GENDER, SEXUALITY AND VULNERABILITY

Sociocultural vulnerabilities to Obstetric Fistula among Female Children in North Western Nigeria.

Introduction: Nigeria ranks as the 7th largest country (with a population of 176, 854,992) in the world after countries like China, India and Pakistan (NDHS, 2013). In Nigeria, the annual obstetric fistula incidence is estimated at 2.11 per 1000 births, being more prevalent in the northern part of the country compared to the southern part due to cultural practices that favor early age of marriage and first pregnancy in Northern Nigeria (Umoiyoho et. al, 2011). In Sub-Saharan Africa, female adolescents form the bulk of the group at risk for developing obstetric fistula due to obstructed labour potentiated by religious beliefs and cultural practices that promotes early marriage (Adedokun 2012). Majority of adolescents less than 15 years of age have under-developed pelvises that cannot withstand the strain of labor and accommodate a fully developed baby, especially since malnutrition is also prevalent in countries within sub-Saharan Africa (Engender Health, 2003). Adolescent girls have been shown to have less than adequate access to family planning services, prenatal care and emergency obstetric care (Tebeu, 2012). The burden of fistula in Nigeria is an indication of poor maternal and reproductive health services at grass root level (WHO, 2013).

Most fistulae occur as a result of cultural factors which promote early marriage, poor obstetric practices and poor nutrition among women of reproductive age group (Adedokun, 2012). Other contributory factors are poor health seeking behavior in pregnancy and childbirth, restriction of women's movement and poverty (Umoiyoho et al, 2011). Also of note is the high rate of unskilled birth attendants during home deliveries in rural areas, delay in accessing adequate emergency obstetric care and late presentation at health facilities (Sambo, 2004). However substantial numbers of fistulas are caused by trauma (sexual abuse or coital injury in child brides), infection (with Lymphogranuloma venereum), and harmful traditional practices (female genital cutting, traditional "gishiri or Angurya" cuts and other forms of unwarranted surgery). Surgical procedure performed within the traditional health care system that may lead to obstetric fistula include female circumcision, the Gishiri cut and Angurya, a traditional practice in which tissue is removed from the vagina by traditional surgeons for the treatment of coital pain, infertility, obstructed labor, amenorrhea, dyspareunia, vulva rash, goiter, and generalized body aches and pains (Sambo 1990; Tahzib 1985; Harrison 1985).

This study examined the impact of these practices on the reproductive health of a girl child utilizing both a retrospective and a cross sectional approach.

Methods

The study area was the North Western part of Nigeria which consists of seven states (Jigawa, Kaduna, Kano, Katsina, Kebbi, Sokoto and Zamfara states) and the population consists predominantly of the Hausa speaking tribe in Nigeria (NPC 2014).

All states within the region have at least one fistula repair centre and accounts for almost half the number of fistula repair centers in Nigeria. The selected states (Kaduna, Sokoto and Zamfara states) each have a fistula centre.

The study population comprised of patients who had their first child before the age of 15 years with obstetric fistula attending the Zaria, Gusau and Sokoto fistula repair centers in the months of September - November 2014.

A descriptive cross sectional study involving women with obstetric fistula (repaired and not repaired) in the fistula centers in Kaduna, Sokoto and Zamfara states was carried out to determine their sociocultural vulnerabilities using a questionnaire and a focus group discussion guide. Focus group discussions were conducted to explore personal experiences of respondents with fistula with regards to cultural practices.

Data collected was coded, entered and analyzed using Statistical Package for Social Science (SPSS version 21). Frequency tables, charts, median and standard deviations were used to summarize quantitative variables. Chi-square test was used to test for statistical significance between variables. Results were considered for statistical significance ($P<0.05$). Thematic analysis was carried out to extract information from the Focus group discussion transcripts.

Results

The respondent's ages were between 13 to 55 years and the mean age was 25.4 ±8.2 years. The numbers of married and divorced respondents were 100 and 101 respectively. The respondents in a polygamous union were 149 while 62 were in a monogamous union. Trading and farming were the most prevalent occupation with 98 respondents each. Almost all the respondents save 2.8% lived on less than 5000 Naira per month. Only 8.5% of respondents had any formal education.

Table 1: showing sociodemographic characteristics of respondents

Variable	Frequency N=211	Percentage (%)
Age (in years)		
10-19	48	22.7
20-29	95	45.0
30-39	54	25.6
40+	14	6.6
Marital Status		
Married	100	47.4
Divorced	101	47.9
Widowed	10	4.7
Type of Marriage		
Polygamous	149	70.6
Monogamous	62	29.4
Occupation		
Trading	98	46.4
Farming	98	46.4
Others	5	11.6
Average monthly income		
500-2500	115	54.5
2500-5000	90	42.7
5000-7500	6	2.8
Educational Status		
No formal education	193	91.5
Formal education (primary/secondary)	18	8.5

The ages at first childbirth of respondents range from 12 to 15 years with a mean age of 14.33 ± 0.712 years. All the respondents have lost at least one baby with 77.2% having lost one and 20.9% having lost two babies. More than half have lived with fistula for more than five years while 46.4% have lived with fistula for less than five years.

Table 2: Showing obstetric and fistula history of respondents

Variable	Frequency N=211	Percentage (%)
Age at first childbirth (in years)		
12	6	2.8
13	12	5.7
14	100	47.4
15	93	44.1
Number of babies lost in the past		
One	163	77.2
Two	44	20.9
Three	3	1.9
Length of time living with fistula		
Less than 5 years	98	46.4
More than 5 years	113	53.6

Majority (83.4%) of the respondents have moderate depression with 3.3% and 13.3% having mild and severe depression respectively.

Table 3: showing respondents mental health score

Variable	Frequency N=211	Percentage (%)
Level of depression		
Mild depression	7	3.3
Moderate depression	176	83.4
Severe depression	28	13.3

Some of the respondents experienced "gishiri cutting" – a type of female genital mutilation.
Concerning their experiences with childbirth, participants in the focus group discussions for this study indicated that majority of childbirths (especially first born children) were delivered at home because of the '*Kunya*" culture amongst the indigenes of the Northern part of Nigeria. This practice encourages women to give birth surrounded by family and is still common place among the residents of the core parts of the Northern parts of Nigeria especially those who have no formal education. In some cases, women do not leave the house or cannot be taken to the hospital without the permission of their husbands or a male guardian even in circumstances when labor is complicated.
Respondents opined that though they received support from their immediate families (especially in the days and months immediately) after fistula occurrence, the help gradually declined over time as the fistula persisted with no apparent end in sight. Others who were not so lucky shared that they had either suffered neglect or were divorced by their husbands as soon as the fistula occurred.

Discussion

Most of the respondents in this study were divorced similar to studies by Cook (2004), Bangser (2006) and Arrowsmith et al (2012), this being the most common marital outcome for women with the obstetric fistula condition. Though this was contrary to the results of Umoiyoho et al's study (2011) in the south eastern Nigeria where none of the respondents were divorced and suggested that it was probably due to the difference in religious and cultural settings for both studies. The low level of income and low educational status of respondents in this index study is consistent with findings of Harouna et al (2001), Gessessew and Mesfin (2003), Gulati et al (2011), showing that obstetric fistula is most common in the women of the lowest social class.

All the respondents had their first childbirth before the age of 15 years which is consistent with the results of Gulati et al (2011), Umoiyoho et al (2011) and Kyari and Ayodele (2014). Adedokun et al (2012) in his article on early pregnancy as a risk to safe motherhood found a link between early pregnancy and development of adverse outcome in childbirth (one of which is development of obstetric fistula) and attributing it to the small size of their pelvises. All respondents of the index study had lost at least one baby in the past; this is consistent with findings of Holme et al (2007), Tebeu et al (2012) and Wall, (2012).

Depression has been found to be the most common outcome of obstetric fistula because of the associated stigma and ostracization (Mselle et al, 2011). In this study, majority of respondents had a moderate level of depression. In this study, respondents with moderate depression were found to have the highest proportion in the study population. This is in agreement with several studies carried out in other African countries by Bangser (2006); Wilson et al, (2011); Arrowsmith et al, (2012) where the stigma associated with obstetric fistula has been linked to poor mental health.

Early marriage has been a common practice among many ethnic groups in the world (Abdullah, 2011). For instance in Nigeria, specifically the Northern Nigeria allows early marriage of the girl-child and (in some parts) having the first child birth at home (the "kunya" culture) was encouraged (Prata et al, 2012). According to Bala (2003), early marriage had a negative trend on the girl child with effects which included emotional and mental distress, intolerance, school drop-out, developmental and reproductive health problems, early widowhood, frustration and hatred for the man. Besides having a negative impact on the girls, the practice of early marriage also has negative consequences on their children, families, and society as a whole (Adedokun et al, 2012).

Premature marriage deprives girls of the opportunity for personal development as well as their rights to full reproductive health and wellbeing, education, and participation in civic life (Kyari and Ayodele, 2014). Abdallah (2011) in a study among adolescents in Nigeria observed that the practice of child marriage is deeply entrenched in tradition, culture and religion and the country has one of the highest rates of child marriage in the world, with estimated 42% of girls married before 18 years; and he furthermore reported that this practice is found among many ethnic groups across the country, its predominance is clearly in the northern part of the country.

Findings from a research conducted by Kyari and Ayodele (2014) on the socio-economic effect of early marriage in Zaria, North-Western Nigeria revealed that there exists a significant relationship between early marriage and girl-child education thus implying that if children are given in marriage it would certainly affect the highest level of education attainable for them. The study concluded that child marriage is an accepted cultural practice in many societies including North-Western Nigeria and is still widely sanctioned, even though it is a violation of the human rights of young girls due to various motives. Population Media Centre (PMC) 2010 similarly reported that early marriage is directly related to fistula, illiteracy and poverty among women in northern Nigeria.

A major social contributor to obstetric fistula is the lack of decision-making power available to women, even in decisions pertaining to their own health.

The interplay of socio-cultural factors predisposing the girl child in Northern Nigeria to obstetric fistula was examined. The factors include early child marriage, home delivery of the first child, female genital cutting, poor nutrition, lack of education, poor health seeking behavior and inability to make decision. Each of these factors acting singly is capable of contributing to maternal morbidity and mortality but portrayed in this study is an interaction of all these factors and how the girl child suffers diverse consequences.