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Tears of Childbirth: Lived Experiences of Women with Obstetric Fistula in Northcentral Nigeria

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Abstract
Motherhood is expected to be a time of joy but women often die or develop complications, such as obstetric fistula during the process of child-bearing. Obstetric fistula is regarded as the most devastating of all childbirth related morbidities. The study explored the lived experiences of women who have had obstetric fistula repair at a Specialist Hospital in the Northcentral, Nigeria. The study was qualitative, descriptive and phenomenological. Total population and purposive sampling techniques were used to guide the recruitment of nineteen women. Tesch's approach of data analysis using open coding was used for the qualitative data while descriptive statistics were used to display participants' demographic profiles. The findings revealed that participants who developed obstetric fistula usually have prolonged or mismanaged labour, two participants had combined forms of fistula. The participants expressed that they were stigmatized, isolated and the ailment affected all areas of their lives. Half of the participants spouses were miserable and eventually abandoned them. The participants also indicated that fistula repair had positive effects on their lives as they can now attend social and religious gatherings. Participants in the study reported unpleasant experiences that affected all facets of life but fistula repair brought back hope and reasons to live again thereby wiping off their tears of childbirth. Obstetric fistula is preventable and treatable; it is a condition that no one should have to endure. Essential obstetric services should be expanded at the community level to address obstetric fistula through prevention and management.

Keywords: Childbirth, lived experiences of women, obstetric fistula

Introduction

The reality of women becoming mothers in developing countries can sometimes become a traumatic and complicated event. Motherhood is expected to be a time of joy but women often die during the normal process of child-bearing. [1-2] As one woman dies during childbirth, others battle with different forms of severe complications such as obstetric fistula.[1] Obstetric fistula is regarded as the most devastating of all childbirth related morbidities.[3]

An obstetric fistula is a hole or an unusual opening that occurred between the vagina and the bladder or with the rectum leading to continuous dribbling of urine, stool or both, typically due to overwhelming injuries, resulting from neglected or prolonged complicated childbirths, affecting more than two million women worldwide.[4-7] It is a condition that usually affect young women who give birth at home particularly in poor and most often in remote areas with very limited or no access to maternal healthcare services.[5-6,8-9]

Although any woman can be susceptible to the development of obstetric fistula, the incidence is higher in African countries. In developed countries, obstetric fistula has practically been eliminated and if they occurred, they are repaired without delay.[4-5] According to WHO [9], Amodu et al. [7] about 50000 to 100000 women globally are affected by obstetric fistula every year and there are about 2 million to 3.5 million girls and women in Asia and sub-Saharan Africa living with untreated fistula. Obstructed labour is the usual cause of obstetric fistula especially in remote African regions, where their obstetric care is inadequate as a result of shortage of hospitals or midwives, complicated childbirth can result in a woman being in labour for days.[9]

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The basic fundamental cause of maternal ill-health, such as obstetric fistula is poor socioeconomic development.[9] According to the World Health Organization (WHO), obstetric fistula is preventable and delaying the age of a woman at first pregnancy, prevention of harmful traditional practices and the provision of accessible, affordable and efficient maternal care can assist in its prevention. The sociocultural status of women contributes to the occurrence of obstetric fistula. For example, in the Northern part of Nigeria, teenage pregnancy following early marriage is culturally acceptable and still much practiced. Consequently, obstetric fistula is a common condition among young girls due to early marriage that often occur before or during puberty.[5,7] In West Africa, 3 to 4 out of every 1000 deliveries results in obstetric fistula and Nigeria has one of the highest prevalence in the world, about 800,000 women are currently reported to be living with fistula and about 20,000 women are affected each year. The highest recorded rate occurred in the Northern part of the country with an estimated 150,000 unrepaired cases.[5,7,9-10] The purpose of this phenomenological study is to explore the lived experience of women with obstetric fistula who have had fistula repair at the selected Hospital in the Northcentral, Nigeria. Also, the study seeks to obtain outcome data pertaining to the women, such as whether they had a successful surgical repair and continued their marriages after the repair.

Methods

Study setting and design

The study was conducted in a Specialist Hospital with fistula repair centre, Ilorin, Kwara State. Kwara is a state located in the North-Central geopolitical region of Nigeria. A descriptive phenomenological study design was used to explore the lived experiences of women with obstetric fistula.

Selection and description of participant

Total population/purposive sampling technique was used to guide the recruitment of 19 women. Criteria for inclusion in the study were women who have had obstetric fistula repair and willing to participate in the study. Appointment were booked with participants through the nursing department of the hospital. To confirm participants availability, physical visits and follow-up phone calls was done. Interviews were conducted at prearranged times at the hospital. Participants were recruited from July to August, 2018.

The total population was used to determine the sample size, all women available were recruited into the study, a total 13 women were on admission after a successful fistula repair and 6 more women (who have had fistula repair in the previous year) were recruited through the assistance of the nursing staff.

Data collection

In-depth interviews and field notes were used for data collection so as to have full understanding of the lived experiences of women with obstetric fistula. Data collection was between August and September 2018. Interviews were conducted according to prearranged time with the participants at the hospital. All the participants agreed to be interviewed at the hospital where the repair was done. The researcher conducted and audiotaped the interviews. Prior to an interview, a participant's' consent, goals and reasons for conducting the research were explained to all participants. An interview schedule was developed to guide the interviewer, open-ended questions were used to gain more information. Also, the original English version of the questionnaire was translated into the local language (Yoruba) and translated back into English.

The interviews took an average of 45 to 50 minutes per participant. The interview questions focused on lived experiences of the women right from the time of fistula diagnosis. Initially, participants were asked questions such as "What was your everyday experience with obstetric fistula?" In order to clarify participants' views, feelings and ideas, follow-up questions were asked so as to gain deeper understanding on different aspects of their experiences with obstetric fistula. Reflective questions were also asked, such as "How do you feel after the fistula repair? Data collection and analysis were done concurrently and transcription of recorded information was completed within a day.

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Before the actual data collection, pre-test interviews with two women (who had obstetric fistula repair in 2017) were conducted during the recruitment phase. The women had similar characteristics to the study participants but were not included in the final data. Categorical variables, such as socio-cultural group, religion, age, marital status among others were asked. With the participants' permission, the interviews were written and audio-recorded, with field notes also taken to complement the recorded information.

Ethical considerations

Prior to the commencement of the study, the research proposal was submitted to the Research Ethics Committee of the Ministry of Health, Kwara State for approval. The permission to conduct the study was granted with reference number MOH/KS/EU/777/25. An official letter was also written to the Chief Medical Director, Specialist Hospital Sobi with the permission letter attached and consent was granted. Before each interview, participant's rights were explained and inform consent and permission to use audio recorder were obtained. Anonymity and confidentiality were maintained by not recording the participant's name. To ensure participants' privacy, the interviews were conducted in a private room in the unit with only the researcher and the participant present.

Data analysis

Tesch's approach of data analysis using open coding was used for the qualitative data.[11] The interviews were transcribed verbatim and read many times so as to find repeated themes and patterns among the themes. Themes were generated from the data and coding was done. The coded material was grouped according to shared meanings and ideas. Descriptive statistics were also used for the presentation of participants' demographic profiles.

Trustworthiness

In order to ensure trustworthiness, the researcher recorded all interviews using an audio taped. The interviews were transcribed verbatim and observational field note was used. The researcher also used other strategies to achieve credibility, such as trust building and interpersonal relationship with participants, triangulation of data gathering methods, peer debriefing, authority of the researcher, dense description and dependability audit were employed.[12]

Results

Participants' demographic profiles

A total of 19 women participated in the study, eight of the participants were over 40 years of age. Five of the participants were never educated, almost half (8 of 19) were traders and had three or more number of children with five of the participants indicating they had no source of income (Table 1).

Table 1. Demographic profile of participants (n = 19)

Variable	N	%
Socio-cultural groups		
Yoruba	17	90
Nupe	1	5
Ibo	1	5
Religion		
Christianity	6	32
Islam	13	68
Age group (years)		
13-19	2	10
20-29	3	15
30-39	6	32
40 and above	8	43
Marital status		
Single	1	5

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Married	8	43
Separated	6	32
Co-habiting	1	5
Divorced	3	15
Educational level		
Never educated	5	26
Primary	5	26
Secondary	4	21
Tertiary	5	26
Monthly income		
None	5	26
Less than N20, 000 (< $50)	10	53
N20,000-N40,000($50-$100	2	10
Above N40,000 (> $100)	1	5
Above N80,000 (> $200)	1	5
Number of children		
None	7	37
One	3	15
Two	1	5
Three and above	8	43

Emerging themes
Six themes emerged: history and experience, personal life, challenges of the condition, coping mechanism, outcome data and suggestions to other women.

History/experience: reproductive experience with reference to disease condition
Eight participants (42.1%, n=19) verbalised that they noticed the disease condition after they given birth to their first child. More than half (12 of 19) of the participants verbalised that they had stillbirths due to prolonged labour and delayed medical care and attention.

The overall analysis indicated that participants who had obstetric fistula had prolonged or mismanaged labour, a participant had this to say:

"I fell into labour around 6pm, so I went to the hospital, I was told not to push yet, because it was not time for the baby to be out, so around 12noon, they told me to push, by that time I was seriously bleeding, so I pushed and gave birth, then they started stitching me, for like 30 minutes they were still on". (P6)

All participants highlighted that the condition made delivery to be extremely uncomfortable, as there were complications such as, delayed placenta or suturing not properly done. This was revealed in the following statement from a participant:

"*During delivery I had tears, so they sutured it, and they told me the tears was extensive, when I was stable I went home, and on the 8th day, I noticed my faeces was hard and it came out through the vagina in small quantity, I went back to the hospital, they sutured it twice again, but it did not work, so I went to a general hospital in Oyo state, they sutured it twice there again, but it kept on breaking down, so I left Oyo state and went to general hospital in Ilorin, Kwara state, they wanted to operate on me but I did not have enough money, so I continued that way, although eventually the stitches stopped breaking down but I kept on defecating uncontrollably…" (P8)*

Everyday experience with obstetric fistula
All the participants (n=19) highlighted that the experiences were quite sad, disheartening and apparently very shameful as many of them had stillbirths. One participant highlighted:

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"I cannot carry heavy load, nor walk a long distance, I cannot pound yam, at work they stigmatize me, so they plot to make me go away because they thought I would die, as a teacher I was transferred to another school. I was transferred to Okene, in Kogi state, so on getting there I explained to the headteacher, so as to prepare her mind, I was afterwards given a job to teach primary 5 pupils. Most days I feel very weak as if I will faint, so a meeting was held and the headmistress decided to demote me to primary 3. In my new class, I felt sick for a week, then I was demoted again to kindergarten, I was very sad". (P10)

It became a scourge such that many were confined and could not move around freely. Participants verbalised that they could not engage in strenuous exercises as they get weak and exhausted almost in no time of engagement.

"I felt like someone in great bondage, I could not be free among my colleagues, it was a terrible experience, the shame alone will not make me go out, some people even thought someone was behind it (witchcraft)". (P16)

Three participants commented that the disease condition had little effect on their activities as they ensured that they get themselves well packed and change their underwear when necessary.

Type of Fistula

A total of 84.2% (16 of 19) of the participants had one or combined (two) forms of fistula. Four participants (21.1%) had rectovaginal fistula (RVF), one participant had uterovaginal fistula (UVF) and the majority (16 of 19) had vesicovaginal fistula (VVF). Two of the participants (11%) had the combined form of the disease and one of them had this to say:

"I stopped seeing the faeces sometimes later, after I had delivered, but it started again after I did the December surgery for the repair of the uncontrollable urine, but eventually again, the faeces stopped and the urine continued." (P3)

Causes of obstetric fistula

Overall analysis indicated that a variety of reasons were mentioned by participants as the causes of fistula such as ignorance, early marriage, incorrect diagnosis, fate, prolonged labour, pregnancy, inadequate medical or surgical experience, lack of pre-natal care, tears, carelessness of healthcare workers among others. Notable among the causes mentioned was consumption of food with chemicals:

"When it happened, I was very sad, I thought I was the only victim, but on getting to the hospital, I met other women with urine smell. I feel it is because of the chemical foods we eat, unlike in the olden days, when they eat fresh foods but now, we eat maggi (spices) a lot and it has exposed us to different dangers". (P17)

Personal Life: Partner/husband's reaction towards participant

Majority of the participants verbalised that their spouses' reaction was somewhat indifferent. Also, spouses' reaction was attributed to parental influence and financial constraints. Nine participants (47.4%) commented that their respective spouses were very unhappy and eventually left. The followings are some of their responses:

"*My husband left me alone, even till now we are separated". (P2)*

"W*hen I had the fistula, he was always supportive, and he spent a lot in my care, but his family members told him to leave me, because the doctors said if they do the repair surgery and its successful, i cannot have a normal vaginal delivery again, that I have to give birth to all my children through caesarean section and since it is expensive to afford, they said he should leave me, and not squander all his money on me'. (P13)*

Ability to work with fistula

Nine (47.3%) participants indicated that they are still able to work with the fistula but the remaining 10 (52.7%) participants owed their inability to work to severe pains and extreme fatigue. One of these participants mentioned:

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'*Whenever the pain was too much I could not go to work and I used to defecate on myself, I showed medical report to my boss, but eventually they understood even though it was tough at first, so when I go to work, I do not bother eating at all so as not to mess myself up'. (P19)*

Challenges regarding sexual relationship with partner/husband
Overall analysis of the participants' comments indicated that, 21.1% (4 of 19) of the participants still had healthy sexual relationship with their spouses, 3 participants still have some sexual relationship but the remaining 12 participants had no active sexual relationship owing to facts like singlehood, separation and divorce.

Challenges regarding relationship with friends and family (Social life)
All the participants (n=19) noted that the disease condition really affects their social lives, relationship with families and friends. Participants expressed that they were stigmatized, isolated and the disease condition did become a scourge. Some of their responses were:

"My friends and relatives are aware, but some of them often look down on me, they consider me as someone that they are not supposed to associate with, they keep running away from me, this makes me feel bad and it reduces my self-esteem, although I try to relate well with them, I do not attend parties, nor church services because of it". (P3)

"*My family members are aware and they do not move close to me or where I am, they always made jest of me, although they did not deprive me of some things like clothes food, etc. But the people in my neighbourhood avoid me". (P15)*

Difficulty in seeking medical care
Two of the 19 participants indicated that they had difficulties in seeking medical care while others did not but downplayed the efficacies of the treatments received as they had to undergo three or more surgeries before a complete repair. One response was:

"*Right from the start it was not hard for me to receive medical care, but I was scared of receiving treatment again. This fistula was diagnosed in Lagos, but I did not do the surgery to repair it, because I already had 3 surgeries, and I thought of the implication of having another surgery done". (P18)*

Fistula treatment undergone so far
Overall analysis indicated that the participants received medications, some were placed on diets (fruits and vegetables), regular check-ups, antibiotics, pain relievers and some have had one or more surgeries done.

Coping mechanism
Measures taken to overcome challenges of obstetric fistula
The participants pointed out reasons, such as (self) personal encouragement, family and moral support, medications including alternative medicine among others as measures that were taken to overcome the challenges of having obstetric fistula.

Worries and anxieties about obstetric fistula
All the participant indicated they were scared, sad and self-conscious and always result to consolation and encouragement from self and relations. One participant mentioned the following:

"I was always worried most of the time, if I finish my period today, like 3 days after I would keep on leaking urine, so most of the time I would just be sad and worried., …Whenever I think about it, I just compare it to being dead, I know it is better to be alive than to be dead but I felt I was not alive". (P16)

Stigmatization/discrimination and isolation
Participants confirmed being stigmatized by colleagues, friends and neighbours. A response was:

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"Even in the hospital, I was always stigmatized, they would not want to treat me the way they ought to, instead they neglected me and told me not to teach them their job, they handled me with nonchalant attitude, even at work my colleagues do not associate well with me". (P14)

Outcome data
All the participants expressed the elatedness and excitement they will have if eventually the fistula did not reoccur or if it is completely resolved. Two of the participants responded as follow:

"I will be very grateful to God, because humans can only do little, everything lies in the hand of God, and because, if I remain grateful, I will be able to receive more from God. I will be very joyful because God deserve all my praises, and some people did not suffer this much but they are dead". (P17)

"Honestly if I have a drum, I will start dancing, I thank God, I thank the free surgery committee, I thank God for my life, I am just very grateful". (P1)

Influence of repair on marital life
Five out of the nineteen participants (26.3%) indicated that their marital life was restored as sex became a non-issue, 13 participants emphasised that they just want to get better first and have not thought about or put into consideration the effects of the repair on their marital life.

Influence of repair on social life (work, friendship/relationship etc)
Some of the participants indicated that repair had a positive effect on their social lives as they can now attend social gatherings and events without fear of being ashamed and stigmatised. A participant response was:

"I became free with everybody, I could eat what I wanted, I could stay long with people whenever I go out or to church". (P5)

Influence of repair on physiological wellbeing
Almost (18 of 19) all the participants verbalised that their physiological wellbeing is now very normal as there were no rooms for anxiety, complaints, thinking and worries. Participants now feel free, happier and can be rest assured that they no longer need to be worried about being stigmatised. This was revealed in the following statement from a participant:

"I am now very stable psychologically, there is not much left for me to worry about, my children are happy to have me again". (P16)

One participant was still anxious and made this comment:

"Although the fistula is gone my mind is not yet at rest because I still do not see my period, that is what bothers me". *(P15)*

Suggestions: Message for pregnant women to avoid the problem of fistula
Participants stressed the importance of antenatal care in the prevention of fistula and urged pregnant women to shun the habit of self-delivery and the use of traditional herbs but should engage in regular exercises and eat good food (balanced diet), constant and regular check-up and avoidance of strenuous activities. Some responses were:

"I plan to organize a gathering for ladies, because some people are not seeking necessary help in the right places. September 8, 2018 will be the fifth month that I have I left my children alone with my sister. I will advise pregnant women to go and register at a good hospital, not just any nearby health centres". (P16)

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"*Pregnant women should not handle their state with levity hands, they should do all within their power to get right care in the hospital, although everything is in God's hands, they should not risk their lives*". (P14).

Discussion

Obstetric fistula is more common among young, often uneducated from poor socioeconomic background. [13-15] These observations were confirmed in this study as more than half of the participants only earn about $50 a month, five of the participants was never educated and five participants also had no source of income.

As revealed in the study, more than half of the participants had prolonged and mismanaged labour. As stated by Ekanem et al. [4], Ahmed et al. [3] and WHO [9], prolonged labour is a common factor in obstetric fistula, while risk factors for obstetric fistula differ from one setting to another but the main cause is prolonged and neglected obstructed labour in more than 90% of the cases. Other factors include primigravida, stillbirth delivery and lower social economic status.[2,8,10] In Ethiopia, more than 60% of the women are carrying their first babies when they develop obstetric fistula with prolonged labour for up to 3.9 days.[10] This was also supported by Browning.[13] The labour is usually unattended, or it will be conducted by an unskilled attendant and the baby delivered most often are stillbirth. Although normal labour can last up to 16 hours, women who developed obstetric fistula suffered 2.5-4.0 days in labour.[3]

On everyday experience with obstetric fistula, all participants in the study reported that their experiences were quite sad, disheartening and very shameful and many had stillbirths. Inability to control urine and faces, retain their marriages, give birth to children, or partake in social and economic activities makes women with obstetric fistula to lose their identity as womenfolk, wives, families, friends and community members.[16] It also leaves women with few prospects of earning a living, thus worsens their poverty.[1,13,15]

According to Ekanem [4], Ahmed et al. [3], most women who developed obstetric fistula may not have the opportunity to achieve their dreams of becoming mothers because most of their children are stillborn. This is similar to this study as majority of the participants had stillbirths. As stated by Ahmed et al. [3], losing a baby to stillbirth is possibly one of the saddest experiences a mother can go through in her lifetime, but then developing an obstetric fistula from the same birth can be more traumatizing and life-shattering. The death of the baby, as well as the inability of the woman to carry her child, besides the shame that accompanies fistula results in severe emotional damage. [1,3,4,17-19]

The participants in the study mentioned various perceived causes of obstetric fistula such as ignorance, early marriage, incorrect diagnosis, fate, prolonged labour, pregnancy, lack of pre-natal care, tears and carelessness. As supported by McFadden et al.,[8] and Barageine et al. [10], maternal age seems to have a role in development of fistula. Illiteracy and ignorance were also mentioned by the participants in the study as likely causes of obstetric fistula. Correspondingly, in Ethiopia 92% of the women who sustained obstetric fistula were illiterate, similar trends of illiterate women were observed by in Nigeria and East Africa series with 78% and 42% of women with fistula having no formal education respectively.[10,20].

According to Barageine et al.,[10] women living with fistula view their condition as either a will of God or even a punishment from God, this is similar to the finding from the study as some of the participants mentioned fate as a perceived cause of obstetric fistula. Majority of the participants' husbands reacted negatively, many were very unhappy about the diagnosis while nine eventually got separated or divorced. The consequences of fistula go beyond the individual woman, apart from the sorrow and shame of losing a child, they also struggle with constant odour from continuous leakage of urine and faeces which can drive away their husbands, family and friends thereby confining them to an involuntary life of solitary.[10,15] In a Tanzanian study [16], participants expressed that obstetric fistula was the main reason why they got separated from their husbands because it restricted their ability to accomplish marital roles. About half of the participants with fistula are divorced due to direct consequences of their incontinence. [13] Some women were mandated to return to their parents, and for women who were still together with their husbands, they were unable to share the same house or room together.

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All the participants noted that the disease condition did have effects on their social lives, relationship with families and friends. Women with obstetric fistula are generally abandoned by families, thereby becoming sufferers of social outcast and suffering other violent responses from unfriendly society.[4,19] Participants in the study expressed that they were stigmatized, isolated and the disease condition did become a scourge. This was supported by Bangser et al. [20], Mselle et al. [16], Barageine et al. [10] and UNFPA [15], that women with obstetric fistula were either ashamed to go out of their homes, rejected by their relatives and community members or prevented from working. Living with obstetric fistula is associated with experiences of various losses ranging from physical, emotional to social which impacted negatively on the identity of the woman as well as identity and quality of life. [10,21-22]

Although women who developed obstetric fistula often develop different coping strategies. Hence, they understand that they are not passive sufferers but rather active survivors of these trials.[1] This is similar to the findings from this study, as participants in the study mentioned that they were scared, sad, self-conscious and have to reassured themselves and also relied on consolation and encouragement from relations. For women suffering from obstetric fistula, with resultant effects that are much more than physical and repairing the fistula alone does not end this torment. Thus, it is paramount they learn to rebuild their lives after the years of isolation.[19] In the study, some of the participants indicated that their marital lives were restored after the repair as sex became a non-issue, the repair also had positive effects on their social and psychological lives as they can now attend social gatherings without been stigmatised.

Limitations

The limitation of the study is the purposive sampling of women with obstetric fistula in the obstetric repair centre, Kwara State, Nigeria; thus, the findings may not be generalised to other areas.

Conclusion and recommendations

Prolonged and mismanaged labour were seen as the major causes of obstetric fistula. Participants in the study reported unpleasant experiences that affected all facets of life but fistula repair brought back hope and reasons to live again thereby wiping off their tears of childbirth. Obstetric fistula is preventable and treatable; it is a condition that no one should have to endure.

Necessary obstetric services should be made available by the government and all concerned at the grassroot, so as to address the problem of obstetric fistula through prevention and management. Broad information on birth preparedness and complication readiness should also be provided by nurses/midwives and other health care professionals. In addition, it is paramount for government and other concern agencies to ensure the establishment of affordable emergency obstetric units within the existing health system especially in rural and underserved communities of the country as this will curtail the problem of prolonged labour.

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