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REHABILITATION AND RE-INTEGRATION OF WOMEN WITH POST OBSTETRIC FISTULA REPAIRS IN NIGERIA

Abimbola Afolabi
Department of Social Work, Faculty of Education
University of Ibadan, Nigeria.
Telephone Number: 08035627992
Email address: drafolabiabimbola@gmail.com
afolabi.abimbola@dlc.ui.edu.ng

Abstract

Global concern exits for a holistic attention on women with Vesico-Vaginal Fistula (VVF) in the area of rehabilitation and re-integration. This paper focused on the rehabilitation and re-integration of women with post-obstetric fistula in Nigeria. The economic and psychosocial effects of this medical condition cannot be over-emphasized. Amongst the factors accountable for its high incidence in Nigeria is traditional/cultural practices of early marriage/childbearing while the consequences include divorce, social isolation, worsening poverty, malnutrition, sexual dysfunction, mental illness (including anxiety/depression), insomnia, general ill health, and thoughts of worthlessness and suicide. To put an end to this avoidable public health pandemic; there is need for holistic consolidation of structures and safety nets for post-obstetric patients. Government should intensify policies enacted to safe-guard the girl child and woman from traditionally harmful activities. There should be engagement of social worker in the rehabilitation and re-integration of women with post-obstetric fistula.

Keywords: Obstetrics care, rehabilitation, re-integration, Vesico-Vaginal Fistula, Nigeria

INTRODUCTION

Obstetric fistula affects up to 3.5 million women in Africa and Asia, with up to 130,000 new cases occurring each year. The backlog of unrepaired cases is believed to approach 1 million in such areas as northern Nigeria alone (Buckley & Roberts, 2013). In high-income countries, obstetric fistula sometimes occurs due to obstetric trauma or surgery rather than prolonged obstructed labor, and they can be repaired surgically with excellent treatment outcome. However, obstetric

fistula disables millions of women and girls in the world's poorest nations, primarily in sub-Saharan Africa and South Asia (Miller, Lester, Webster, et al., 2005). Although fistulas after prolonged labor are rare in developed countries, they are still a relatively frequent occurrence in undeveloped countries.

Nigeria is perceived to bear the world's heaviest burden of obstetric fistulas, followed by Ethiopia, Uganda and Sudan (Akinlusi, 2021). In Nigeria, 12,000 fresh cases occur annually while 150,000 in the pool await repair (Federal Ministry of Health, Nigeria; 2019). Only 43% of births are attended to by skilled medical personnel (Nigeria Fistula Foundation; 2021). Nigeria accounts for about 40% of the annual global burden of VVF (United Nations Population Fund - UNFPA, 2008. These figures may be low because accurate prevalence rates of obstetric fistula are not easy to come by due to inaccurate reporting, under reporting and shame, which keep women from complaining about fistula (Miller *et al.*, 2005). The majority of women who develop a vaginal fistula do so after obstructed labor that is not relieved by a Cesarean section, but there is also growing concern that operative injuries from poorly performed Cesarean sections account for a growing proportion of fistulae (Onsrud, Sjoveian, Mukwege, 2011; Raassen, Ngongo, Mahendeka, 2014).

Urinary fistulas especially obstetric are associated with misery and isolation, expensive and difficult to treat. Healthcare financing is low in many developing countries data base (World Health Organization Global Health Expenditure, 2020) and may not be able to accommodate the management of genitourinary fistulas. There is the need for proper rehabilitation and re-integration of women with post-obstetrics/vesico-vaginal fistula to enhance their quality of lives and to ensure that the negative effects of the condition on them are reduced.

Literature Review

Obstetric fistula is an abnormal hole connecting the vagina to the bladder (VVF), the rectum (RVF), the ureter (UVF) or a combination of these which leads to uncontrollable leakage of urine or feces or both through the vagina, and resulted usually as a complication of difficult labor. (Anyaeze, 2021). The development of obstetric fistula is directly linked to one of the major causes of maternal mortality: obstructed labour. Women who experience obstetric fistula suffer constant incontinence, shame, social segregation and health problems. It is estimated that more than 2 million young women live with untreated obstetric fistula in Asia and sub-Saharan Africa.

Most common cases of VVF occur as a result of prolonged obstructed labor resulting from cephalopelvic disproportion, with resulting pressure necrosis to the anterior vaginal wall, bladder, bladder neck, and proximal urethra from the baby (Arrowsmith et al., 1996). Apart from prolonged obstructed labour, other causes of fistula according to Chineme (2021) include; prolonged and obstructed labour, obstructed labor, injury to the bladder during cesarean section, uterine

rupture into the bladder, perineal tear during childbirth and forceps lacerations. In well-resourced countries, more than 83.2% of fistulae occurred following surgery, whereas in low-resourced countries, more than 95% are associated with childbirth. Obstetric fistulae can occur at any age or parity but are most common in first births, particularly in young girls with a poorly developed pelvis. They can also be due to trauma at the time of pelvic surgery or as a result of rape, and in parts of Africa, some 15% of cases are caused by harmful Female Genital Mutilation - FGM/Female Genital Cutting - FGC before or during labor by unskilled birth attendants. (Mark & Landon, 2021)

Characteristics of Women with VVF in Nigeria

An estimate of 50,000 to 100,000 women according to World Health Organisation (2005) is found to be developing obstetric fistulae each year. In developing countries, in particular, more than two million women living with obstetrical fistulae are under the age of 30 years. The youngest patients are 12-13 years in under-develop countries. However, 50% to 80% women are younger than 20 years in developing countries. Approximately 2 million women were estimated to be living with unrepaired VVF and about half of the total from developing countries was from Nigeria (USAID, 2015). As observed by Cowgill, Bishop, Norgaard, Rubens, and Gravett (2015) in their compilation of Obstetric fistula incidence/prevalence estimates by countries; based on Nigeria's 1999 Demographic and Health Survey (DHS), projected incidence was at 2.11 per 1000 deliveries in women 12-49 years,4.09 per 1000 deliveries in women less than 20 years. Rates of obstetric fistula in Nigeria, have been observed to be on the increase which accounts for half of the global incidence (USAID, 2016).

Several factors have been responsible for VVF in developing countries including Nigeria. According to Wall (1998), these factors include illiteracy, early marriage, poverty, unsupervised or poorly supervised home deliveries and poor health seeking behaviour etc. Ijaiya, Rahman, Rehan, Aboyeji et al., (2010) asserted that many Nigerian women are living with VVF with the annual incidence estimated at 2.11 per 1000 births. They further argued that the occurrence of VVF is more prevalent in northern Nigeria than southern Nigeria. They submitted that the predisposing factors for this are early marriage and pregnancy which is common in the north. Child marriage is more popular in the North West region of Nigeria, with figures as high as 76% (Save the Children, 2016).

A reflective study of 80 cases of VVF managed over a 10-year period in northeastern Nigeria by Kullima, Audu, &Bukar (2009) revealed that 23.8% were teenagers. The study further revealed that majority of the patients did not undergo supervised antenatal care but had home deliveries under the supervision of TBAs. A substantial number of the case (90%) were linked to prolonged obstructed labour and majority of the patients were from very poor households thus limiting their access to care.

Psychosocial Effects of VVF

Research (e.g. Pope, Bangser, Harris Requejo, 2011) has shown that the majority of women who suffered obstetric fistula all exhibit similar issues and challenges. The condition comes with a lot of discrimination and stigmatization. The malodorous nature of VVF exposes its victims to mistreatment and stigmatization leading them to be ostracized by their husbands, families, and community (Pope, Bangser, Harris Requejo, 2011). Scholars have reported about family members not wanting women with VVF to share food at family events (Khisa et al., 2012). In addition, there are reports that that vaginal injuries sometimes result in a woman's inability to perform some house chores and marital obligation to her husband (Ahmed & Holtz, 2007). In societies like Nigeria where a woman's worth is dependent on fulfilling her marital (sexual) duties, this situation is devastating. The lives of women with fistula are generally uneasy (Okoye, et al., 2014). This condition is entrenched in poverty, predominantly affecting marginalized women who lack access to quality emergency obstetrics care, typically of lower socio-economic status, perform harmful traditional practices, with no or lower levels of education, dwelling in rural areas with preference for home delivery and avoidance of caesarean section, without prenatal care and married at younger age (Federal Ministry of Nigeria, 2012).

The societal challenges encountered by patients with VVF are intense. Women going through this condition experience uncontrolled series of urine or feaces coming out of their vagina; as reported by Wall (1998). The situation is both physical and social. There is no way around the incessant droplet of urine and smell of stool all day long. This condition makes VVF victims not to be associated with and avoided by their friends and relatives. As a result of stigmatization; they have to settle for unimaginable living conditions including begging to earn a living and in extreme cases indulge in prostitution.

The primary cause of obstetric fistula being obstructed labour has previously rendered the some victims childless. Childlessness in a Nigerian marriage can lead to divorce / separation. Murphy (1981) revealed in his study that 77% of women who have lived with fistula for up to three years are no longer living with their husbands. Ojanuga (1993) gave credence to this finding with report that VVF patients as a result of their predicament are often divorced or separated from their husbands. The psycho-social effect of VVF are made more depressing due to the divorce and abandonment by loved ones, loss of employment and thoughts of suicide by patients because of their inability to manage the agony.

VVF puts its victims in a state of physical, emotional, financial and social depression (Odu, 2000). Not getting any form of assistance from their husbands, the families and society are the most severe implication that VVF victims have to contend with; which causes victims to commit suicide (Odu, 2000). According to Orley (1970), a VVF patient is treated as though she has epilepsy. The rejection, pain, sadness and loss of hope that a VVF patient experience is only compounded by her lack of education, employment, finance, vocational skill and a means of

livelihood. According to a study by Gharoro and Agholor (2009) about VVF patients, it revealed that 50% lost their means of livelihood while 45% had a feeling of banishment; they couldn't attend public engagements. While over 50% were abandoned by their husbands, divorce rate increased by 25%. Those that didn't consider divorce had extra marital affairs. Husbands that stayed married were compelled by threats from in-laws.

Psycho-Social Support for Women with Obstetric Fistula in Nigeria

Access to genital fistula surgery has improved in sub-Saharan Africa and many women experience improvements in physical and mental health following fistula repair alone; however, numerous women face continued physical and psychological challenges to resuming prior roles or adjusting to new circumstances. They may require further medical care depending on injury severity and surgical outcomes, and medical support for subsequent pregnancies and births. Longitudinal studies from sub-Saharan Africa have identified concerning adversity following fistula surgery, including fistula recurrence, persistent fistula-related symptoms, subsequent fertility challenges, and adverse prenatal outcomes (Pope, Bangser & Requejo, 2011; Delamou, Utz, Delvaux, Beavogui, Shahabuddin, 2016; Drew, et al., 2016; Delamou, et al., 2017; Kopp, et al., 2017).

The rehabilitation of women after fistula repair surgery and post-repair interventions to maximize their quality of life will result into a great feeling of relief and happiness following repair (Donnelly, Oliveras, Tilahun, Belachew, & Asnake, 2015). Holistic care for obstetric fistula patients should include mental health treatment as a complement to surgery, so that women receive comprehensive treatment and support for their condition (Watt, et al., 2015). Women who are admitted for repair generally spend several weeks in the hospital, providing a window of opportunity to address the psychological symptoms accumulated from living with this socially marginalizing condition, and to develop coping skills to facilitate reintegration after repair. Although the need to address mental health issues in this population has been recognized (Muleta, 2006; Muleta, Hamlin, Fantahun, Kennedy, Tafesse, 2008; Pope, Bangser, & Requejo, 2011).

The psychological damage of an obstetric fistula may result from the traumatic childbirth and/or the resulting physical condition itself (Goh, Sloane, Krause, Browning, & Akhter, 2005; Semere & Nour, 2008). Fortunately, surgical care is increasingly available for fistula repair. However, there is critical need to also address the psychological morbidity of this patient population. Studies have shown that women with obstetric fistula have high rates of depression (Balogun, 1994; Weston et al, 2014).

Evidence-based psychological treatment, based on cognitive behavioral therapy (CBT) (Beck, 2011) and the theory of stress and coping (Lazarus & Folkman, 1984) has the potential to improve the coping behavior and mental health symptoms of this patient population, and in turn to improve social well-

being and functioning to promote successful reintegration to the community (Watt, et al., 2015). In rigorous trials, CBT demonstrates impacts on mental health, quality of life, and shame, in both Western and non-Western contexts (Butler, Chapman, Forman & Beck, 2006; Neuner, et al., 2008; Swan, Watson & Nathan, 2009; Tshabalala & Visser, 2011; Van't Hof, Cuijpers, Waheed & Stein, 2011).

The theory of stress and coping suggests that improvement in coping skills leads to an increase in positive emotionality, reductions in mental health dysfunction, and improvements in self-care (Penley, Tomaka & Wiebe, 2002). While mental health treatments have been developed for physical disabilities in the United States (Dorstyn, Mathias, & Denson, 2011; Mehta, et al., 2011) and in low-resource countries (Daniel & Manigandan, 2005; Lundgren, Dahl, Melin, & Kies, 2006), an intervention for obstetric fistula patients must be tailored specifically to address physical health concerns, trauma history, stigma, and internalized shame. These dimensions of an intervention must, in turn, reflect the context of gender inequalities in which women develop and live with a fistula (Watt, et al., 2015)

Re-Integration and Rehabilitation Plan for Victims

Considering the relationship between obstetric fistula and maternal morbidity, disability and lifestyle change, the need for reintegration and rehabilitation is essential. Social reintegration and rehabilitation of obstetric fistula patients before and after treatment enhance their overall status. Re-integration and rehabilitation of a survivor of obstetric fistula into the society is very essential to enable societal acceptance so such individual can live a normal life as everybody else (Mselle, et al., 2012). Benefits of such re-integration include socialization; employment and economic stability, satisfaction, independence, self-regulated coping strategy and parenting.

Research (e.g., Ojengbede, 2017) has it that Nigeria has 40% of the world burden of obstetric fistula; this has necessitated action on its eradication and other associated issues (Ojengbede, 2017). To this end, the federal government developed a framework a National Strategic Framework for Elimination of Obstetric Fistula for implementation at all levels. There are 12 dedicated care centers that also incorporate reintegration and rehabilitation as part of their care plan. Yearly, the centers undertake between 200,000 and 400,000 loses but there is still a huge backlog that will require about 100 years to clear; which does not include new cases of about 20,000 yearly. Included in the mantra of the Federal Ministry of Health and stakeholders is reduction of the incidence of Obstetric Fistula by 50% and rehabilitation by same.

Capes (2011) undertook a study in Nigeria on postoperative care which revealed that all fistula centers and some teaching hospitals have counseling centers where patients can be referred after treatment. Coupled with the above; the Foundation for Women's Health Research and Development (FORWARD) and Amref Health Africa (AHA) provide comprehensive care including empowerment

and rehabilitation training including giving handouts (Shittu, Ojengbede, & Walla, 2007; Capes, Ascher-Walsh, Abdoulaye, & Brodman, 2011; Fistula Foundation, 2018). A study by Ojengbede (2017) revealed that 67% of women who have completed repair require family support as cushion to their effective reintegration while another 60% takes work resumption as a priority to feeling normal and accepted.

Social reintegration helps to mend the bridge of acceptance for obstetric fistula patients particularly for those that their environment has been mean to them (Byamugisha, et al., 2015). As reported by Ojengbede (2017), this can be improved through increasing opportunities and promoting social interactions among patients in their communities. The inclusion of obstetric fistula patients and survivors in the holistic intervention programmes (prevention, treatment, rehabilitation and reintegration) has yielded positive effects in some African countries including Nigeria (United Nations Population Fund, 2003; UNFPA, 2004; Donnelly, et al., 2015).

Although efforts are been put into social reintegration and rehabilitation of obstetric fistula after repair; there is still a great need for widespread sensitization through outreach projects and home-based care to increase the level of community consciousness and corrects myths about obstetric fistula which will in turn increase community and family support.

Social Worker and Rehabilitation of Women with VVF

A social worker is an individual who is trained to handle interactions with social beings through counseling in all forms to build a strong internal shield to withstand societal challenges. This fundamental knowledge empowers the social worker to support victims of obstetric fistula before and after their repair towards rehabilitation and re-integration into the society. This make its essential for the engagement of social workers in all fistula centers in the country to mentor patients in their VVF recovery journey.

The social workers can be incorporated to undertake sensitization campaigns with traditional health workers / attendants and community leaders during community meetings to educate and also advocate for fistula survivors towards re-integration without stigmatization. This will go a long way to change cultural beliefs systems about VVF and create a platform for individuals other than social workers to join in the advocacy.

Even though social work in Nigeria is still a young profession, there is a widespread effort from various groups to make solidly establish the profession (Okoye, 2013). Initiatives to make social work more visible is on-going; but requires willingness and open by social workers to share experiences and apply home -based knowledge to address contemporary problems such as VVF. The model of making social work more visible and relevant in Nigeria is to venture into new horizon of social work education as reported by Anucha (2008), will enable family and community involvement in social work as reported by Burke

and Ngonyani (2004) in Tanzania. Conceptualizing this idea, will go a long way to give support to VVF patients in Nigeria

CONCLUSION

Obstetric or VVF is still common in the country especially in the northern part of the country. This can be linked to the high rate of child or early marriage in this region of the country. Obstetric or VVF is preventable public health disease; it can largely be avoided by delaying the age of first pregnancy; the cessation of harmful traditional practices; and timely access to obstetric care. Apart from medical services (surgery/repairs of the damaged organs), psychosocial, rehabilitation and reintegration services for patients with Obstetric or VVF should be adopted. However, there is the need to increase the involvement of social workers in these processes in order to provide a comprehensive and effective psychosocial, emotional and mental health services.

Recommendations

The need for quality maternal health services to complement Emergency Obstetric Care is essential to strengthen health care systems. Intervention options include capacity building for care providers on antenatal, intrapartum, postpartum periods, early identification and treatment of fistula cases, referrals including assessment of all women with fistula-like symptoms. There is critical need for sensitization campaigns and prevention services for rural and underfed women, since they are at greatest risk of fistula.

Harmful cultural and unhealthy practices (e.g. early/child marriage) should be discouraged. This should be emphasized during sensitization and awareness campaign to be anchored by trained social workers for patients with post obstetric fistula. This will better convey the message and will gradually increase the success index of patients both at pre and post obstetric experience. Stakeholders and development partners can undertake advocacy visit to government structures and its agencies towards driving policy action to discourage early and child marriage because of its effects and sanctions should be included for offenders.

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