each session had 7-12 participants, with a total of four (4) FGD sessions. Each session was audio-taped and lasted between 45- 60 minutes.

**Method of Data Analysis**

Data collected with the questionnaire for sections A and B were presented using frequency distribution Tables and percentages. Whereas data collected for sections C and D on a likert scale

were presented in Tables using mean and standard deviation.The data collected with the focused group discussion guide were analyzed from a descriptive perspective using the procedures identified by Tesch and Giorgi (1985) in Polit and Tetano-Beck (2008) as well as bar chart, for clearer and quicker understanding. The steps included;

1. Intensive reading of transcripts to get a general understanding of participants expression about the phenomenon
2. Reading transcribed interviews severally and condensing the text into structures of meanings
3. Clustering the meanings of units identified into themes relating to the question
4. Writing down the themes
5. Identifying subthemes by exploring the themes
6. Refining the subthemes

The researcher and a co-coder (a qualitative research analyst) studied the audio-taped record and manuscript to formulate meanings. As well as cluster the meanings to develop themes. Excerpts were reported as quotations or paraphrases, while the narrative summaries were presented in barcharts.

**Trustworthiness of the Study**

To ensure trust worthiness of a qualitative research, Guba and Lincoln (1989) proposed four (4) criteria. They include credibility, dependability, confirmability and transferability.

1. ***Credibility*** refers to confidence in the truth of data and interpretations of data. In this study, the researcher used two techniques namely; investigator- triangulation and prolonged engagement to ensure credibility.

a. *Investigator- triangulation:* The researcher used a qualitative research analyst as a co-coder. The researcher and co-coder transcribed and coded data independently using the same coding techniques of Tesch and Giorgi (1985).

b. *Prolonged engagement:* Collection of data lasted a period of eight (8) weeks during a quarterly VVF repair campaign. Participants were engaged in the data collection between 12noon and 2pm daily.

2. ***Dependability*** refers to data stability over time and over conditions. In this study, the researcher established dependability by using audit method, that is; two (2) external reviewers to scrutinize the data, themes and relevant support documents.

3. ***Confirmability*** refers to the objectivity of the data. The project supervisor audited the data collected, field notes and the interpretation of themes for confimability.

4. ***Transferability*** refers to the extent to which findings from the data can be transferred to other settings or groups. The researcher tried to ensure transferability by providing a description of the study setting of this research.

## CHAPTER FOUR

## PRESENTATION OF RESULTS

This chapter deals with the presentation of results for data collected from the survey (questionnaire) and focused group discussion guide. The findings are presented in Tables and bar charts.

**Table 2: Respondents' Socio-Demographic Characteristics**

n= 35

| Variables | Variables Classification | F | % |
|---|---|---|---|
| Age (in years) | <15 | 4 | 11.4 |
| | 15-21 | 3 | 8.6 |
| | 22-28 | 7 | 20.0 |
| | 29-35 | 12 | 34.3 |
| | 36 | 9 | 25.7 |
| Age at Marriage (in years) | <15 | 13 | 37.1 |
| | 15-21 | 7 | 20.0 |
| | 22-28 | 8 | 22.9 |
| | 29-35 | 4 | 11.4 |
| | >36 | 3 | 8.6 |
| Marital Status | Single | 0 | 0 |
| | Married | 10 | 28.6 |
| | Separated | 20 | 57.1 |
| | Divorced | 1 | 2.9 |
| | Windowed | 4 | 11.4 |
| Polygamous Marriage | Yes | 5 | 14.3 |
| | No | 30 | 85.7 |
| Level of Education | No formal education | 10 | 28.6 |
| | Qurôanic | 7 | 20.0 |
| | Primary | 8 | 22.9 |
| | Secondary | 6 | 17.1 |
| | Tertiary | 4 | 11.4 |
| Occupation | House wife | 6 | 17.1 |
| | Apprentice | 5 | 14.3 |
| | Trading | 10 | 28.6 |
| | Farming | 6 | 17.1 |
| | Student | 5 | 14.3 |
| | Civil-servant | 3 | 8.6 |

From the questionnaire, figures in Table 2 indicated that 4 (11.4%) were less than 15 years old, 22 (62.9%) were within the age bracket of 15-35 years, and 9 (25.7%) were above 35 years old.

From the variable classification on age at marriage, 13 (37.1%) of the respondents married before age 15 years, 19 (54.3%) married between 15 and 35 years while 3 (8.6%) married after age 35 years

Ten (28.6%) of the respondents were married, 20 (57.1%) were separated, 4 (11.4%) were widowed and only 1 (2.9%) was divorced.

Among the respondents, 5 (14.3%) were married in polygamous setting.

From the variable classification, 10 (28.6%) of the respondents had no formal education, 7 (20.0%) had qurôanic education, 8 (22.9%) had primary level of education, 6 (17.1%) had secondary level of education and only 4 (11.4%) had tertiary level of education.

Table 2 also showed that 6 (17.1%) of the respondents were housewives, 5 (14.3%) were apprentice, 10 (28.6%) were traders, 6 (17.1%) were farmers, 5 (14.3%) were students and only 3 (8.6%) were civil servants.

**Table 3: Respondents Obstetric Characteristics**

n= 35

| Variables | Variables Classification | F | % |
|---|---|---|---|
| Cause of VVF | Prolonged Labour | 20 | 57.1 |
| | Caesarean Section | 8 | 22.9 |
| | Traditional Episiotomy | 7 | 20.0 |
| No of Pregnancies before the VVF Occurred | None | 4 | 11.4 |
| | 1 | 9 | 25.7 |
| | 2-4 | 15 | 42.9 |
| | 5 and above | 7 | 20.0 |
| Number of Living Children | None | 7 | 20.0 |
| | 1 | 14 | 40.0 |
| | 2-4 | 10 | 28.6 |
| | 5 and above | 4 | 11.4 |
| Usual Place of delivery | Home | 6 | 17.1 |
| | TBAôs place | 12 | 34.3 |
| | Private | 10 | 28.6 |
| | Government hospital | 7 | 20.0 |
| Place of Delivery when VVF Occurred | Home | 4 | 11.1 |
| | TBAôs place | 12 | 34.3 |
| | Private | 14 | 40.0 |
| | Government hospital | 5 | 14.3 |

From the Table 3, the major cause of VVF reported by 20 (51.7%) was prolonged labour.

Four (11.4%) of the respondents had no pregnancy before the VVF formation, 24 (68.6%) had 4 pregnancies or less, while a total of 7 (20.0%) had more than 4 pregnancies before the VVF formation.

From the variable classification on number of living children, 7 (20%) had none, while 28 (80%) had 1 or more living child before the VVF formation.

Among the respondents, 6 (17.1%) usually delivered their baby(s) at home, 12 (34.3%) usually delivered at the TBAôs place, 10 (28.6%) usually delivered at a Private clinic, and 7 (20.0%) usually delivered at a Government hospital.

Table 3 also indicated that 14 (40.0%) of the respondents had their deliveries at the Private clinic when VVF occurred, 12 (34.3%) had their deliveries at the TBAôs place when the VVF occurred, and minority 4 (11.4%) had their deliveries at home when the VVF occurred.

**Objective one:** To assess how VVF affects the emotional health of patients at National Obstetric fistula centre, Abakaliki.

**Table 4: Result of how VVF affects the emotional health of respondents**

| ***Challenge*** | ***Mean*** | ***Standard Deviation*** |
|---|---|---|
| Unhappiness | 4.71 | 1.77 |
| Lost respect from family members | 4.49 | 3.18 |
| Worried | 4.66 | 2.93 |
| Ashamed | 4.66 | 2.93 |
| Aggregate score | 4.63 | 2.70 |

From Table 4, the questionnaire revealed that with an aggregate mean score of 4.63, the psychological challenge of unhappiness ranked first, while being worried and ashamed ranked second. Hence, the result showed that only these three factors constituted the major psychological challenges affecting the emotional health of VVF patients in the National Obstetric Fistula Centre, Abakaliki, Ebonyi State.

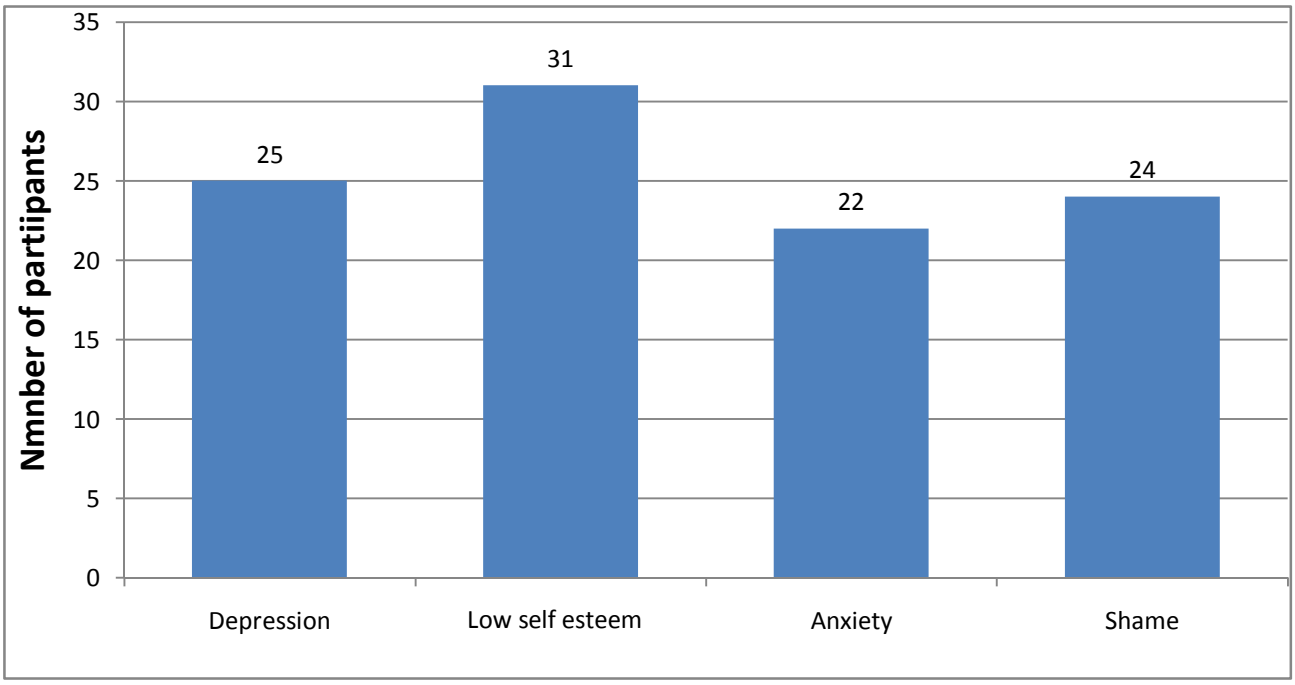



**Figure I: How VVF affects the emotional health of participants**

From figure I, the themes which emerged in the FGD as psychological challenges affecting the emotional health of participants as a result of their VVF condition were depression, low self esteem, anxiety and shame.

The theme ñdepressionò addressed the feeling of loneliness, unhappiness and sadness experienced by majority of the participants, because their condition always got them thinking and invariably affected their mood badly. These intense emotions worsened whenever they remembered their predicament and a few mentioned that they sometimes thought of ending their problems by committing suicide. One of the participants said *…each time I think of this illness, I become so sad and angry with myself (sighs)*, while another participant said é *I sometimes think of committing suicide".*

Another theme was ñlow self esteemò which addressed the way most participants felt loss of confidence in themselves because of their VVF condition. Almost all of them pointed to the fact that the feeling was especially because of how other people reacted to their condition. For instance, one of the participants said *I have lost confidence in myself. I can't walk with my shoulders high,* another participant said *I have noticed the way people hold their nose when I come close. So I just feel the ground should open and swallow me.* Many others shared similar experiences.

The theme ñanxietyò addressed the fear and worries expressed by majority of the participants about the outcome of their disease condition, since they were short of ideas on how best to tackle their condition. Majority of the participants were troubled by their condition and some were troubled to the extent that they did not know how to face another day. One of the participants said *"Each time this illness comes to my mind, I become troubled because I do not know how to go about it"...,* while another participant said é *am so worried that I am so afraid of facing another day…*Many others expressed that they had similar experiences.

The theme ñshameò addressed the way majority the participants felt unworthy and ashamed of themselves. Since, they no longer felt comfortable with and about themselves in their present condition. Some of them are ashamed because, they could not imagine that they smell urine and even bed wet. One of the participants said é *"I cannot even imagine the kind of smell I perceive from the body of a beautiful and elegant lady like me"...,* while another participant said *I do not know what shame is more than bed wetting after training your little children to stop bed wetting (sighs)…*

**Objective two:** To determine how the attitude of significant others affect the social health of patients at National Obstetric fistula centre, Abakaliki.

**Table 5: Result of how the attitude of significant others affect the social health of respondents**

| Challenge | Mean | Standard deviation |
|---|---|---|
| Separation from husband | 4.60 | 3.48 |
| Deprivation of sex | 4.37 | 4.17 |
| Lacking physical attention | 4.11 | 3.42 |
| Avoidance by significant others | 3.90 | 4.19 |
| Avoiding social functions | 4.74 | 2.94 |
| Avoiding religious activities | 4.03 | 3.18 |
| Changed to less paid job | 3.54 | 4.27 |
| Aggregate score | 4.07 | 3.66 |

From Table 5, the questionnaire revealed that with an aggregate mean score of 4.07, the psychological challenge of avoiding social functions ranked first, separation from husband ranked second, deprivation of sex ranked third, while lacking physical attention ranked fourth. Therefore, these four factors constituted the major psychological challenges affecting the social health of VVF patients in the National Obstetric Fistula Centre, Abakaliki, Ebonyi State.

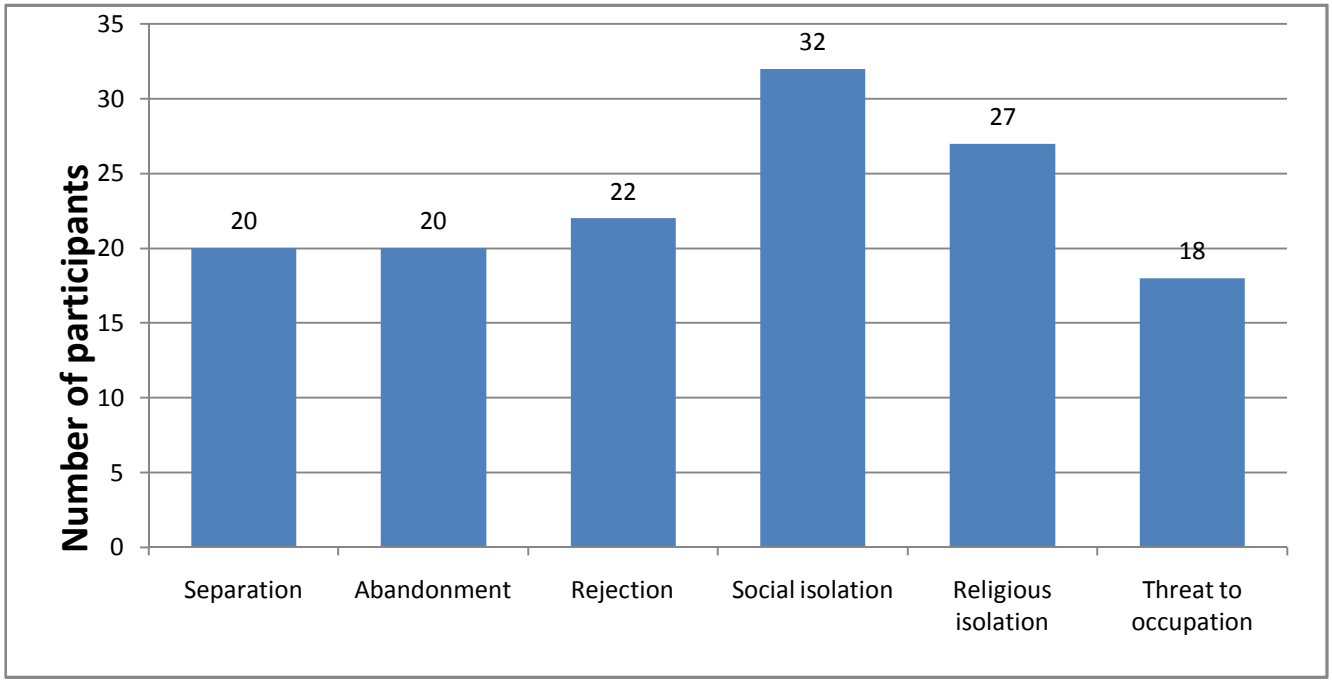



**Figure II: How the attitude of significant others affect the social health of participants**

From figure II, the themes separation from husband, abandonment by husband, rejection by significant others, social isolation, religious isolation and threat to occupation emerged in the FGD as psychological challenges affecting the social health of participants because of the attitude of their significant others.

The theme ñseparation from husbandò addresses the fact that most of the participants no longer relate closely with their husbands, and have been separated from their husbands in different ways as a result of their VVF condition. Some of the participants mentioned that they have been out-rightly sent packing from their husbandôs house, while others noted that they no longer share the same room with their husbandsô. In the words of a participant,*...I no longer live in the same room with my husband...,* while another participant said *...he packed me away from his house and told me never to return until I become as well as I was when he married me...*This was a common experience shared by several other participants.

The theme ñabandonment by husbandò addresses the fact that some of the participants have experienced different degrees of deprivation of the usual touch, love, sex and physical attention received from their husbandôs. As a result of VVF, they no longer had regular physical contact with their husbands. Some of them could not have the usual face-to-face contact with their husbands, while a few were only permitted to communicate with their husband via phone calls. few of the participants mentioned that their husbandôs employed nanny to take care of them because they could not cope with the physical demands of the VVF condition. However, majority of the participants mentioned that they were deprived physical touch and sex which was very devastating. Some of the participants pointed out that their husbandôs now obviously kept extra-marital affairs. A few added that their husbandôs even brought their concubines into their matrimonial home. One of the participants said *... he does not care about me anymore. Inshort he has left me alone to my fate.,* a second participant said *...instead of showing me love in this trying time, he went to the extent of employing a nanny to take care of me but will not come into the room to even see me...we only discuss on phone (crying)"...,*still another participant said *...my husband who cannot do without sex even when am menstruating has not had sex with me for over eleven (11) months because of VVF...,* while a fourth participant said *...my husband has seen a genuine reason to bring women into our matrimonial home (sighs)...*

The theme ñrejection by significant othersò addresses the fact that some of the participants experienced avoidance by their significant others who were aware of their predicament. For some of them, their in-laws want them out of their matrimonial homes. A few of them mentioned that their children and other significant others no longer visited them as frequently as usual. A participant said *...even my in-laws have asked my husband to send me packing...although he has not, I think he has not made up his mind...*, while another participant said *...I observed that my*

*children don't visit me as frequently as usual except my first daughter…*This was a common experience shared by many other participants.

The theme ñsocial isolationò addresses the fact that almost all the participants have resorted to restrict themselves from participating in social functions like club meetings, parties and other social gatherings, so that more persons will not find out that they have such a problem..in the words of a participant *…I am a very social person but I no longer feel comfortable attending social gatherings because of the smell…,* while another participant said *…when am invited to social functions, I give one excuse or the other, just to avoid the gathering.*

The theme ñreligious isolationò addresses the fact that majority of the participants no longer attended church or mosque activities because it was either an abomination, they did no longer feel the need to, or because they felt God had forgotten them. One participant said *…I no longer feel comfortable attending church services because of the smell…,* another participant said *…"am a religious person o…but I can't even go to the mosque to pray with this condition…it is an abomination"…,* while another participant added *"I already feel that God has forgotten me, so what am I going to church for?"*

The theme ñthreat to occupationò addresses the fact that as a result of VVF, some of the participantôs notably the traders and apprentices needed to change their occupation to less productive jobs. Many others depended on alms to survive. Moreso, there was impending sack for the civil servants because of frequent absenteeism. One of the traders said *…am a food vendor…my customers no longer patronize me so well, so I have changed business to selling pure water…,* an apprentice said *…I am learning tailoring but my madam asked me to stop working for her because her customers are complaining that I stink…,* another participant said *…things are not working out…so I depend on the support I get from churches…*, while a civil servant saidé *my immediate boss covers up for me so that I can close from work earlier than usual or be absent at times…otherwise I would have lost my job…even at the moment, there are queries to my boss about my frequent absence by management staff…*

**Objective three:** To determine the relationship between psychological challenges and social health of VVF patients at the National Obstetric Fistula Centre, Abakaliki.

Based on the themes formulated from the significant statements of the participants in the FGD sessions, the researcher selected and did a correlation between some psychological challenges and social health of VVF patients in the questionnaire. The aim was to determine the statistical relationship existing between these variates, using the quantitative data gathered with the questionnaire. The specific correlation done using the Pearsonós Product moment correlation at 0.001 level of significance are as shown in Tables 6 and 7:

**Table 6: Correlation between attitude of significant others and the psychological challenges affecting the social health of VVF patients at the National Obstetric Fistula Centre, Abakaliki.**

| Correlation between attitude of significant others and the psyc. chall. affecting social health of the respondents | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Q19 Significant others | Q16 Seperation | Q17 Deprives me sex | Q18 No physical attention | Q20 Avoid Social function | Q21 Avoid religious activities | Q22 Threat to Job |
| Q19 Avoidance by Significant others | Pearson Correlation | 1 | .472** | .517** | .625** | .479** | .464** | .687** |
| | Sig. (2-tailed) | | .004 | .001 | .000 | .004 | .005 | .000 |
| | N | 35 | 35 | 35 | 35 | 35 | 35 | 35 |
| Q16 Seperation | Pearson Correlation | .472** | 1 | .831** | .695** | .665** | .634** | .629** |
| | Sig. (2-tailed) | .004 | | .000 | .000 | .000 | .000 | .000 |
| | N | 35 | 35 | 35 | 35 | 35 | 35 | 35 |
| Q17 Deprives me sex | Pearson Correlation | .517** | .831** | 1 | .827** | .814** | .760** | .702** |
| | Sig. (2-tailed) | .001 | .000 | | .000 | .000 | .000 | .000 |
| | N | 35 | 35 | 35 | 35 | 35 | 35 | 35 |
| Q18 No physical attention | Pearson Correlation | .625** | .695** | .827** | 1 | .718** | .748** | .700** |
| | Sig. (2-tailed) | .000 | .000 | .000 | | .000 | .000 | .000 |
| | N | 35 | 35 | 35 | 35 | 35 | 35 | 35 |
| Q20 Avoid social function | Pearson Correlation | .479** | .665** | .814** | .718** | 1 | .872** | .639** |
| | Sig. (2-tailed) | .004 | .000 | .000 | .000 | | .000 | .000 |
| | N | 35 | 35 | 35 | 35 | 35 | 35 | 35 |
| Q21 Avoid religious activities | Pearson Correlation | .464** | .634** | .760** | .748** | .872** | 1 | .765** |
| | Sig. (2-tailed) | .005 | .000 | .000 | .000 | .000 | | .000 |
| | N | 35 | 35 | 35 | 35 | 35 | 35 | 35 |
| Q22 Threat to Job | Pearson Correlation | .687** | .629** | .702** | .700** | .639** | .765** | 1 |
| | Sig. (2-tailed) | .000 | .000 | .000 | .000 | .000 | .000 | |
| | N | 35 | 35 | 35 | 35 | 35 | 35 | 35 |

The result in Table 6 showed that there is a direct positive relationship between the attitude of significant others and the social health of the respondents. This means that as the attitude of their significant others change, there will be separation between the partners, deprivation of sex, no physical attention, avoidance of social cum religious functions and threat to job.

**Table 7: Correlation between the feeling of unhappiness and avoidance of social function by VVF patients at the National Obstetric Fistula Centre, Abakaliki**

| Correlation between feeling of unhappiness and avoidance of social function | | | | |
|---|---|---|---|---|
| | | Q12 VVF unhappiness | Q20 Avoid Social function | Q21 Avoid religious activities |
| Q12 VVF Unhappiness | Pearson Correlation | 1 | .527** | .519** |
| | Sig. (2-tailed) | | .001 | .001 |
| | N | 35 | 35 | 35 |
| Q20 Avoid social function | Pearson Correlation | .527** | 1 | .872** |
| | Sig. (2-tailed) | .001 | | .000 |
| | N | 35 | 35 | 35 |
| Q21 Avoid religious activities | Pearson Correlation | .519** | .872** | 1 |
| | Sig. (2-tailed) | .001 | .000 | |
| | N | 35 | 35 | 35 |

The correlation result in Table 7 showed a strong correlation (r = 0.87) between the feeling of unhappiness brought about by VVF and avoidance of social cum religious functions.

From all the results presented in chapter four, VVF affects the emotional health of patients because it led to depression, low self esteem, anxiety and shame. In addition, the negative attitude of significant others which most VVF patients reported as avoidance is responsible for separation, abandonment, rejection, social cum religious isolation and threat to job. However, the correlation result showed a positive relationship between the avoidance attitude of significant others and the psychosocial challenges affecting the social health of VVF patients, as well as between the patientsô feeling of unhappiness brought about by VVF and the avoidance of social cum religious functions.

# CHAPTER FIVE

# DISCUSSION OF FINDINGS

This chapter presents the discussion of major findings, implications for Nursing and Midwifery, limitations of the study, summary, conclusion and recommendations.

## Discussion of Major Findings

*How VVF affects the emotional health of patients at the National Obstetric Fistula Centre, Abakaliki.*

From Table 2 and figure I, VVF affected the emotional health of most participants because, it led them into experiencing depression, low self esteem, anxiety and shame.

This finding on depression with three (3) sub-themes (loneliness, unhappiness and sadness) is in agreement with the finding of Okoye et al., (2014) in their study on ñliving with vesico-vaginal fistula: experience of women awaiting repairs in Ebonyi State, Nigeria.ò According to them, majority of the participants in their study experienced depression due to VVF. This pointed out that majority of VVF patients experienced loneliness, unhappiness and sadness because of their VVF condition.

The finding of this study on low self esteem with one (1) sub-theme (loss of confidence) is in agreement with the finding of Gbola (2007) in his study on ñvesico-vaginal fistula and psycho-social well-being of women in Nigeriaò. According to him, the attitude meted out to most of the VVF victims often made them perceive themselves as worthless or useless individuals. This showed that most VVF patients lost high level of confidence in themselves as a result of VVF.

The finding of this study on anxiety with two (2) sub-themes (fear and worries) is in line with the finding of Okoye et al., (2014) in their study on ñliving with vesico-vaginal fistula: experience of women awaiting repairs in Ebonyi State, Nigeria.ò According to them, most of the

participants experienced anxiety because of their yet-to-be successful attempts towards improving their VVF condition. This revealed that a significant number of VVF patients developed fear and worries based on their VVF condition.

The finding of this study on shame with one sub-theme (ashamed) is in agreement with the finding of Alio et al., (2010) in their study on ñthe psychosocial impact of vesico-vaginal fistula in Nigerò. According to them, majority of the participants reported that they felt ashamed because VVF made neat women like them to leak and smell urine. This confirmed that a greater number of VVF patients were ashamed of themselves because of the offensive smell that resulted from the urinary incontinence associated with VVF.

*How the attitude of significant others affect the social health of VVF patients at the National Obstetric Fistula Centre, Abakaliki.*

From Table 3 and figure II, the avoidance attitude showed by the significant others of participants led them to experiencing psychological challenges which affected their social health. The effect was separation from husband, deprivation of sex, rejection by significant others, lack of physical attention, avoidance of social functions, avoidance of religious activities and threat to job.

The finding of this study on separation from husband with two (2) sub-themes (Out-rightly sent packing and no longer shared the same room) is in agreement with the finding of Okoye et al., (2014) in their study on ñliving with vesico-vaginal fistula: experience of women awaiting repairs in Ebonyi State, Nigeria.ò According to them, most of the participants were separated from their husbandôs room or even house, just to avoid touching or sleeping with them because of the offensive smell of urine which characterized VVF patients. This indicated that most VVF

patients either faced the problem of being sent packing from their matrimonial home or being separated from their matrimonial room because of their VVF condition.

The finding of this study on abandonment by husband with four (4) sub-themes (deprivation of touch, love, sex and physical attention) is in agreement with the finding of Alio et al., (2010) in their study on ñthe psychosocial impact of vesico-vaginal fistula in Nigerò. According to them, some of these participants have been divorced and/or abandoned by their husbands, because their problem of VVF was often attributed to be the womenôs fault. This confirmed that majority of VVF patients were deprived touch, love, sex and physical attention by their husband because of VVF.

The finding of this study onrejection by significant others with two (2) sub-themes (relatives no longer visited and in-laws wanted them to pack out) is in agreement with the finding of Okoye et al., (2014) in their study on ñliving with vesico-vaginal fistula: experience of women awaiting repairs in Ebonyi State, Nigeria.ò According to them, most of the participants expressed how their friends, relations and children generally avoided them because they believed they have brought shame to them. It is also supported by the finding of Aboh et al., (2013) in their study on ñclinical features of patients diagnosed with vesico vaginal fistula (VVF) in South East Nigeriaò. According to them, almost half of their participants reported of haven lost their social network and support as a result of their fistula. This showed that a reasonable number of VVF patients suffered rejection by their significant others because of their VVF condition.

The finding of this study on social isolation with one (1) sub-theme (avoidance of social functions) is in agreement with the finding of Alio et al., (2010) in their study on ñthe psychosocial impact of vesico-vaginal fistula in Nigerò. According to them, most of the participants reported isolation from social activities, so that more people will not find out about

their VVF condition. This pointed out that many victims of VVF avoided social functions when they developed VVF.

The finding of this study on religious isolation with two (2) sub-themes (no longer attended church or mosque activities) is a contradiction to the finding of Okoye et al., (2014) in their study on ñliving with vesico-vaginal fistula: experience of women awaiting repairs in Ebonyi State, Nigeria.ò According to them, most of their participants reported the use of religion as a means of coping. Hence, they engaged in religious activities such as attending religious crusades and seeking the counsel of religious leaders. Corroborating this finding, Gbola (2007) in his study on ñvesico-vaginal fistula and psycho-social well-being of women in Nigeriaò found out that 2 out of 7 Muslims which participated in his study had converted to Christianity in order to receive spiritual care from churches, since it was an abomination to enter the mosque with such an unclean condition. These two dimensions signified that, while many VVF patients isolated themselves from religious activities, others adopted attendance of religious functions as a coping strategy for their predicament.

The finding of this study on threat to occupation with one (1) sub-theme (change to less productive job) is in agreement with the finding of Gbola (2007) in his study on ñvesico-vaginal fistula and psycho-social well-being of women in Nigeriaò. According to him, most of the participants in his study reported that their jobs prior to VVF required physical contact with other people. However, with VVF these associations with employers and/or customers were affected. Hence, they needed to change to less productive jobs either willingly or by compulsion.

*Some correlates of VVF among the VVF patients at the National Obstetric Fistula Centre, Abakaliki.*

From Table 4, the avoidance attitude put up by the significant others of VVF patientsô affected the social health of the respondents. This finding is in agreement with the finding of Onwunali (2012) in her study on ñEffect of vesico vaginal fistula on psycho-social well-being of victims in Nigeria.ò According to her, all the participants in her study acknowledged that attitude of family members, employers and religious associates significantly affected the social health of VVF victims in Nigeria. This revealed that most VVF patients were avoided by their significant others because of their VVF condition and this severely affected their social wellbeing.

From Table 5, there is positive relationship between the feeling of unhappiness brought about by VVF and the avoidance of social and religious function by VVF patients. This finding is in agreement with the finding of Onwunali (2012) in her study on ñEffect of vesico vaginal fistula on psycho-social well-being of victims in Nigeria.ò According to her the feeling of unhappiness brought about by VVF resulted in their avoidance of social and religious function. This inferred that the feeling of unhappiness which many VVF patients experienced was a prominent reason for their avoidance of both social and religious functions.

**Implications for Nursing and Midwifery**

The findings of this study revealed that VVF patients experience psychosocial challenges that grossly affect their emotional and social health. Therefore, nurses and midwives need to:

- Plan and organize sensitization programs to enlighten women and the entire populace on the need to attend ante-natal care during pregnancy, seek professional/ hospital delivery during labour, as well as consent to elective caesarean section when the need arises, in order to prevent the incidence of VVF and its devastating complications.

- Plan holistic care that will address the social and psychological needs of VVF patients as much as their physical needs. This is important because often times, health care providers focus more on the physical aspects of the patients care with little or no concern about their psycho-social health.
- Carryout public enlightenment programmes that will prepare the public to accept and support VVF patients in their communities, as this will aid the adaptation of VVF patients to their communities after treatment, thus improving their overall psychosocial health.

**Limitations of the Study**

The study had the following limitations:

1. Tape recording: Participants felt unsafe with the tape recording and therefore requested that the tapes be destroyed as soon as the instrument was transcribed.
2. Long period of data collection: The study involved eight (8) weeks of data collection which interfered with other academic activities of the researcher.

**Summary**

The purpose of this study was to assess the psycho-social challenges experienced by patients with vesico-vaginal fistula (VVF), at the National Obstetric Fistula Centre (NOFIC), Abakaliki, Ebonyi State. To achieve this purpose, two (2) instruments were developed and used to collect data. A questionnaire which consisted of twenty-two (22) items in four (4) sections collected data on the social characteristics, obstetric characteristics, how VVF affects the emotional health of patients and how the attitude of significant others affect the social health of VVF patients, while a focused group discussion was used to collect qualitative data on how VVF affects the emotional health of patients and how the attitude of significant others affect the social

health of VVF patients. The result presented revealed that VVF patients experienced depression, loss of self esteem, anxiety, and shame, as well as separation from husband, abandonment, rejection, social isolation, religious isolation and threat to occupation. Also, the correlation result showed a direct positive relationship between the attitude of significant others and the social health of the respondents, and a strong correlation between the feeling of unhappiness brought about by VVF and the avoidance of social cum religious functions by VVF patients

**Conclusion**

The study investigated the psycho-social challenges of women with vesico-vagina fistula at National Obstetric Fistula Centre, Abakaliki, Ebonyi State. The aspects of psychosocial challenges investigated were emotional and social health of participants. A total of 35 participants who met the inclusion criteria were conveniently selected for the study. From the thematic analysis of the data, it was established that VVF patients suffered several psychosocial challenges which affect their emotional and social health.

**Recommendations**

On the basis of the findings revealed by this study, the following recommendations are made:

1. The study revealed that the psycho-social challenges experienced by VVF patients was intense. It is recommended that Nigerian Government should establish more VVF Centres which will offer VVF repair at no or subsidized cost. As well as encourage more doctors and nurses to specialize in VVF repair in order to speed up the rehabilitation and integration of these patients into their respective families and communities.

2. The findings of this study revealed that VVF patients suffer several psychosocial challenges. It is therefore recommended that Clinical Psychologists and Counselors should be employed at VVF Centres to provide regular psychotherapy throughout the period of hospitalization of these patients until they are finally discharged home. Also, social workers should be employed to follow these women up into their communities and ensure their successful adaptation.
3. The findings of this study revealed that VVF patients lacked the needed support of their significant others, which aggravated their psychosocial challenges. It is recommended that health campaigns, community outreaches and health education through the mass media should be organized to correct existing misconceptions about VVF to facilitate the support of victims by their relatives, encourage visit to VVF facilities as soon as the problem arose, and to enhance the reintegration of patients into their families and communities without difficulty after repair.
4. Similar researches should be carried out in other VVF Centres that were not used by the researcher to assess and compare the psycho-social challenges of VVF patients.

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## APPENDIX I

## QUESTIONNAIRE

Department of Nursing Science

Faculty of Health Sciences and Technology,

University of Nigeria,

Enugu Campus,

Enugu State.

Dear respondent,

I am a Masterôs student of the above mentioned Department, currently carrying out a research on ñAssessing Psychosocial Challenges of women with Vesico- Vaginal Fistula [VVF] at the National Obstetric Fistula Centre, Abakaliki, Ebonyi Stateò. Your participation is voluntary. Please endeavor to answer the following questions carefully and sincerely. All answers are exclusively for research purpose and will be treated with strict confidentiality.

Thank you.

**KANIKWU NWAMAKA**

**Researcher**

**SECTION A: Socio-demographic Characteristics**

Instruction: Please, fill in appropriate answers and tick (ã ) in the appropriate box.

1. Age (in years) é é é é é é é é .

2. Age at marriage (in years) é é é é é é é .

3. Marital Status

   A. Single [ ]

   B. Married [ ]

   C. Separated [ ]

   D. Divorced [ ]

   E. Widowed [ ]

4. Are you married in a polygamous setting?

   A. Yes

   B. No

5. Level of Education

   A. No formal education [ ]

   B. Qurôanic [ ]

   C. Primary [ ]

   D. Secondary [ ]

   E. Tertiary [ ]

   F. Others (Specify)é .....

6. Occupation

A. Housewife [ ]

B. Apprentice [ ]

C. Trading [ ]

D. Farming [ ]

E. Student [ ]

F. Civil Servant [ ]

G. Others (Specify) é é é é é é é é é é é é é é é é é é

**SECTION B: Obstetric Characteristics**

7. Cause of VVF é é é é é é é é é é é

8. No of pregnancies before the VVF occurred

A. None [ ]

B. 1 [ ]

C. 2 - 4 [ ]

D. 5 and above [ ]

9. Number of living children

A. None [ ]

B. 1 [ ]

C. 2 ï 4 [ ]

D. 5 and above [ ]

10. Usual place of delivery

A. Home [ ]

B. TBAôs place [ ]

C. Private clinic [ ]

D. Government hospital [ ]

11. Place of delivery when VVF occurred

A. Home [ ]

B. TBAôs place [ ]

C. Private clinic [ ]

D. Government hospital [ ]

**Instruction:**The following statements assess psycho-social challenges affecting the emotional health of VVF patients on a five-point Likert scale. Please tick (ã ) against the option that best describes your feeling about each statement.

KEY:
SA- Strongly Agree
A- Agree
U- Undecided
D ï Disagree
SD- Strongly Disagree

**SECTION C: How VVF affects the emotional health of patients**

| S/N | | SA | A | U | D | SD |
|---|---|---|---|---|---|---|
| 12. | VVF has brought me unhappiness. | | | | | |
| 13. | I have lost my respect from family members due to VVF. | | | | | |
| 14. | The thought of having VVF gets me worried. | | | | | |
| 15. | VVF condition makes me feel ashamed of myself. | | | | | |

**SECTION D: How the attitude of significant others affect the social health of VVF patients**

| S/N | | SA | A | U | D | SD |
|---|---|---|---|---|---|---|
| 16. | VVF condition has caused a separation between my husband and I. | | | | | |
| 17. | My husband deprives me sex as a result of VVF. | | | | | |
| 18. | I no longer get the physical attention of my husband as a result of VVF. | | | | | |
| 19. | My significant others avoid me as a result of VVF. | | | | | |
| 20. | I avoid attending social functions because of my VVF condition. | | | | | |
| 21. | I avoid attending religious activities because of my VVF condition. | | | | | |
| 22. | I got a less paid job because of VVF. | | | | | |

## APPENDIX II

**Focus Group Discussion Guide for VVF Patients**

**i. Preliminaries**

a. Introduction: Welcome participants and describe what FGD is (it is a group discussion that allows you to discuss among yourselves the topic rather than talking to us).

b. Purpose/Modus Operandi: We will be discussing your psycho-social challenges as it relates to VVF. We are interested in all your ideas, comments and suggestions. All comments both positive and negative are welcome. Please feel free to disagree with one another because we would like to have many points of view.

c. Explain the use of audio tape, adding that all comments are confidential and for research purposes only. We would also want you to speak one at a time, so that the tape recorder can pick your voice clearly.

**ii. Questions on psycho-social challenges**

1. Emotional health

i. Please, tell me how having VVF has affected your mood *(probe where necessary)*

ii. Please, tell me how having VVF has changed the way you see yourself *(probe where necessary)*

iii. Please, tell me what your worries are about VVF *(probe where necessary)*

iv. Please, tell me how the reaction of people around you regarding your VVF makes you feel *(probe where necessary)*

2. Social health

i. Please, tell me how close your relationship with your husband is, in your VVF condition *(probe where necessary)*

ii. Please, tell me what has changed in your relationship with your husband because of your VVF condition *(probe where necessary)*

iii. Please, tell me how VVF has affected your relationship with your relatives *(probe where necessary)*

iv. Please, tell me how VVF has affected your participation in social functions *(probe where necessary)*

v. Please, tell me how VVF has affected your participation in religious activities *(probe where necessary)*

vi. Please, tell me how VVF has affected your occupation *(probe where necessary)*

**iii. Conclusion**

a. Appreciate them for their time.

b. Reassure them that their comments are for research purposes only.

## APPENDIX IV

Department of Nursing Science,
Faculty of Health Sciences and Technology,
University of Nigeria,
Enugu Campus.
Enugu State.
February 27, 2014.

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Sir / Ma,

**REQUEST TO VET A QUESTIONNAIRE AND FOCUSED GROUP DISCUSSION GUIDE**

I am a postgraduate student of the above mentioned institution, conducting a research on ñAssessing Psycho-social Challenges of women with Vesico-Vaginal Fistula (VVF) at National Obstetric Fistula Centre, Abakaliki, Ebonyi Stateò.

On the basis of your professional expertise and experience, you have been selected to critically examine and make necessary corrections on these research instruments for their improvement.

I humbly request you to vet and return them to the researcher as soon as possible.

Thank you.

Yours faithfully,

**Kanikwu Phoebe Nwamaka**
*(Researcher)*

## APPENDIX V

Department of Nursing Science,
Faculty of Health Sciences and Technology,
University of Nigeria,
Enugu Campus.
Enugu State.
February 27, 2014.

The Medical Director,
National Obstetric Fistula Centre,
Abakaliki.
Ebonyi State.

Through:
The Chairman,
Ethical Research/ Committee,

Sir,

**APPLICATION FOR ETHICAL CLEARANCE TO CONDUCT A RESEARCH IN THE VESICO- VAGINAL FISTULA (VVF) CENTRE OF YOUR INSTITUTION**

I am a postgraduate student of the above mentioned institution with registration number PG/M.SC/12/64134.

I humbly write to apply for ethical clearance to carry out a research study titled ñAssessing Psycho-social challenges of women with Vesico- Vaginal Fistula (VVF)ò in your institution. This research is a prerequisite for the award of Masters of Science in Maternal and Child Health Nursing.

The target population comprises women with vesico- vaginal fistula admitted into the National Obstetric Fistula Centre, Abakaliki, Ebonyi State.

Attached is a copy of my research proposal for your perusal.

Accept the assurances of my highest regard.

Yours faithfully,

**Kanikwu Phoebe Nwamaka**
*(Researcher)*

## APPENDIX VII

### Informed Consent form

**Topic:** **Assessing Psycho-social challenges of women with Vesico-Vagina Fistula at National Obstetric Fistula Centre, Abakaliki, Ebonyi State.**

**Introduction:** My name is Kanikwu Phoebe Nwamaka. I am a Postgraduate student of Department of Nursing Science, Faculty of Health Sciences and Technology, University of Nigeria Enugu Campus.

**Voluntary Nature of Participation**

Participation in this study is entirely voluntary. You have the right to withdraw consent and discontinue participating in the study at any given time without prejudice to present or future treatment at this hospital.

**Confidentiality:**

Please note that any information you give will he kept confidential. You will be given a number and your name will not be written. Your name will never be used in connection with any information you provided.

**Feedback:**

In case of any further clarification, you can also contact me on Phone Number 08068769343 or e-mail nwakanikwu@gmail.com

**Response:**

The study has been well explained to me and I fully understand the content of the study process. I am willing to participate in the study described above.

**……..** **……**
**Respondent's Number and Signature** **Date**

**……** **……**
**Researcher's Name and Signature** **Date**

**……** **……..**
**Witness' Name and Signature** **Date**

## APPENDIX VIII

**Result of Reliability Statistics**

| | | | |
|---|---|---|---|
| Cronbach's Alpha | Part 1 | Value | .235 |
| | | N of Items | 2[a] |
| | Part 2 | Value | .800 |
| | | N of Items | 2[b] |
| | Total N of Items | | 4 |
| Correlation Between Forms | | | .575 |
| Spearman-Brown Coefficient | Equal Length | | .730 |
| | Unequal Length | | .730 |
| Guttman Split-Half Coefficient | | | .714 |
| Inter item correlation | | | .833 |