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Research article

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Evaluation of the Impact of Educational Status and Cultural Beliefs on the Health Seeking Behavior of Women with Obstetric Fistula in South-South and South Eastern Nigeria

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Abstract

Background: *Obstetric fistula is a serious health problem affecting women in low and middle-income countries. It continues to exist in Nigeria because the health care system has failed to provide quality, accessible and affordable maternal health care including family planning, skilled care at birth, basic and comprehensive emergency obstetric care and inadequate access to treatment of obstetric fistula cases. The purpose of this study was to evaluate the impact of educational status and cultural beliefs on the health seeking behavior of women with obstetric fistula in South-South and South Eastern Nigeria.*

Methods: *This was a cross-sectional study. Non-probability sampling involving purposive and simple random sampling technique was adopted in the selection of one hundred and fifty (150) post-operative patients. The data was analyzed using thematic analysis frequency tables and percentage distribution.*

Results: *The findings were that educational status and cultural belief exert significant influence on the health seeking behavior of women with obstetric fistula.*

Conclusion: *The study indicated that obstetric fistula is a major reproductive health challenge affecting women of childbearing age in Nigeria. Based on the findings of the study, educational status and cultural belief of women with obstetric fistula are the major serious challenges to health seeking behaviour of the women with Vesico-vaginal fistula (VVF). It was therefore recommended that more awareness on obstetric fistula should be created using strategies such as sex education programmed in secondary schools and churches so as to educate them on issues concerning obstetric fistula as well as health talk on VVF for youths.*

Keywords: Obstetric fistula, Cultural belief, Educational status and Health seeking behaviour

Introduction

Obstetric fistula is one of the most serious and tragic child birth injuries which occur as a result of prolonged obstructed labour due to cephalo-pelvic disproportion and with the continuous uterine contraction forcing the head of the baby against pelvic organs, and the pelvic bones, restrict the blood flow and damage tissues between the vagina and the bladder or rectum or both [1].

The World Health Organization (2005) asserted that obstetric fistula is a health condition caused by interplay of numerous physical

factors interplaying with the social cultural, political and economic situation of woman [1]. The physical factors that give rise to the incidence of vesico vaginal fistula include obstructed labour, accidental surgical injuries related to pregnancy and crude attempts at induced abortion. There are other causes of obstetric fistula such as sexual trauma, injuries from surgery, radiation therapy and penetrating injuries like that from cow's horn or stick and harmful traditional practice such as female genital mutilation and "gishiri" cutting in the Northern Nigeria.

Globally, obstetric fistula remains a source of public health concern because large number of woman about 2-3.5 million are affected by it, mostly in Sub-Sahara Africa, Asia and other developing countries including Nigeria where over 1million women are affected. Currently, there is no satisfactory action in the rate of prevention and treatment of the backlog of obstetric fistula in Nigeria [3]. Also, about 50,000 to 100,000 women are affected by obstetric fistula with the prevalence of 3.2 per 1000 birth and Nigeria accounts for about 40 percent of global fistula cases with 12,000 new cases yearly. A prevalence of 43.6 per 1000 birth was reported in South-East Nigeria [4].

Obstetric fistula affects women in mainly low and middle-income countries. It continues to exist in Nigeria because the health care system has failed to provide quality, accessible and affordable maternal health care including family planning, skilled care at birth, basic and comprehensive emergency obstetric care and inadequate access to treatment of obstetric fistula cases [4].

To contextualize the health seeking behaviour of obstetric fistula patients in south and south east Nigeria, we conducted a qualitative cross-sectional study with post-operative obstetric fistula patients on the impact of educational status and cultural belief on the health seeking behaviour. Several publications detail the major role education played in determining health seeking behaviour of women, eradication of disease, including obstetric fistula, empowering women with resultant alleviation of poverty which have been documented as risk for obstetric fistula. Similarly, the type of treatment people would seek highly depends on the level of education of the participant with the uneducated and low educated preferring to seek treatment from traditional healer and spiritual houses whereas those with high level of education would prefer to consult trained health professionals [5-7].

Nonetheless literate women have been reported to have made better use of antenatal care, family planning information and other reproductive health service. Education also determine the age at marriage and first birth as educated female tend to marry later than uneducated ones. Several multi-country studies including Nigeria found out that the average women living with obstetric fistula in Africa had little schooling, married young and development obstetric fistula as a multigravida. (Beth S. Phillip el at), National population commission 2013), Eyo and Udobang (2014) [8, 9].

Research studies have also examined the cultural belief influences on obstetric fistula occurrences among patient presenting at fistula treatment centres and reported that the cultural practices of the people not only affect their health but also affect all aspect of life including social relationship, contribution to societal functioning and disease condition. The women absolve themselves of any blame for their obstetric fistula, and instead believe their incontinence was caused by 'witchcraft' or jealousy by supposed enemies.

Cultural and traditional harmful practices like early marriages, genital cutting, unequal educational opportunities for girl child and male child dominance continue to drive gender inequality [10]. The practice of waiting for the head of the family (usually the man of the house) to be present before decisions are taken in relation to the choice of treatment even during emergencies contribute greatly to the delay in accessing emergency care [11, 12]. Woldeamanuel 2012, stated that that due to cultural reasons, matter associated with pregnancy and labour are not to be discussed and should not be talked openly [13]. Therefore, cultural influence has further hidden the existing problem and aggravated the delay in seeking treatment. A study by Roush (2009) indicated that many girls were divorce by their husbands, partners, disowned by family, ridiculed by friends and even isolated by health workers due to cultural and religion sentiments [14]. Despite the widespread of obstetric fistula in Nigeria, little qualitative research exists about the health seeking behaviour of women with obstetric fistula. It is against this backdrop that the study seeks to add to the limited body of fistula knowledge by exploring more on the impact of educational status and cultural beliefs on the health seeking behaviour of women with obstetric fistula in south –south and south eastern Nigeria.

Methodology

Study design

This was cross-sectional study.

Research Area

The study was carried out in two locations: Family Life Centre, Mbreibit Itam, Uyo, Akwa Ibom State in South-South Geo-political zone and the National Fistula Centre, Abakaliki, Ebonyi State in South Eastern Nigeria. These centers were chosen because they are both referral centers for all cases of obstetric fistula treatment, training, rehabilitation, prevention and research.

Population of the Study

The population of study was all the women with obstetric fistula attending Family Life Centre, Mbreibit Itam, Uyo and National Fistula Centre, Abakaliki during the period of research (January 2018-January 2019).

Sample and Sampling Technique

Non-probability sampling involving purposive and simple random sampling technique was adopted in the selection of one hundred and fifty (150) post- operative patients.

Data Collection Technique

The study tools were in-depth interview and observation. In-depth interview was conducted using semi structured questions as interview guide that were grouped into sociodemographic data, educational status and cultural belief as they affect the health seeking behaviour of the women with obstetric fistula. The interview guide was used to guide the researcher on areas to ask questions. The interview was conducted face-to-face with the respondents and the researcher sitting in a corner that was conducive for the patients both for their privacy and confidentiality.

Procedure for Data Collection

Based on the nature of the research design, primary data were considered useful for the study. The primary data comprise first-hand information and data were obtained by the researcher in the course of the field-survey, using a combination of a detail interview and observation instruments.

Method of Data Analysis

The qualitative and descriptive approaches were adopted. The data were analyzed using thematic analysis involving frequency tables and percentage distribution.

Ethical Issues

Ethical approvals were obtained from authorities in both National Fistula Hospital, Abakaliki and Family Life Centre, Mbreibit Itam, Uyo for study. Participants were required to sign the informed consent form and personal identifiers were not included for confidentiality.

Results

Frequency and Percentage Distribution of the Socio-demographic Characteristic of women with VVF (n=150)

VARIABLES	Frequency (Uyo)	Percentage (%) (Uyo)	Frequency (Abakiliki)	Percentage (%) (Abakiliki)
AGE				
18-22	4	3.3	2	6.7
23-27	8	6.7	4	13.3
28-32	64	53.4	6	20
33-37	37	30.8	13	43.3
38 and above	7	5.8	5	16.7
Total	120	100	30	100
MARITAL STATUS				
Single	39	32.5	8	26.7
Married	65	54.2	18	60
Divorced/Separated	14	11.7	3	10
Widow	2	1.6	1	3.3
Total	120	100	30	100
LEVEL OF EDUCATION				
No Formal Education	12	10	5	16.7
Primary Education	86	71.7	14	46.6
Secondary Education	17	14.2	8	26.7
Post-Secondary Education	5	4.1	3	10
Total	120	100	30	100
RELIGION				
Christianity	120	100	30	100
Islam	-	-	-	-
Total	120	100	30	100
STATE OF ORIGIN				
Ebonyi State	-	-	22	73.3
Akwa Ibom State	96	80	-	-
Other State	24	20	8	26.7
Total	120	100	30	100
OCCUPATION				
Farmer	31	25.8	16	53.4

Trader	68	56.7	61	20
Civil servant	7	5.8	3	10
House wife	11	9.2	4	13.3
Unemployed	3	2.5	1	3.3
Total	**120**	**100**	**30**	**100**

Source: Fieldwork, (2018).

Majority (64; 53.4% and 64; 53.4%) of the respondents for Uyo and Abakaliki respectively were adults. Similarly, majority (65; 54.2% and18; 60%) from both centres were married. The level of educational status percentage distribution revealed that the population was mostly illiterate. All the respondents were Christians. Most of the respondents (>90%) were indigenes of both centres while just a few were from other States. This implied that both Uyo Centre and Abakaliki have non indigenes that were referred to the Centres for treatment. Majority of the respondents from both centres were farmers.

Respondents View on the Impact of Educational status and Health Seeking Behaviour

One of the factors that influenced obstetric fistula health problems in Nigeria was the educational status of women with obstetric fistula. Most of the respondents interviewed had primary education and their level of awareness on obstetrics fistula was low. Majority of the patients complained that it was after developing the condition and were taken to the hospital for treatment that they were told what the condition was all about and they never knew or heard about this condition before.

Similarly, majority of the correspondents said they had stayed for so many years without visiting medical facilities for treatment because they did not know that the condition could be treated in the hospital. Rather, they kept visiting traditional healers, herbalist, spiritualist and chemist for treatment to no avail. Some said because of the nature of the diseases they were so ashamed to go to the hospital or to even ask questions on where to get treatment and they were also afraid of being stigmatized.

Respondents view on the impact of Cultural belief and Health Seeking Behaviour

Cultural belief and practice in most of the societies affected the health seeking behavior of women in the communities. Most of the women interviewed from both centres had their different views depending on their culture. In Abakaliki Centre, majority of women responded that it is a taboo for women to take decision regarding their health and that of the members of their family except the husband. Some said it is a sign of respect to allow men to decide, while in some communities, women's decisions are not regarded as important and also in some families the husband used the ill-health of their wives to punish them by ignoring the woman with her sickness.

Contrary to the view of Abakaliki women on decision making on health matters in the family, majority of the respondents in Family Life Centre, Uyo, viewed this in a different perspective. Most of the women confessed that though there is a cultural belief in their society that women cannot take decision in the family especially regarding health problem, they don't abide by such culture or practice because it is a way of intimidating women. Some said they are in a civilized world, where women are now enlightened as they do take decisions on health issues and inform their husbands accordingly. Despite the differences in the cultural belief existing between these geopolitical zones, some of the women explained that, these beliefs mainly affected fulltime house wives who solely depended on their husband for everything.

Closely linked to most responses of the respondents about the causes of obstetric fistula is their faith or religion. According to the demographic data of the respondents almost all of them are Christians but their denominations differ. About 45% of the respondents said VVF is a case put forth by their enemies through witchcraft or from the gods as punishment. They believed that Satan is always attacking the children of God, so any bad thing that befalls them is from their enemies which could be either member of their families, neighbors, etc.

Majority who believed that it was caused by their enemies, witchcraft, and punishment from the gods prefer going to traditional healers, spiritualists, herbalists, etc. for treatment. Similarly, those who believed the cause is natural, and those who said it is due to ignorance and poverty still pass through alternative treatment first before accessing medical treatment as a last resort which are the main reasons they delayed in seeking medical treatment.

Discussion

The educational status of women with obstetric fistula in both South-South and South Eastern Nigeria was a major factor that affected their health seeking behaviour. The result of the study revealed that most of the respondents had primary education and their level of awareness on obstetrics fistula was low. Most of them stayed for so many years without visiting medical facilities for treatment because they did not know that the condition could be treated in the hospital. Because of the nature of the diseases they were so ashamed to go to the hospital or to even ask questions on where to get treatment and they were also afraid of meeting someone they know or being stigmatized. The findings are in agreement with Aja-Okorie who argued that education is constantly an essential part of any strategy on eradicating a disease of which obstetric fistula is included [5]. It does not only make the women and community knowledgeable; it also aids empowering women with resultant alleviation of poverty which has been documented as risk factors for obstetric fistula. Also, the Nigeria Demographic and Health Survey (2013) reported that less than a quarter (11.5%) of girls aged 15-19 years completed secondary school while almost half (46.7%) of adolescent mothers with no education have begun

childbearing or are pregnant with their first child [15].

Also, a quantitative study by Tebekaw (2010) concluded that there was a relationship between educational status and obstetric fistula, regardless of socio-economic characteristics like region, age, religion, and place of residence [16]. The study found that women with secondary or higher education are less affected by obstetric fistula than the relatively less educated women. Therefore, the level of education and prevalence of obstetric fistula are negatively associated.

The findings of the study also indicated that cultural belief and practice in most of the societies in South-South and South Eastern Nigeria affected the health seeking behaviour of women in the communities. Most of the women interviewed from both centres had their different views depending on their culture. Women from South Eastern Nigeria responded that it is a taboo for women to take decision regarding their health and that of the member of the family except the husband. Some said it is a sign of respect to allow men to decide. This in turn caused delay in seeking medical treatment for these women. Majority of the women were afraid of going to the hospital for treatment because of the nature of the hospital environment; they were afraid of seeing someone they know and or stigmatization. The above finding supports the view of Abokaiagana who identified cultural practices such as the practice of waiting for the head of the family (usually the man of the house) to be present before decisions are taken in relation to the choice of treatment even during emergencies as contributing to the delay in accessing emergencies care [12].

Contrary to the view of South Eastern Nigeria women on decision making as it concerned health matters in the family, majority of the respondents in South-South view this cultural practice as a way of intimidating women, and that as at today this practice has been overtaken by civilization. This finding is in line with World Health Organization (2007) that argued that the cultural practice of people not only affect their health but also affect all aspects of life including social relationship, contributing to social function and disease condition [10]. People living in interactive society are affected by what happens in their environment and how they react to it. To the women with obstetric fistula in Uyo centre, this type of cultural practice has negative effect on their health seeking behaviour. Also, Mumbi (2013) indicated that some societal belief systems are harmful to women's obstetric health and may contribute to increase in development of obstetric fistula [17]. The Hausa of Niger and northern Nigeria believe that there must be an appropriate body balance between sweet and sour, bitter and salty substances. Obstructed labour is attributed to an imbalance in the woman's body resulting from "too much salt or gishiri that produces a membrane over the vagina inhibiting the baby from coming out." In order to treat this condition, the vagina is cut with a sharp instrument such as razor, knife, and other objects, sometimes inadvertently, causing injuries to the urethra, bladder or rectum that result in obstetric fistula.

Also, Umeora and Emma-Echiegu opined that cultural and traditional harmful practices like early marriages, genital cutting, unequal educational opportunities for the girl child and male dominance continue to drive gender inequality [11]. These promote maternal morbidity including vesico vaginal fistula, drives vesico vaginal fistula victims aground and hence preserving the already high prevalence of the condition. Emeka (2016) reported that there are socio-cultural issues that presuppose fistula including lack of education for girls, early marriage and other issues of harmful traditional practices in our communities which affect the health seeking behaviour of women with obstetric fistula [18]. He concluded that until we tackle these practices all over Nigeria, Fistula will continue to remain an issue for us [19-23].

Conclusion

The study indicated that obstetric fistula is a major reproductive health challenge affecting women of childbearing age in Nigeria. This health condition has been aggravated by the low educational status and cultural belief of women with obstetric fistula especially as it concerns their health seeking. Based on the findings of the study, educational status and cultural belief of women with obstetric fistula are the major serious challenges to health seeking behaviour of the women with VVF. It was therefore recommended that more awareness on obstetric fistula should be created using strategies such as sex education programmes in secondary schools so as to educate them on issues concerning obstetric fistula as well as health talk on VVF for youths and women associations in the churches and in the community using the local languages the people will understand.

Also, an avenue should be created to educate the women in South-South and South Eastern, Nigeria against the practice and belief in certain traditional practices and culture that opposes modern discoveries in science and technology which should have salutary effects on their health.

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