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Tackling Socio-Economic Factors as A Catalyst to Minimising Obstetric Fistula in Katsina State, Nigeria

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ABSTRACT:

Obstetric fistulae has been a source of concern to the United Nations and its member state because of the large number of women, (about 2 million)afflicted by it, mostly in developing countries, like Nigeria. Available statisticsof obstetric fistula in Nigeria, indicate that northern states such as Katsina state, have the highest number of women afflicted with fistula. The government formulated the 2004 revised national health policy which seeks to reduce fistula occurrence by 50% within a period of ten years. The study therefore seeks to analyse the outcome of the implementation process of the 2004 revised national health from Babbar Ruga obstetric fistula center, to determine if the conventional method of providing well equipped healthcare facilities had actually resulted in reduction of the menace of obstetric fistula in Katsina state and finally to determine if women education could be a panacea to stamping out obstetric fistula. Method: The data for the research was collected via primary sources i.e a field research work carried from one hospital, where mixed research methods was used i.e an open ended questionnaires. A total of 367 questionnaires were administered on obstetric fistula women, and also an in-depth interview was held with two top officials (Medical director and chief nursing sister of the hospital). The research findings indicate that socio-cultural and socio-economic factors and not entirely absence of sufficient health facilities are the biggest factors causing fistula.

Keywords: *2004 Nigeria National Health Policy, Obstetric Fistula, Socio-economic and Socio-Cultural*

INTRODUCTION

Globally, it was estimated that more than 2 million women live with obstetric fistula and about 100,000 new cases occur each year (Royston, 1989). In Nigeria, it was estimated that about 400,000-800,000 women are believed to be living with obstetric fistula, and that about 20,000 new cases are recorded yearly in Nigeria (Nursing World Nigeria, 2013).

In order to address the above reproductive health challenges, the United Nations organized various international conferences where conventions aimed at developing health policies and strategies to improve women's health within its member states over a period of time. Some of these conventions includes but are not limited to the United Nations Millennium Declaration/Development Goals (2000); Paris declaration (2005); the second primary health care revolution (2006); the (2008) Ouagadougou declaration on primary health care PHC and health system in Africa and the convention on the elimination of All Forms of Discrimination Against women (Aneikwu, 2005; WHO, 2008).

The above conventions therefore, served as inspiration to member states of the UN by implementing various health policies to improve the reproductive health of their citizens. Accordingly, over the past three decades, Nigerian government had formulated and implemented a number of health policies with the sole aim of improving its health care system. Some of the health policies it implemented include: Health Policy and Strategy 1988; maternal health child health (1994); National Breast Feeding Policy (1994); National Adolescent Health Policy (1995); national health insurance scheme act (1999); Reproductive Health Policy(2001), Policy on Elimination of Female Genital Mutilation in Nigeria (2002), and the Revised National Health Policy 2004 (Federal Ministry of Health, 2004).The main clause of the 2004 Revised National Health Policy is to invigorate and improve the Nigerian Health System in order to provide effective, efficient, quality, accessible and affordable health services based on the provisions of the millennium development goals (MDGs). The aims of the 2004 Revised Health Policy is therefore among others cut to down by 66% of under 5-mortality rate, maternal mortality rate by 66%, HIV/AIDS by 66% and to stop the incidence of malaria and other major diseases, and obstetric fistula by 50% between 1990 and 2015.

Unfortunately however, the success recorded during the implementation of these policies were limited due to factors such as lack of funding, insufficient health systems/infrastructures, insufficient health personnel and socio-cultural factors etc.(Asuzu 2004, Abdulraheem 2012; Mairiga et al. 2009; FMH, 2004).

The study therefore, seeks to evaluate the effects of socio-economic factors on the implementation process of the health policy at Babbar Ruga national fistula center, Katsina state, and to determine if tackling socio-economic factors could be a catalyst to minimizing the occurrence of fistula rather than the present conventional method of spending enormousre sources establishing obstetric fistula hospitals to treat women afflicted by the fistula, which is akin to medicine after death.

THE ORETICAL FRAMEWORK AND LITERATURE REVIEW

The paper, finds the theory of Hardee, et al. (2004) on policy implementation and evaluation quite relevant because it identified six factors which could affect the outcome of policy implementation. These factors are grouped under six Ps - problem identification, people, process, price, place and paper.

Obstetric fistula (OF) have been viewed in different ways by scholars. The United Nations Population Fund (UNFPA, 2012), defined obstetric fistula as a childbirth injury that is caused as result of a prolonged, obstructed labor, without nippy medical intervention or emergency Caesarean attention and as well sustained pressure of the baby's head on the mother's pelvic bone which in turn damages the soft tissues, hence creating a hole or fistula between the vagina and the bladder and/or some times in the rectum. Waaldjik (1997) on the other hand described obstetric fistulae as an irregular connection linking the urinary bladder and the vagina that results to uncontrollable dripping/leakage of urine and sometimes faeces.

It was estimated that about 2 million women suffer from obstetric fistulae globally and that 1.5 million of these victims live in developing countries (UNFPA, 2003 and Eneil, 2009). Each year there are about 50,000 fresh cases (UNFPA, 2003). 33,000 of these fresh cases occur each year in sub-Saharan Africa (Kelly, 1999). In Nigeria, it is assumed that over

600,000 women died annually due to pregnancy related causes. About 10-20 women suffer everlasting deformity such as obstetric fistulae (The National foundation on Vesico Vaginal Fistulae, 2003). Additionally, about 400,000-800,000 women are believed to be living with OF, and that about 20,000 new cases are recorded yearly in Nigeria (Nursing World Nigeria, 2013). Similarly, another report indicates that about 800,000 women are plagued by the OF scourge, a majority of them are living in rural areas where there is inadequate or complete lack of Primary health care. Furthermore, Nigeria accounts for about 40% of the global burden of obstetric fistula (The Guardian, 2007).

Obstetric fistula is today commonly found in developing countries due to their poor health facilities and existence of socio-cultural beliefs/practices and socio-economic factors (Eneil, 2009). Developed countries of Europe and America, were able to address socio-economic, socio-cultural factors, as well as improvement of their health care system during the 18th and 19th centuries. This resulted in the elimination or significant reduction of fistula in their societies (Wall, 2006). Therefore, it can be argued that fistula and maternal mortality are closely linked to the level of nations development in health care, education, economy etc. This probably explains reasons why fistula is now commonly found in developing nations.

The causes of maternal mortality and mortality have been well documented and the element can be prevented if necessary health measures are taken earlier as well as addressing issues to deal with delays in respect of decision to seek for care, secure transport to health facilities and delays experienced by patients at the hospitals due to insufficient health care facilities. (The National foundation on Vesico Vaginal Fistulae, 2003). Several factors have been identified as causes of fistula. This includes physical and socio-cultural factors that are the major cause of fistula in developing nations; damage to the genital tissue because of prolonged labor of about 3.6 days (Wall, 2004 and Talizib, 1983, Goh, 1998; Lewis, et al. 2009 and Browning, et al. 2010). Other factors that causes fistula include surgery, Malignancy, radiation, trauma, congenital malformation, infection, and cuts in the vagina using a razor blade/a knife/other sharp instruments that are used to facilitate the birth passage especially by traditional birth attendants in rural areas (Waaldjik, 2008 and Ramphaly, 2006).

EFFECTS OF OBSTETRIC FISTULA ON WOMEN

So many studies (Wall 2004; Raassen 2008; and Meyer 2007) have identified many physical, psychological and mental effects of obstetric fistula on its victims. According to them "untreated fistulae leads to devastating social consequences on the afflicted women. These women are often forced to live in appalling conditions. The development of fistula is accompanied with a fatal loss in 85% of 9.2 of all women". Furthermore, women who develop fistulae experience problems like urethral, amenorrhea, infection, shortening of the vagina and neurological injuries like foot drop (Uprety, 2008).Similarly, Meyer (2007) noted that a lot of women are subjected to social stigma such as separation from their family and their husbands, are rejected by the society. Consequently, some are subjected to poverty etc.

The most graphic description of the suffering of obstetric fistula patients was from Dr. Reginald and Catherine Hamlin founding fathers of the second largest fistulae hospital located in Addis Ababa. They said it is a profound experience to meet one of the mothers who are grieving the death of their baby, these women lives with continuous dribbling of urine that cause them to be ashamed. They are rejected by their husband and their friends thus

making them homeless, they are unemployable and have lost all hope in life and continue to suffer their sorrows in silence. Their miseries remain untreated as no world charities have ever had on them (The National foundation on Vesico Vaginal Fistulae, 2003). Similarly, obstetric fistula has also been described as "one of the most dreadful miseries that affects human kind. The victims of this misfortune continuously leaks urine which wets their clothes and hurts their feelings thus making them an outcast in the society because all kinds of social interactions is severed with them by their husbands, families and society at large (The National foundation, 2003).

Wall, (2004); and Tahzib, (1983) gave a graphic description of VVF victims as deprived, adolescent, uneducated women with short stature living in rural areas. Obstetric fistula (OF) is among top gynecological problems that have been affecting women globally since the ancient times. VVF was prevalent in developed nations during the last three centuries. But, because of the rapid socio-economic development achieved in Europe and America which resulted in improved medical facilities, fistula scourge became a thing of the past. However, in developing nations, like Mali, Niger, Nigeria, Rwanda, Sierra-Leone, South Africa, Benin, Afghanistan, Bangladesh, India, Pakistan and Nepal fistula is very much prevalent, this could be as a result of poor health facilities, poor socio economic development base, and socio-cultural beliefs (Forward Nigeria, 2002).

METHODOLOGY

Mixed research methods was used during the data collection - a total of 367 questionnaires were administered on pregnant women and also an in-depth interview was held with two top officials (1 Medical director with 1 chief nursing sister of the hospital). The questionnaire for the beneficiary women was administered by the researchers in Hausa Language (as most of them were not literate), while the in-depth interview with the officials of the hospitals was conducted in English Language. The questionnaires were analyzed and the results presented in a tabular form and narrations, with the women responses coming first, followed by the interview conducted with the officials of the obstetric fistula center, Babbar Ruga Katsina, Katsina state, Nigeria.

DATA ANALYSIS AND RESULTS

Quantitative: Responses of Women with fistula

Questionnaires were administered on 367 pregnant women from Babbar Ruga Obstetric fistula center and below are the responses received, presented in a tabular form.

Table 1 ***Respondent's Age***

Age	Frequency	Percentage
15 – 25	127	34.6
26 – 35	125	34.0
36 – 45	96	26.2
46 – 55	19	5.2
Total (N)	**367**	**100.0**

From table above, it can be seen that 127 of the respondents representing 34.6% were within the ages of 15-25 years, while 125 of the respondents or 34.0% were between the ages 26-35 years. Similarly, 96 of the respondents or 26.2% were between the ages of 36-45 years. However, 19 of the respondents or 5.2% were between the ages of 46-55 years.

Table 2 ***Respondents Place of Residence***

Category	Frequency	Percentage (%)
Urban	99	27.0
Rural	268	73.0
Total (N)	**367**	**100.0**

The above table shows, that majority of the respondents i.e. 268 or 73% live in rural areas, while 99 or 27% live in urban areas. This shows that awareness about safe motherhood as well as the benefits of attending ANC and delivery children in a government health facilities is low as most of them rely on traditional birth attendants during ANC and child delivery.

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Table 3 ***Respondent's Educational Status***

Category	Frequency	Percentage
No formal education	140	38.1
Secondary	86	23.4
Primary	45	12.3
Qur'anic	96	26.2
Total (N)	**367**	**100.0**

From the table above, it can be seen that majority of the respondents i.e. 140 or 38.1% have no formal education,while 86 or 23.4% had acquired secondary school education, similarly 45 or 12.3% of the respondents had acquired primary education. Finally 96 or 26.2% had gone through Qur'anic education.

Table 4 ***Respondent's Occupation Status***

Category	Frequency	Percentage
Housewives	161	43.9
Traders	120	32.7
civil servants	75	20.4
Farmers	11	3.0
Total (N)	**367**	**100.0**

The table above indicates that, majority of the respondents i.e. 161 or 43.9% were housewives, while 120 or 32.7% of the respondents were traders. Similarly, 75 or 20.4% of the respondents were civil servants and 11 or 3.0% of the respondents were farmers.

Table 5 ***Impact of Socio Cultural Factors***.

Category	Frequency	Percentage
Strongly Disagreed	5	1.4
Undecided	13	3.5
Disagree	41	11.2
Agree	134	36.5
Strongly Agree	174	47.4
Total (N)	**367**	**100.0**

Table above, indicates that majority of the respondents (i.e. 174 or 47.4% and 134 or 36.5%) strongly agreed and agreed respectively that socio-cultural factors affects utilization of health care facilities by pregnant women especially those living in rural areas, thus leading to complications, while 41 or 11.2% of the respondents had disagreed.

Table 6 ***Effect of Lack Education and Awareness on Health Care Access***

Category	Frequency	Percentage
Strongly Disagreed	8	2.2
Undecided	12	3.2
Disagree	49	13.4
Agree	106	28.9
Strongly Agree	192	52.3
Total (N)	**367**	**100.0**

Table above, indicates that majority of the respondents (i.e. 192 or 52.3% and 106 or 28.9%) strongly agreed and agreed respectively that lack of education and awareness affects access to health facilities by pregnant women, while 49 or 13.4% of the respondents disagreed, and 12 or 3.2% were undecided and 8 or 2.2% of the respondents strongly disagreed.

Table 7 ***Effects of Lack of Income on Health Care Access***

Category	Frequency	Percentage
Strongly Disagreed	3	0.8
Undecided	6	1.6
Disagree	36	9.8
Agree	114	31.1
Strongly Agree	208	56.7
Total (N)	**367**	**100.0**

Table above, indicates that majority of the respondents (i.e. 208 or 56.7% and 114 or 31.1%) strongly agreed and agreed respectively that lack of income affects access to health care facilities by pregnant women, while 36 or 9.8% of the respondents disagreed and 6 or 1.6% were undecided and 3 or 0.8% of the respondents strongly disagreed.

Table8 ***Effects of Women Empowerment on Health Care Access***

Category	Frequency	Percentage
Strongly Agreed	3	0.8
Undecided	2	0.5
Disagree	35	9.5
Agree	92	25.1
Strongly Agree	235	64.0
Total (N)	**367**	**100.0**

Table above, indicates that majority of the respondents (i.e. 235 or 64.0% and 92 or 25.1%) strongly agreed and agreed respectively that women empowerment encourages women to take care of health needs without depending on husbands.

Indeth Interview With Officials of Babbar Ruga National Fistula Center

On government Support provided during the Implementation on the Policy

"Both Federal and Katsina State governments are serious about tackling fistula. This hospital has been taken over by the Federal Governments and hopefully things are going to improve here very soon". (MD_1)

He added that:

"Before the recent takeover of the hospital, Katsina State Government maintains the hospital – pay salaries, utility bills etc. Non-Governmental Organizations and locally individuals also assist the hospital in areas such as construction of operating theatres, equipment, hostels etc. I don't have exact figures. These initiatives have been helpful in sustaining the hospital". (MD_1)

"The State Government has tried. This hospital was managed by it since 1935 when it was established. It has also established a rehabilitation centre fully to rehabilitate our patients so that they can start business and integrate back to the society. "It also trained Traditional Birth Attendants (TBAs), Health Extension Workers (CHEWs), and voluntary community mobilizers all to promote reproductive health".(CNS_1)

She expressed that:

"...I have no idea how much is given to the hospital. But government pays our salaries, it trains us, provide most of the facilities here". (CNS_1)

Effects of Physical Infrastructure, Equipment and Consumables

"As far as obstetric fistula is concerned, this is the only hospital in the state. So every fistula case in the state has to come here". (MD_1)

"I really do not know the number of hospital built by the government. I know each of the 34 Local Governments have a hospital. These hospitals are also reasonably equipped. (CNS_1)

Effects of Health Personnel in the Fistula center

"Recently about 140 health staff had been recruited by the Federal Government comprising of 4 doctors, 20 nurses, and other Para-medical staff including administrative staffs". (MD1)

'The staff strength has increased and it is expected that the work stress would reduce" (CNS_1)

Effects of the Policy implementation on fistula prevalence

"From 2009 – 2014, a total number of 4,153 have been admitted into the hospital with various degree of fistula damage. I think the situation has not improved. Hopefully the recent takeover of the hospital by Federal Government would results in improvements". (MD_1)
"…You can see number of victims in the hospital is still quite large". So it can be concluded that MMR is dropping in the state, while fistula levels remains the same. (CNS_1)

Effects of on socio-cultural factors:

"Fistula is still prevalent particularly in rural areas. It is doubtful if this policy can eradicate it, since the rural areas lack sufficient and equipped health care system. May be another policy that would give sensitization against socio-cultural factors would be better as the government always say there is insufficient funds to make our rural hospitals better. Socio-cultural beliefs still affect access to healthcare among rural and uneducated women. Over 95% of fistula patients are from rural areas, where they need permission of their husbands before going to hospital. So it would appreciate that this causes the high cases of fistula among rural women". (MD_1)

"Majority of the patients you see here are from rural areas, which did not go hospital for ANC, but instead delivered at home, therefore resulting into unavoidable complications. Government should pay more attention to tackling socio-cultural beliefs and practices that discourages or causes delay in getting access to hospital". (CNS_1)

Effects of Socio-Economic Factors on the Policy Implementation

"Poverty is very prevalent in the state. In fact they affect access to healthcare by people generally but in particular pregnant women".(MD_1)

He added that:

"At this hospital, we are seeing the effects of socio-economic factors. Most if not all, the patients here are poor, illiterate, unemployed and from rural areas. They rely on the husbands for money. Most of them live on government and NGOs charity because they have been abandoned". (MD_1)

She added that:
"The government has realized the effects of poverty on access to hospital, introduced free medical care to pregnant women from ANC to delivery stages". (CNS_1)

She added by expressing her feelings on socio-cultural factors as:

"Socio-cultural factors still play an important role in discouraging pregnant women to access hospital. That is why fistula is still very much prevalent, and would continue unless poverty and illiteracy is cut down by government and NGOs through serious empowerment programmes. It can be concluded thatsocio-cultural and economic factors affects access to hospitals in rural areas''. (CNS_1)

Effects of NGOs and Wealthy Individuals support on the policy implementation

"..NGO and wealthy individuals provided half of the physical structures in this hospital. They also constructed boreholes and assist with drugs and counseling of our patients". (MD_1)

"...We shall remain grateful to them. Without them we could perform the way we performing today". (CNS_1)

Effects of the policy implementation on reduction obstetric fistula

"Frankly speaking not much success story has been recorded as still many women are fallen victim of fistula majority from rural areas. This could be as a result of non-availability of health facilities, poorly equipped health centres, effects of socio-cultural and socio-economic factors. It is very much hoped that the recent conversion and takeover from the state government by the Federal Government would lead to improvement. But government need to address socio-cultural and socio-economic factors widely prevalent n the rural areas in order to reduce significantly cases of fistula".(MD_1)

"...With regards to fistula reduction not much has been achieved at least the great number are rural women, they were the majority of the victims before, and they still constitute the majority of the victims today".(CNS_1)

Difficulties Hospitals Experienced that Affected the Implementation of the Policy

"We had bigger problems of underfunding, insufficient staffing, drugs etc. when the hospital was under Katsina State Government. But we hope these problems would be addressed by the new owner of the hospital - the Federal Government". (MD_1)

"Indeed apart from payment of salaries by the government, they rely on donations from NGOs and wealthy individuals" (CNS_1)

DISCUSSIONS OF FINDINGS

From the findings above, it can be stated that the Federal government of Nigeria have demonstrated strong support towards tackling the prevalence of obstetric fistula in Katsina state. For example it converted the Babbar Ruga fistula hospital hitherto under the control of Katsina state, to national fistula center, this initiatives is expected to provide better health facilities in medical personnel to provide effective health care to the unfortunate victims of fistula in the state and other neighbouring states of Katsina state. The study also confirmed the existence of some challenges that affected the overall success of the implementation process of the policy, on reduction of obstetric fistula in the state. Some of these challenges

include insufficient funding, insufficient personnel, insufficient infrastructure and the continues effect of socio-cultural and socio-economic factors. However, NGOs and wealthy individuals had played a significant role in cushioning the effects of these challenges through the provision of some infrastructure such as operating theatres, water projects, equipments, drugs and sensitization programs which targeted mostly women on rural areas where the effects of socio-economic and socio-cultural factors are more pronounced as indicated by the study.

The effects of socio-economic factors, as confirmed by the findings of this study to be some of the major causes of fistula especially amongst women in rural areas, was also reaffirmed by various scholars. According to Samad (1989), reported that all women in his study group were of low socio-economic status and most of them came from rural areas. Similarly, Ahmed (1989), in his findings also stated that 38 out of 68 fistula patients, he studied were from low socio-economic groups. Furthermore, Pendse (1989), also revealed in his study that about 90% of fistula patients were illitrate, of low socio-economic background, While, Ijaiya et al. (2010), in their paper titled vesicovaginal fistula: a review of Nigerian experience, reported that majority of the fistula victims are illiterate, ignorant, in abject poverty and from rural areas.

Similarly, a study conducted by Kabir et al. (2004),Odusoga et al. (2001) and Figo, (2006)reiterated that majority of vesicovaginal fistula patients are non-literate, vulnerablein the society and mostly from a poor homes. In addition, early marriage and lack of education had place women with fistula to a disadvantage positions Gulati, et al. (2011).Ibrahim, et al. (2000) and Wall, et al.(2004), in their previous studies conducted in states of Ilorin, Kano, Sokoto, Jos and Sagamu found that fistula women are mostly non-literate and full time housewives. Similarly, Ijaiya et al. (2010), cited in their studies that previous scholars reported that in states like Ilorin, Kano, Jos and Sagamu, majority of the fistula patients had no formal education and girl were married out at the age of 15 years of age. Nevertheless, all the previous studies mentioned above had coincided with indepth-inteviews of hospital officials and responses of fistula patients of this study, as they all reported poverty is very prevalent with high rate of illiteracy, unemployed as they rely on husbands and relatives for livelihood and are mostly resided in rural areas. The Prevention and Management of Obstetric Fistula (2012) from their study opined that gender discrimination is much in African countries, where socio-economic status of women is rated very low i.e. educational opportunities is restricted and poverty very high.

However, there is need for government to adopt an alternative approach to compliment the present conventional approach of building more hospitals and equipping them, which is akin to medicine after death to the fistula patients. This can be achieved through addressing the effects of soci-economic and socio-cultural factors that are the main causes of fistula in rural areas. This can be achieved through the the enforcement publicity and education to sensitize our women and men folk as well as enactment of regulations to prohibit early marriage and make girl-child education to secondary school level compulsory. Empowerment programs should be persued by the government to ensure that women are gainfully employed, to enable them earn income to address their health needs without much dependence from their husbands.

Furthermore, the right of all citizens, especially women, to control all aspects of their heath, in particular their own fertility, is basic to their empowerment. Therefore, a society where

individuals have knowledge, skills and resources to enjoy their life as citizens, is a great nation need.

RECOMMENDATIONS

The following plans need to be implemented to prevent or reduced to the barest minimum vesico vaginal fistula in Nigeria:

The government is required to eradicate poverty, improve on the socio-economic status of the populace and facilitate economic opportunities for womenfolk i.e. empowerment and incentives to boast their livehood.

Government should pay more attention to education of women, so that they would appreciate their health needs and challenges better.

Government should formulate legislations to guarantee rights of women to education, to at least secondary school level before marriage, and it should be made free and compulsory.

Government should strengthen collaboration with traditional birth attendants in rural areas by given then necessary modern skills to undertake anti natal care to pregnant women and child delivery particularly in rural areas, where primary health care centers are lacking or inadequate.

Government should collaborate with traditional/religious leaders, media, NGOs, to sensitize the public on the importance of girl child towards reduction of perilous socio-cultural practices like refusing women permission to go to hospitals, over bearing of children without proper care and child spacing, attending of deliveries by unqualified traditional birth attendants (TBs) etc.

CONCLUSION

It is apparent that socio-economic factors still play significant role in depriving pregnant women from access to health care systems in developing countries, thus leading to occurance of fistula. It appears that more efforts are needed by the government, NGOs and other stakeholders to tackle socio-economic factors particularly in rural areas, where they are still more pronounced. Once socio-economic factors are addressed, then government would discover that it does not have to go extra mile by providing free drugs, free ANC, and surgery to pregnant women, because most of them would be able to afford them on their own. Furthermore, tackling of socio-economic factors would reduce the three delays women usually experienced, with respect to access to health care facilities. Eventually, therefore it is expected that fistula would be a thing of the past, just in the same way smallpox, polio etc were eradicated globally. This further justifies the need to encourage women to engage in entrepreneurship as a means of enhancing their economic wellbeing which would further enable them to take care of their needs, including health Rohana (2006).

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