Clinical Features Of Patients Diagnosed With Vesico Vaginal Fistula (Vvf) In South East Nigeria

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Abstract: This study examined the clinical features of patients diagnosed with Vesicovaginal Fistula (VVF). 125 medical records of patients with VVF were reviewed. The patients were between the ages of 17 to 65 years (M = 34.05; SD = 5.84). The participants were sampled using convenience sampling technique from National Obstetric Fistula Centre, Abakaliki and Gynaecology department Nnamdi Azikiwe University Teaching Hospital, Nnewi. Ex-post facto design was adopted while descriptive (%) and quantitative (Chi-Square (X^2) statistics was applied in testing the hypotheses. The result revealed that clinical features (rejection = 64.29%; X^2 = 21, and depression = 73.81%; X^2 = 31.85) all at p<.001 level of significance had significant difference on patients diagnosed with VVF. The findings were discussed and recommendations made. Based on the outcomes, it was concluded that clinical features had a remarkable difference on the prevalence and incidence of VVF among diagnosed patients.
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1. Introduction

Confinement is a life-changing event which is a pleasant and joyful experience for many mothers. On the other hand, it is a difficult and regretful period for others particularly, when it is accompanied by serious illness, debilitating injuries and death of the baby, mother or both. About half a million women die yearly from causes related to pregnancy and delivery and for each maternal death approximately 10–15 other women sustain serious morbidity including vesicovaginal fistula (VVF) (Ashford, 2002; Lewis & de Bernis, 2006; Aboyeji, Ijaiya & Fawole, 2007; Orji, Adeloju & Orji, 2007; Rizvi, 1999). Thus, vesicovaginal fistula (VVF) can be described as aftermath of a 'near miss maternal death'. However, VVF appears to have been in existence since antiquity evident by references made to genital fistula in Ebers papyrus and in an Egyptian mummy in 2000BC and 2050BC respectively (Rizvi, 1999). Fistulas destroy the lives of many young women in the developing world. While obstetric vesicovaginal fistulas have vanished from the industrialized world, despite the efforts of many charitable organizations, they continue to occur in epidemic numbers in developing countries. The national and local governments of these countries do not have either the resources or the political will to address this problem and help these outcast women. The number of vesicovaginal fistulas in a region reflects the quality and the level of prenatal care delivered by the local health systems. In regions where health care (particularly maternal health care) is poor or absent, the number of obstetric fistulas is likely to be high. Vesicovaginal fistula is a preventable disease but is prevalent among the less privileged and marginalized members of the population; the poor, young, illiterate girls and women in the remote rural areas of the world, where access to emergency obstetric care, family planning services and skilled birth attendance are unavailable and where available poorly utilized (Lewis & de Bernis, 2006). From the foregoing, it is worthy to understand that, a fistula is an abnormal communication between the vagina and the bladder (or rectum) of a woman that results in a constant leakage of urine and/or faeces. The term "vesico" according to the medical profession is called urinary bladder. Vesicovaginal fistula is thus the abnormal connection between the urinary tract and the vagina such that there is an uncontrollable leakage of urine into the vaginal tract. According to Valerie and Riley (2004), "VVF is an abnormal communication between the urinary bladder and the vagina that results in the continuous involuntary discharge of urine into the vaginal vault". The incidence of fistula varies from country to country and continent to continent as do the main causative factors. There are large differences in the incidence of VVF among populations. Globally, over two million women are estimated to be living with vesicovaginal fistula and majority is in Sub-Saharan Africa and South Asia (Kelly & Kwast, 1993). The reported incidence rates of vesicovaginal fistula in West Africa range between 1– 4 per 1,000 deliveries (Ijaiya, 2004; Margolis & Marcer, 1994; Ijaiya, 2002). An annual obstetric fistula incidence is estimated at 2.11 per 1000 births

(Tsui, Creanga, & Ahmed, 2007); from 100,000–1,000,000 Nigerians live with obstetric fistula (Wall, 1998). Over 70,000 Bangladeshi women live with obstetric fistula (UNFPA, 2004; Technical Report, 2001) and about 9,000 new cases occur each year in Ethiopia (Technical Report, 2001). It is however not impossible that some of these incidences/ prevalence are under reported. World Health Organization (WHO, 2006) estimates that in developing countries each year five million women suffer severe maternal morbidity, obstetric fistula being on the top of the list. It is also estimated that currently more than 2 million women are waiting for surgery worldwide and about 50 to 100,000 new cases are added each year mostly in Africa and Asia (Nawaz, Khan, Tareen, & Khan, 2010). In developed countries on the contrary, fistulae are related to Gynaecologic surgery or radiation therapy (Wall et al. 2004). The clinical and psychosocial consequences of this morbidity are also very detrimental to women. The women are often rejected by their husbands, family and community, while suffering the loss of their stillborn baby. Although husbands and family members may initially be supportive and compassionate to these women, when it becomes clear that the constant loss of urine or faeces is a chronic condition (viewed as incurable in the context of the traditional local culture) these women are usually divorced or abandoned by their husbands and are often cast out by their families These attitudes might lead to depression, low self esteem, and other psychopathological issues as the case maybe. There is a great need on highlighting the importance of investigating and attending to psychological health issues among women who have sustained an obstetric fistula/VVF. VVF is considered a major public health problem in Nigeria, with the prevalence rate on the increase because of rising poverty and declining quality of maternal care. However, since the national safe motherhood conference in Nigeria in 1990, the problem of maternal mortality has been placed on the national agenda, but very little has been done to address the problem of VVF. Victims of obstetrics VVF are usually the lucky survivors of traumatic prolonged childbirth, but oftentimes without the joy of a baby as the baby invariably dies during childbirth. They become social outcasts. Divorced and rejected by families, they travel long distances in search of treatment, which often eludes them. They often have to take to begging or prostitution for survival. Although the treatment of women with obstetric fistulas is a worthy endeavour, the ultimate goal should be to eliminate fistulas entirely by providing adequate maternal health services and prenatal care. As some Africans say: 'Treating obstetric fistulas is like taking a serpent by the tail—you can only control the snake by taking it by the head." The ultimate goal must be fistula prevention. Therefore, this study was designed to investigate the psychosocial features of patients diagnosed with VVF.

Purpose of the Study

The aim of this study is to determine the Clinical features' of patients diagnosed with VVF.

- Will there be significant difference in clinical features of patients diagnosed with VVF?

Clinical Features and VVF

Recent publications (Wall,& colleagues, 2004; Browning, Fentahun, & Goh, 2007; Goh, Sloane, Krause, Browning, & Akhter, 2005; Murphy, 1981) and a review by Ahmed and Holtz (2007) have documented the physical, social, economic, emotional and psychological consequences of fistulas in affected women. A meta-analysis of the literature published between 1985 and 2005 showed that 36% (95% CI: 27%-46%) of women afflicted with fistulas were divorced or separated and foetal loss occurred in 85% of cases in which a fistula developed. Low self-esteem, feelings of rejection, depression, stress, anxiety, loss of libido and loss of sexual pleasure were commonly reported by these women.

It also appears that the rates of separation or divorce increases the longer a woman lives with a fistula, particularly if she remains childless (Browning, & Menber, 2008). Not surprisingly, successful fistula repair reduces the prevalence of these psychosocial pathologies (Ahmed & Holtz, 2007).Three recent articles further document the presence of these problems in women with fistulas. In their 2007 article on the health and social problems of women with fistulas in Ethiopia, Muleta, Fantahun, Tafesse, Hamlin and Kennedy (2007) reported 69.2% of fistula victims were divorced, only 19.2% were members of a local community association, and 44.2% ate separately from other family members. Forty-eight of 52 women felt listless and 28 had suicidal thoughts. Goh & colleagues (2005) conducted a prospective observational study to screen women in Bangladesh and Ethiopia with fistulas for mental health dysfunction. Of the 68 women with fistulas screened, 66 were at risk for mental dysfunction as measured by the General Health Questionnaire (GHQ-28) compared with only 9 of 28 controls. In a prospective interventional study, 51 women with fistulas in the north of Ethiopia were screened for mental health issues before and 2 weeks after surgery using the GHQ-28. Prior to surgery, all women had signs of mental dysfunction, but two weeks after fistula surgery, only 36% still had signs of mental distress. Among the 45 women who were cured of their incontinence, only 27% had signs of mental dysfunction two weeks after surgery, whereas

all of the six patients who remained incontinent continued to screen positive for mental distress on the GHQ-28 (Browning & colleagues, 2007).

In a study by Alio, Merrell, Roxburgh, Clayton, Marty, Bomboka, Traore and Salihu (2007) in Niger, women reported many psychological consequences of VVF including depression, feelings of shame, and loneliness. Others reported feeling devalued as a woman and wanting to end their lives. Social consequences of fistula reported by these women included rejection from society, isolation, rejection from husband and/or divorce. Almost half of the women reported of having lost their social network and support as a result of the fistula. Women with VVF were deemed unworthy, and their illness was often attributed to some fault of their own.

The theoretical explanation hinges on the classification system, causes/development of VVF (physical and sociocultural factors) were highlighted. This study tapped from the wealth of literature on this reviewed literature in establishing basis for the current study. Again, from the empirical studies reviewed, they showed that many studies have been carried out in the sub Saharan African countries and Nigeria in particular. However, the paucity of research in the area of the clinical aspect of patients diagnosed with VVF triggered of the passion for this study and aimed at closing the gap created by the dearth of research.

Hypotheses

The following hypotheses were tested:

- There will be no significant difference in clinical features of patients diagnosed with VVF.

2. Material and Methods

Participants:

A total of 125 medical records of patients with VVF were reviewed. The patients are between the ages of 17 to 65 years with a mean age of 34.05 and standard deviation of 5.84. The participants were sampled using convenience sampling technique from National Obstetric Fistula Centre, Abakiliki and Gynaecology department Nnamdi Azikiwe University Teaching Hospital, Nnewi, South East Nigeria.

Instrument

This study adopted qualitative method in data collection. The qualitative data were gathered from the secondary sources (medical records) of VVF patients.

Ethical Standards

The researchers obtained oral permission/approval as waivers to written permission from the two institutions to access the medical file of their patients in the study. The management consented orally to permit the study since it is purely for academic purpose and teaching and there were no form of external funding from any agency to the study. The oral permissions for this study were given as a waiver to written permission by the medical directors of these centres who directed the records/data departments of these centres to allow us have access to the medical records of their patients. It is important to note here that VVF is a condition that happens to the uneducated poor people who dwell in the rural areas. As a special research centre for the treatment of VVF, the management informed us that all the patients do sign at their admission to permit the hospital management to keep their data and use it for research purpose only.

Procedure:

A total of 125 medical records of VVF patients were reviewed and 100 copies of the questionnaire were administered within 7 weeks. This recorded review and administration of questionnaire was carried out in National Obstetric Fistula Centre, Abakaliki and Gynaecology Department Nnamdi Azikiwe University Teaching Hospital, Nnewi. The medical records reviewed covered from 2008 to 2012.

Design/Statistics:

The design adopted for this study was Ex-post facto design. This entails gathering of detailed information about one individual or group and might include a detailed account of experiences relevant to the issue, which makes the person of a particular research interest (Coolican, 2009). However, descriptive statistics and inferential statistic, percentage (%) and Chi – Square (X^2) were applied respectively in testing the hypotheses. This position was upheld by Patton (2002) who states: qualitative analysis transforms data into findings.

3. Results

Summary tables of percentage and Chi – Square on clinical features' of patients diagnosed with VVF.

Table I: VVF patients' perception of societal reaction towards patients diagnosed with VVF.

Hypothesis I:

Societal reaction	Frequency	%	X^2	P
Sympathetic	12	28.57		
Rejected	27	64.29	21	<.001
Indifferent	3	7.14		
Total	42	100		

From table I above, it was observed that rejection received the highest frequency accounting for 64.29% of the patients' responses on perceived

societal reaction toward patients diagnosed with VVF. Furthermore, X^2 – calculated value of 21 at p<.001 level of significance was found to be greater than X^2 – critical value of 10.83, indicating that rejection as a clinical feature's had a significant difference on patients' diagnosed with VVF. This means that VVF patients perceived themselves as been rejected by the society.

Table II: patients diagnosed with VVF reaction to their conditions.
Hypothesis II:

VVF patients' reaction	**Frequency**	**%**	**X^2**	**P**
Fate	8	19.05		
Depressed	31	73.81	31.85	<.001
Indifferent	3	7.14		
Total	42	100		

From table II above, depression received the highest frequency accounting for 73.81% of the VVF patients' reaction towards their condition. Also, X^2 – calculated value of 31.85 at p<.001 was found to be greater than X^2 – critical value of 10.83, indicating that depression as a clinical feature had a significance on patients diagnosed with VVF. This means that patients diagnosed with VVF have depression as a serious clinical problem.

4. Discussion

The hypothesis which stated that "There will be a significant difference in clinical features of patients diagnosed with VVF" was confirmed, on the basis that the clinical features had significant difference on patients diagnosed with VVF. Patients in this study reported high rate of rejection and depression as a result of their medical condition. These outcomes are consistent with previous studies by Kabir & colleagues (2003) in Kano, who reported that one third of VVF patients had psychological depression and over half suffered from societal negative reaction. In a study by Alio & colleagues (2007) in Niger, women reported many psychological consequences of VVF including depression, feelings of shame, and loneliness. Others reported feeling devalued as a woman and wanting to end their lives. Social consequences of fistula reported by these women included rejection from society, isolation, rejection from husband and/or divorce. Almost half of the women reported of having lost their social network and support as a result of the fistula. Women with VVF were deemed unworthy, and their illness was often attributed to some fault of their own. However, the outcomes of this study were not surprising as the plight of these unfortunate victims can be so devastating and dehumanizing that even when cured after surgery some of them never regain their self esteem and as such shun social life. The high level of perceived rejection observed in this study could be as a result of separation, divorce or low self-esteem common among these patients. Economically they cannot work because they cannot stay in the public and will not be employed. The patient thus becomes an economic burden to others. These social problems were also observed by Murphy (1981) among VVF patients in Zaria.

Implications of the Study

Government at all level should launch a campaign against teenage marriage, create special counseling and enlightenment programme for the people on the benefits of prenatal health care and VVF, developing and building functional health care centers in the rural areas to reduce traditional form of midwifery. The study has also shown that VVF patients suffer physically, emotionally and socially. They suffer from unnecessary and avoidable clinical complications such as loss of self esteem,divorce/separation and depression. Most patients cannot work or attend social gathering because of smell of urine. A campaign similar to that of anti HIV/AIDS campaign should be instituted by government and non governmental agencies to help in curbing the menace of stigmatization on VVF victims. Families should rarely round VVF patients to give them moral support and encouragement to live with their medical condition happily. Fistula centers should be built and manage by the federal government as this will give hope to the patients and their relations and help eradicate the hopelessness being faced by patients and care givers. Also, adequate advertisement should be carried out on the successfully repaired cases of fistula as this will increase the awareness and hope of concerned persons. Fistula centers should be adequately funded and equipped with both human and material resources, roads leading to all health care facilities should be properly done especially those in the rural areas to allow ease access to these facilities. As this will go a long way in reducing the incidence and increase the repair of existing VVF among patients.

Recommendations:

Based on the outcomes of this study, the researcher recommended that;

Government should pass a bill against teenage marriage. The campaign for the girl child education should be doubled and monitored to achieve effective compliance. Any divorce that has to do with VVF should be handled by the court of law and a bill should be passed to protect VVF victims from the agony of divorce coupled with their condition. While surgical repair helps victims to get on with a normal

life, it is not enough to deal with the effect the scourge has had on their psychological well-being. Therefore, patients diagnosed with VVF should be assigned a psychologist/social worker who will work on their psychological aspect of the problem. Victims of VVF need people to give them the confidence to relate their experience. With this opportunity, bottled up emotions are let out and victims would be able to gradually gain a good confidence level. Also, they should build network of people with the same problem as victims often tend to relate with one another, this form of association helps them to discuss their problems freely, thus they are able to alleviate the stigma associated with their condition. This type of network can be strengthened and empowered by the local authority to mount campaign against the incidence of VVF. Awareness campaign should be carried out to curb stigmatization among patients diagnosed with VVF. Local communities should be enlightened on the problems faced by VVF victims. Afflicted women are only victims of their socio-cultural circumstances; therefore the society should be enlightened to accept them. Hospital should be built specifically for fistula cases in all the 36 states of the federation and located in the prone areas for this disease as this will increase the hope of victims and their relations thereby reducing rejection and depression.

Limitations of the study

Research of this nature comes with a lot of limitations and challenges;

First, the data that produced the outcome of this study are generated from the medical files of the patients which limited the direct interaction with the victims. Therefore, generalization of the result should be done with caution as the result were presented qualitatively and sampled from available sample. Second, locating the VVF victims for direct interaction was an uphill task and the nature of their condition made them to decline participating in the study. Finally, time constraint, distance location of the fistula centers, bureaucratic bottle neck in assessing these patients medical records.

Suggestion for further Studies

Based on the outcome of this study, a community based study should be carried out to determine the true incidence and prevalence of the condition in the community and need for a prospective study with multivariate analysis to ascertain the level of involvement of the possible contributory factors. This will guide in making informed recommendations towards prevention and eradication of the condition. In other to cross validate the outcome of this study, future researchers should sample from other fistula centers so as to increase the sample size. They should also consider a retrospective study of VVF patients in this part of the country. Finally, a complete psychological investigation should be carried out this will help in developing counseling and psychological intervention for the identified psychosocial features.

Conclusion

From the outcomes of this study clinical features showed a remarkable percentage difference in patients diagnosed with VVF. This significance difference showed that the incidences and prevalence of VVF as a disease are anchored on these variables. The findings here largely agree with findings of earlier studies. The lack of skilled supervision and adequate obstetric emergency facilities are to blame. The medical and social consequences of the disease amount to agony and unqualified tragedy of its unfortunate victims while the disease is largely preventable (Kabir & Colleagues, 2003). The clinical conditions reported showed to be greatly significant in destroying their emotional well-being. It should be noted that the pains and suffering endured by VVF victims is the result of the social isolation and abandonment and subsequent loss of self-esteem coupled with economic deprivation that results from this social isolation (Wall & colleagues, 2004). The outcome of this study should be seen as a complement to other studies by other researchers with reference to the circumstances surrounding the incidence and prevalence of VVF and its impact on the psychological well-being of Nigerian women. It is a complement in the sense that it serves as direct report that gives the victims voices of their own, since the researchers adopted a qualitative analysis unlike the conventional quantitative reports. To this end, the researchers concluded that clinical features had influence on the incidence and prevalence of VVF in Nigeria with regard to diagnosed patients of VVF. Therefore, it is imperative that constituted authority should hearken to this study's recommendations and chart a course towards eradicating the scourge as obtained in the developed countries.

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