

Obstetric Fistula Policy in Nigeria: A Critical Discourse Analysis

by

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## **Abstract**

Obstetric fistula continues to affect women in Nigeria in spite of the existence of a policy to eliminate obstetric fistula in Nigeria. First I discussed the socio-cultural issues related to obstetric in Northern Nigeria. I used a critical discourse analysis to explore the obstetric fistula (OF) policy in Nigeria and broader social policies and constitutional law on which the policy was based. Findings of the analysis revealed that the OF policy did not capture the full reality of the constitutional environment in Nigeria as it contradicts with the agenda to end OF. The policy semantic was medicalized with significant silence on the role of other stakeholders in health, such as midwives, in the agenda for ending obstetric fistula. The policy was focused on reduction rather elimination. There was significant victim stereotyping of women with a behaviour change strategy fashioned after parent Safe Motherhood strategies. For there to be a head way in the agenda to end OF, social policies related to reproductive health and rights of girls must be made to align with the agenda to eliminate obstetric fistula. In particular, the Marriage act and the Matrimonial Causes Act of Nigeria needs to establish appropriate age of consent for marriage to protect minors from forced marriages at national and sub-national level. As long as child marriages exist, a policy to eliminate obstetric fistula cannot be realized. Also, midwifery services need to be expanded all over Africa to have more women deliver their babies safely.

*Keywords:* Obstetric Fistula, Critical Discourse analysis, Policy

## **Preface**

This thesis is an original work by Oluwakemi Amodu. The work received a publication award from the Faculty of Nursing University of Alberta. Project Name “Obstetric Fistula Policy in Nigeria: A Critical Discourse Analysis”.

## **Dedication**

This thesis is dedicated to my loving heavenly father who helps me through all my endeavors.

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## Chapter 1

### Introduction

Obstetric fistula (OF) is one of the most debilitating maternal morbidities affecting over 2 million women and girls in low resourced countries (Tunçalp, Isah, Landry & Stanton, 2014). OF commonly results from child birth injuries that occur when labour does not progress normally, and the fetal presenting part becomes impacted within the birth canal. OF like many other maternal mortalities and morbidities, is almost inexistent in developed countries because emergency obstetric care is never far from a woman in labour. OF sometimes occurs in developed countries as a complication of interventions like cancer treatment and pelvic surgery, for instance post-hysterectomy (Wall, 2012). OF is predominant in Africa with about 100,000 new cases occurring yearly (Tuncalp, et al., 2015; Wall, 2014). The event of OF in these areas is typically preceded by a long hard labour that is unrelieved because the hospital where a caesarean section could be done is out of reach, either physically, financially, or socially (Maine, 1999). Of all the maternal morbidities in sub-Saharan Africa, OF receives the most attention because it has the most debilitating effect on women's lives (Hardee & Blanc, 2012). Also, the accompanying problems are instituted by sociocultural and political conditions that perpetuate health inequities and injustices. The incidence of OF particularly in sub-Saharan Africa is an indicator of the poor state of maternal health coverage and, existing inequities in access to health care for women. The accompanying social and psychological impact of OF on the woman is an even more significant cause for concern. According to Wall (2006), these social problems can be worse than death. These issues for women are yet worsened by societal hegemonies and traditions related to reproductive health ideals and this is why Harrison (1983) described the situation as "one calamity too many".



According to the literature, there are three theories that explain why OF largely affects women in Africa: biological, economic and sociocultural explanations (Wall, 2006). The biologic theory states that African women are predisposed to dystocia and OF because their pelvis is narrower compared to Europeans (Kolawole, Adamu & Evans, 1978). Economic justifications link the high incidence of OF with poverty and poor health infrastructure: poverty creates a chain reaction that starts with malnutrition, and also acts as a driver of child marriage. Malnutrition limits pelvic expansion in girls, because although growth in height slows after menarche, the pelvic capacity continues to increase after epiphyseal growth plates are fused. Child marriage and teenage pregnancy further complicates this situation by increasing the risk of cephalopelvic disproportion and prolonged labour which in turn increases the risk of OF (Rahimi, Capes, & Ascher-Walsh, 2013; Ukwoma, 2014; Wall, 2006). While the biologic and economic factors are quite well established in the literature, the sociocultural etiological factors are complex, multifaceted and not fully represented. These factors include social constraints to skilled care access and caesarian section, low decision making power for women, folklore beliefs about the inevitability of maternal injuries, traditional beliefs about pregnancy and child birth processes, sociopolitical conditions perpetrating child marriage and so on (Umoiyoho & Inyang-Etoh, 2013). These factors are socio-politically mediated and in most cases, and are beyond the control of the individual woman.

United Nations Population Fund (UNFPA) conducted a landmark study in 2003, a facility-based needs assessment survey, in partnership with EngenderHealth. This landmark study was conducted to expound knowledge on the OF situation in 9 sub-Saharan African countries (Velez, Ramsey, & Tell 2007). What the assessments revealed is that each country has unique maternal health challenges embedded within the governing policies and societal norms and, OF is a culture based problem that is linked with broader issues of reproductive health and

social justice. United Nations (UN) agencies and partners thus motivated each country to take ownership of their policy agenda for eradication of OF. This means inculcating the policy on OF within national development plans.

UNFPA began their collaboration with African nations to develop National Policies to end OF. Nigeria and Guinea were pioneers of this development in West Africa. Nigeria is said to account for almost half of world-wide OF prevalence rates of 400,000 to 800,000 cases and a yearly incidence rate of 20,000 new cases. A report revealed that many more women are affected but are too ashamed to visit a doctor (Oduah, 2015). Thousands of cases occur each year and OF repair specialists are not able to decrease the backlog of unrepaired cases of OF though, where OF repairs have been done in the past, success rates are high reaching 90% (Hardee, Gay, & Blanc, 2012; Ijaiya et al., 2010). It has been estimated that it will take over 30 years to clear the back log of existing OF cases in Nigeria alone (Mikah et al., 2011).

Nigeria is the most populous country in Africa with a population of over 173 million (WHO, 2015). Nigeria and India alone account for one-third of global maternal deaths and while India's maternal mortality rate has reduced by 65% between 1990 and 2013, Nigeria's maternal mortality rate has only reduced by 52% within the same period (WHO, 2014). In the past two decades, United States Agency for International Development (USAID) has supported various fistula eradication institutions in Nigeria including Fistula Care and Fistula Foundation and, has provided support to 33 fistula repair and treatment sites nationwide between 2004 and 2013. Specifically, efforts have been targeted towards capacity building; institutional and human resource development for the delivery of safe motherhood with a focus on emergency obstetric care services. There has been training of over 450 Nigerian nurses and doctors to perform OF repair surgery, with more than 10,000 OF repairs preformed. Fistula Care has worked extensively in Nigeria to develop policy and support the institutionalization of OF services at the

national and state levels. In spite of these efforts, the incidence of OF in Nigeria continues to rise as population growth expands (EngenderHealth, 2016). The challenge is that surgeries are costly for most women, and some women forgo government hospitals, opting to receive care at the private, faith-based clinics. The OF center at Evangel Hospital in the city of treated thousands of women since opening in 1992. Women come to clinic, established by the Evangelical Church of West Africa, from all across Nigeria and neighboring countries (Oduah, 2015). A report showed that some of the centers operating units do not have enough beds, supplies or adequate electricity to operate (Valez Ramsey & Tell, 2007). It is ironic that Nigeria provides care to foreigners yet cannot adequately meet the needs of its citizens.

Most studies on OF are conducted in tertiary institutions (Umoiyoho, Abasiattai, & Akaiso, 2011) and interventions focus on developing OF treatment centers, provision of medical supplies, funding to ministries of health and training OF repair experts (Capes et al., 2011). These strategies can only address the problem of OF superficially. There is a failure of the global community to address the broader social determinants of health related to the OF issue. The agenda for country specific framework for solving the problem of OF cannot be effective without fully understanding the ways political discourses and social environments constitute the OF problems. Similarly, because the burden of OF is centralized within the poorest 15% of the world's population, the associated social exclusion is worsened. Affected women are exceptionally vulnerable and have been described as “the women of the bottom billion” (Wall, 2006/2014). This engenders a need to mainstream emancipatory perspectives for tackling OF issues (Cook, Dickens, & Syed, 2004; Gil-González, Carrasco-Portiño & Ruiz, 2006) and to strengthen national plans for eliminating OF (Osotimehin, 2014). It is imperative to take an emancipatory approach for critical analysis of the discourses on OF to see how OF issues are conceptualized through social policies. In line with this global agenda for country-specific

analysis, policy development and solution building, this study will examine the OF policy discourse in Nigeria, a country with the highest burden of OF in the world with close to 1 million affected women (EngenderHealth, 2003; Oduah, 2015).

### **Significance**

The Goal 3 of the sustainable development goals “towards 2030” supports integrating maternal health issues into national strategies (Open Working Group, 2014). African countries like Nigeria have adopted this vision but this agenda to strengthen individual country capacity to tackle OF has not yielded much quantifiable success partly because there are no objective measures to determine this and secondly because the policy stipulated elapses without any prior process to assess that it was fitting with broader reproductive health plans in the country. The National Strategic Framework for the Elimination of Obstetric Fistula (NSFEOF) is the main OF policy in Nigeria, it serves a political purpose and represents universal public interest on issues of OF. OF funding decisions, budgetary allocation, distribution of aid and the focus of the research community are determined from the meanings and interpretations derived from the language of this policy framework, hence this policy shapes most of the reality of women affected by OF and what is known about the issue in Nigeria. Therefore, analysis of this text will be a useful fulcrum for deconstructing the political context within which the policy was developed. Using a critical discourse analysis as a methodology, I focus on the language of the OF policy framework in Nigeria as a gateway to evaluate the OF situations and related problems in Nigeria. This analysis will serve to raise political consciousness about OF discourses as they interact with issues of reproductive justice and also offer a recommendation for future policy development.

## Objectives

- To critically analyze the language of policy discourses on OF in Nigeria
- To substantiate the dialectic relationships between the dominant discourse practices and social policy in Nigeria

In the following chapters, I present first (chapter 2) a literature review paper on the sociocultural factors related to obstetric fistula in Northern Nigeria. I discuss how the traditional beliefs and folklore practices in the Hausa ethnolinguistic community of Northern Nigeria predisposes women and girls to obstetric fistula. These practices include early marriage and early child bearing, traditional maternity and reproductive interventions and, sociocultural barriers to health access. I discuss implications for nurses and midwives, women and for policy.

In the chapter following (Chapter 3), I present findings of Critical Discourse Analysis (CDA) of the Obstetric Fistula Policy in Nigeria (National Strategic Framework for the elimination of Obstetric fistula in Nigeria). I presented a history to the OF policy context in Africa and Nigeria. I gave a description of CDA as a methodology that aims to deconstruct how text conceptualizes issues within a socio political context. The analysis of the policy followed a three step process and rigor was maintained throughout the analysis. I discussed the main findings of my analysis, including the contradictions in OF policy discourse and broader social policy. I highlighted some of the limitations to the study and the implications of my findings.

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## Chapter 2

### Abstract

#### **Background**

Obstetric fistula is a childbirth injury that disproportionately affects women in sub-Saharan Africa. Although poverty plays an important role in perpetuating obstetric fistulas, sociocultural practices has a significant influence on susceptibility to the condition.

#### **Aim**

This paper aims to review the literature on obstetric fistula in the context of Hausa ethno-lingual community of Northern Nigeria.

#### **Methods**

The literature on ‘culture’ and ‘folklore practices’ are discussed in relation to obstetric fistula among women and girls in the Hausa ethno lingual community of Northern Nigeria

#### **Discussion**

Three major cultural practices predispose Hausa women to obstetric fistulas: early marriages and early child bearing; unskilled birth attendance and female circumcision and cultural constraints to healthcare access for women in labour. A preventative approach is recommended for obstetric fistula. Recommendations include the need to redefine the role of nurses and midwives in obstetric fistula prevention. International policy should be instituted to prohibit child marriages and harmful traditional birthing practices in marginalized communities.

#### **Conclusion**

To improve health access for women, there is a need for increase political commitment and budget for health human resource distribution to underserved areas in the Hausa community.

There is also a need to advance power and voice of women to resist oppressive traditions and to

provide them with empowerment opportunities to improve their social status. The practice of traditional birth attendants can be regulated and the primary health care services strengthened.

Keywords: Birth attendance, Culture, Nigeria, Obstetric fistula, Rectovaginal fistula, Vesicovaginal fistula

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<sup>1</sup> Chapter 2 has been submitted for publication in Women and Birth

## Summary of Relevance

### **Problem**

Hausa folklore practices put women at risk for obstetric fistula.

### **What is Already Known**

Globally, early childhood marriage contributes to obstetric fistula. In addition to a high rate of early childhood marriage in Nigeria, evidence indicates that women and girls with obstetric fistula in Nigeria are delayed from accessing maternal care by factors beyond their control.

### **What this Paper Adds**

Cultural beliefs are an important contributory factor to women's predisposition to obstetric fistula among Hausas in Nigeria. There is potential for building on community strengths to resist oppressive traditions. We recommend a revolution in nurses' and midwives' role related to obstetric fistula prevention and management in northern Nigeria.

## Introduction

Obstetric fistula (OF) is a complication of childbirth that results from prolonged obstructed labour. This complication results when the presenting part of the baby is compressed within the birth canal for an extended period, leading to a tear to the vaginal wall of the woman. This tear or opening creates a link between the vagina and bladder, i.e., vesico-vaginal fistula, and/or the rectum, i.e., recto-vaginal fistula (1). The result of this is uncontrolled leakage of urine and/or faeces through the vagina. The condition may be further complicated by infection, painful rash, vaginal ulcers, scarring and stillbirths, as observed in 78-95% of cases (2, 3). Obstetric fistula affects approximately 2 million women, mostly in sub-Saharan Africa, and in Asia (1). The condition is rare in high income countries such as Europe, Australia, and North America because women are able to plan better for their births and have access to high quality maternal healthcare services during labour (4). The higher prevalence of obstetric fistula in low income countries reflects existing disparities in healthcare access for women between high and low income countries (5). This inequity requires more in-depth examination of the underlying factors that put women at risk for obstetric fistula. As one of the United Nations' Sustainable Development Goals maintains that maternal health challenges are a priority global health concern, there is an urgent need to explore the facts known about OF as presented in the research literature, and specifically its occurrence in high prevalence areas.

Obstetric fistula is most prevalent in sub-Saharan Africa fundamentally because many women and girls give birth to their babies alone or without a skilled birth attendant (4). Of all countries in sub-Sahara Africa, Nigeria has been classified as the country where women are most likely to be alone in childbirth (6), making this population of women most vulnerable to birth injuries like OF. According to the literature, women and girls in northern regions of Nigeria are particularly more predisposed to obstetric fistula because of sociocultural practices that

compromise the maternal health of women (20, 23) and the crisis situation resulting from Boko Haram terrorist attacks that limit healthcare personnel in these areas (21). In this paper we will describe first, the current state of obstetric fistula in northern Nigeria, and second, the cultural practices that influence the incidence of obstetric fistula.

### **Obstetric Fistula in Northern Nigeria**

Although Nigeria constitutes only 2% of the world's population, it accounts for 14% (40,000) of global maternal deaths, and ranks second highest after India, whose population is eight times greater (7). The maternal health of women within Nigeria differs based on geographical location. The national maternal mortality rate in 2015 was 814 deaths per 100,000 births (8) but, according to data from the Nigerian Demographic Health Survey (DHS) in 2008, women in the northeastern zone experienced a disproportionately higher mortality rate of 1549 deaths per 100,000 live births as compared to 165 deaths per 100,000 live births in southwest Nigeria (9). The incidence of obstetric fistula ranges in similar imbalance across Nigeria, with northern regions experiencing significantly more cases than the southern region. According to the most recent Demographic and Health Survey results, the occurrence of obstetric fistula in the southern region ranged between 0.2% and 0.5% among women of reproductive age, while values ranged between 0.3% and 0.8% in the northern region (10). Northern regions of Nigeria also record lower rates of assisted births, antenatal care and contraceptive use than other regions of the country, resulting in especially high incidences of birth complications in general (11). Some investigators have given economic explanations for this disparity, stating that women in the south have greater capacity to control their sexuality because they are able to monopolize trading and retain their income (12). Most assumptions about women affected by obstetric fistula in the northern region are retrieved from hospital data and obstetric fistula clinic-based surveys. The picture often painted is that women in this region are worst hit because they are poor and

illiterate and somehow powerless. Heller conducted a study in Niger, a country at the border of northern Nigeria that shares very similar traditions with respect to women in northern Nigeria. She identified that culture in this region has a crucial influence on the obstetric fistula experience. In northern Nigeria, little attention has been paid to how culture affects the maternal safety of childbearing women and girls living in these zones and predisposes them to obstetric fistula.

The Hausa ethno-lingual tribe predominates in the northern region of Nigeria. It is a Muslim-dominated region with a long-standing tradition of centralized kingship, patriarchal order and gendered division of labour (13). The Hausa are one of the largest ethnic groups in Africa, and the largest in West Africa (14). Hausa social life is organized around the family unit, which is traditionally housed within an enclosed mud-brick compound and communal home system. Studies have shown that Hausa men demonstrate strong initiative and resolve, and take risks to improve their social status and maintain their dignity (13). In the Hausa community, reproduction is the organizing principle for female social status, and the transition from teenage girl to wife may be abrupt (15). There is a marked separation of privileges by gender. The Hausa people have a tradition known as *purdah*, or wife seclusion, where women and girls once married, are confined to the household. Hausas retain faith in traditional pharmacopoeia and traditional labour interventions; their folklore beliefs often put women at risk. Evidence shows that people in the Hausa communities have not come to trust Western medicine (16).

Obstetric fistula is so commonplace in the Hausa communities of northern Nigeria that the women have composed a 'song of praise' for the condition in their local language: "Fitsari 'Dan Duniya", which translates as "Urine, the Oppressor of the World" (17). In his dissertation on this subject, Muhammad described the usual situation of an affected girl in one sentence: "destitute, illiterate, divorced and smelly teenager who has lost control of her bladder functions,

and is constantly wearing rag in between her legs during the day and wetting her bed at night”(18). This quote, appalling as it is, depicts only a part of the infirmity experienced by these women and girls. Alongside the indignity of incontinence and grief of a stillbirth (which accompanies obstetric fistula in many instances), affected women and girls are often stigmatized and isolated by their families (19). The sense of marginalization and hopelessness created by obstetric fistula is reported by Wall (20). He stated that when girls develop obstetric fistula they lie motionless in bed for long periods, frightened and hoping that the flow of urine will stop. Reeking of urine and sometimes stool, their experience of isolation is deep. They are not allowed to cook because they smell of urine and sometimes faeces. This affects their feeling of self-worth as they are unable to fulfill their role as housewife and to engage in social events. Most of them are Muslim, and because the practice of Islam requires cleanliness as a prerequisite for worship, affected women or girls are considered unclean and may be unable to participate in religious activities, hence, obstetric fistula has spiritual consequences for women and girls as well (21, 22).

Even after obstetric fistula repair, social re-integration remains a challenge for many women; because their sense of belonging is threatened, they are in need of mental rehabilitation which is often unavailable. In spite of these complexities, reports tell of the heroic efforts made by women who walk from far communities to reach obstetric fistula centers to seek treatment. Women wait in line for long periods outside such centers, demonstrating strength and resilience as they hope for effective treatment. In her photo essay, Heller describes how women in nearby Niger build community and solidarity in “spaces of waiting” (23). Some fistula survivors work as advocates with public health agencies and local women’s groups to give hope to other women. Their resilience is a crucial model and tool for psychosocial rehabilitation for themselves and for other women who deal with obstetric fistula. The risk factors that predispose Hausa women to



obstetric fistula cannot be isolated from the cultural outlook of the Hausa community. Effective prevention and treatment of obstetric fistula requires multifaceted culture-sensitive exploration in the context of Hausa tradition, to explicate the normative factors in society that perpetuate this problem and to suggest region-specific preventive strategies. Next, we review the literature on the culturally-related risk factors for obstetric fistula in the Hausa ethno-lingual culture of northern Nigeria.

### **Cultural Risk Factors for Obstetric Fistula**

Health for women and girls in Hausa communities is influenced by a complex interplay of gender-based power dynamics, societal role expectations of women, and traditional belief systems about marriage, pregnancy and childbirth (24). From our review of the literature, three main factors relating to Hausa system of folklore practices were found to put women at risk specifically for obstetric fistula. These practices are: early marriage and early child bearing; traditional birthing interventions and female circumcision; and cultural constraints to timely healthcare for women in labour—a situation that is further complicated by broader healthcare personnel resource issues in the northern region.

#### **Early marriage and early child bearing**

In Nigeria, 43 per cent of girls are married off before they are 18, despite adoption of the UNICEF Child's Right Act of 2003, which prohibits the marriage of anyone under the age of 18 (25). Scholarly articles and global reports (3, 25, 26) recognize that child marriage and early child bearing is a classic reason why obstetric fistula occurs in young women in northern Nigeria. The prevalence of child marriage is as high as 76% in the northern region, compared with 10% in southern parts, and poverty is one of its drivers (27, 28). Childbirth occurring before pelvic growth is complete leads to traumatic outcomes, and the younger the girl, the less likely

she will be able to make independent choices about her reproductive health (29). In many areas, girls are betrothed as early as age nine or at menarche to much older men (30). Although the Child's Rights Act was put in place in 2003, its implementation has been impeded by local customs of Sharia which permit the marriage of girls once they have reached menarche. The practice of child marriage results in social and financial disempowerment of women, denying them of their rights to make decisions on when to get married, when to give birth, and how, and to practice child spacing at will (3).

In a prospective comparative case study designed to identify risk factors for obstetric fistula among 80 women managed at Federal Medical Centre, Gombe, in northeastern Nigeria, 83.8% of the participants developed obstetric fistula before the age of 15 years (31). The women with obstetric fistula were married at an average age of 14 years, and 93.7% of them had experienced obstructed labour. Childbearing at this early age, combined with malnutrition in some of the cases, put girls at greater risk for cephalo-pelvic disproportion (when the capacity of the pelvis is inadequate to allow the fetus to negotiate the birth canal), increasing the risk of a birth injury.

### **Traditional birthing interventions and female circumcision**

Traditional Hausa medicine is still relied upon for labour interventions. The results of OF clinic-based surveys reveal that a good number of women rely on traditional birth attendants and women relatives to give birth (32, 33). Many of these traditional midwives use sharp objects to make incisions in the laboring woman's genitalia, making random cuts (gishiri-cutting) in attempts to expand the woman's pelvic outlet when there is an obstruction during labour (6). In traditional Hausa tribes, the Gishiri cut/ "yankan gishiri", a type 4 female genital cutting, is commonly done by traditional birth attendants to intervene in obstructed labour (16). Usually the cut is made raggedly on the anterior vaginal wall with a sharp object such as a knife or razor

blade to enlarge the birth canal. In a study conducted at Ahmadu Bello University Teaching Hospital, 30.3% of Gishiri cut victims had sustained obstetric fistula, and over half of the women who had detectable “female genital cutting” on assessment were unaware that their genitalia had been cut (34). These procedures are performed under unhygienic conditions and also put women at a high risk for infection.

Another study done in three specialist hospitals in the northern region of Nigeria revealed that ‘*yankan gishiri*’ led to 5.68% of obstetric fistula among 1372 cases of obstetric fistula patients between 2007 and 2010 (35). Female circumcision is also reported to contribute to the incidence of obstetric fistula in the Hausa community (36). In Hausa communities, type 1 female circumcision, which is limited to the clitoris, is typically done, similar to women in Sudan and Somalia, except that in Sudan and Somalia, type 3 female circumcision is done, which involves narrowing of the vaginal orifice with creation of a covering seal by cutting the labia minora and/or the labia majora, with or without removal of the clitoris (also known as infibulation) (34). Such practices have contributed to obstetric fistula for many decades, although comprehensive studies are necessary to establish the associations between female genital cutting and obstetric fistula (15, 37).

### **Cultural constraints to health access**

The international public health community set a target to have skilled attendance at 90% of all births for a 75% reduction in maternal mortality by 2015 (38), yet in Nigeria, only 35% of labours are attended by skilled personnel. This value falls even below the 50% rate in the general sub-Saharan region (39), and is in sharp contrast to the rates of 98%, 99% and 99.3% for skilled attendance in Canada, United States and Australia respectively (40, 41). Both economic and socio-cultural constraints underpin these disparities. During the Nigerian oil boom in the 1970s, free medical services increased rates of hospital births, but with the implementation of the fee-

for-service scheme at the turn of the century, institutional births in Nigeria plummeted (42).

Aside from economic factors, sociocultural constraints present a more profound barrier against women's access to skilled birth attendance. These factors are of utmost significance for nurses and midwives because they are the most amenable to health education and advocacy, and if attention is focused here, the maternal health situation of women can be transformed (38).

The sociocultural barriers against health access can be grouped under a 'three delay model', as presented by Maine: delay in seeking care; delay in reaching a facility; and delay in receiving care when the woman reaches the health facility (43). The level of autonomy that women in the northern region have for decision making on reproductive health is low, whereas women in the south enjoy more autonomy (44). The practice of *purdah* (wife seclusion) in northern Nigeria, and among the Malian population in Accra Ghana, constrains women to the home and in this practice, women are not allowed to earn a living (45). Hence, women in the northern region in Nigeria are more inclined towards experiencing delay at the first two levels (15). Delay in seeking and reaching a health facility occurs because Hausa women traditionally have limited decision making power to seek care during labour. In the north, husbands and extended family have superior control over the decision on whether or not to go to a hospital (15, 16, 46). For instance, a story is told of a woman who lived a 10 minutes' walk from the hospital, but because her husband was away on business, she could not get permission to go to a hospital. After laboring at home for several days she had a stillbirth and developed obstetric fistula (15).

Surveys carried out among Hausa groups have also revealed that labour is not considered prolonged until it has lasted beyond 2 to 4 days (17). Expressing pain in labour is considered a taboo, so an obstructed labour may go unnoticed by relatives and even sometimes health personnel. Moreover, there is a strong cultural resentment for caesarian sections and a preference for home birth, especially for first births. The traditional belief is that 'real' women give birth per

vagina. Delay in receiving care is exacerbated by the general issue of inadequate healthcare personnel in the form of health worker shortages and unequal distribution of health workers to grossly underserved zones in Hausa communities (47). Two major factors that contribute to this issue of inadequate healthcare personnel are: security threats in northern Nigeria, especially with Boko Haram terrorism; and the low education rate of the population, especially women, to train as nurses and midwives (6). Health facilities providing obstetric care in many areas are understaffed, without partograph monitoring or proper referral systems, and lack the necessary equipment and medication to intervene in obstructed labour. Unfriendly attitudes of health workers also contribute to the social barriers to health seeking among women (16).

### **Implications for Nurses and Midwives**

The high prevalence of obstetric fistula in northern Nigeria presents a challenge to nurses and midwives. The available health resources and surgery are not sufficient to curb the high incidence of obstetric fistula or even clear the backlog of women who await treatment (48, 49). Meeting the enormous physical and psychological needs of women in obstetric fistula centers places a huge burden on the nurses and midwives working in northern Nigeria. In Kano state, relatives have to assume caring roles for the women on admission because of the shortage of nurses in obstetric fistula centers (48). Obstetric fistula continues to re-occur in Hausa communities creating a burden on families, communities and the health system. Clearly, surgical management is insufficient to end obstetric fistula in this population. The root causes of obstetric fistula are embedded within broader sociocultural circumstances including poverty, low education level, and the culture of the Hausa community; and while these issues remain unchanged, the incidence of obstetric fistula will continue to rise. As World Health Organization obstetric fistula guidelines recommend, a multidisciplinary approach to OF management is required and should entail preventative strategies. Nurses and midwives need to develop social

interventions that build community capacity and utilize community-based resources to map out interventions (50).

### **Re-defining the role of nurses and midwives in Obstetric Fistula prevention**

Hitherto, the role of nurses and midwives in the elimination of obstetric fistula in northern Nigeria has been underrepresented. Obstetric fistula care is based on surgical models of intervention, and nurses and midwives have been relegated to the role of surgical team appendages. This surgical assistive role does not fully represent nurses' priority responsibility towards women affected by obstetric fistula. For instance, the principles of care reflected in the World Health Organization guiding principles for clinical management and program development centers on the role of the nurse in obstetric fistula surgery and physiotherapy, passive exercises, and reassurance during and after obstetric fistula surgery (50). All through this report, the role of the nurse is paralleled with that of a nurse's aide. The role of the nurse and the midwife in obstetric fistula care needs to be re-defined. The role of the nurse as human rights advocate and upholder of health equity needs to be upheld both in principle and in practice (51, 52). Nurses and midwives should shift to obstetric fistula prevention and advocacy by engaging actors within and outside the health sector to represent the views of marginalized women in the broader political environment.

There is a need to move from a nursing training curriculum that focuses on skills acquisition for obstetric fistula repair assistive roles to critical, literacy-based training for nurses and midwives to become conscious of their positionality as advocates for affected women. Nurses and midwives in this area can organize education and enlightenment campaigns to address the multiple cultural factors that predispose women and girls (including Hausas) to obstetric fistula (28, 53). Midwives can address the misconceptions about Western perinatal care and about OF by establishing trusting relationships with women, girls and their families in the

community in a way that appreciates the cultural sensitivities of marginalized communities.

Likewise, by engaging in home birthing assistance, family counseling and follow-up care, nurses and midwives can be better positioned to bridge the social distance between women and the care they need.

Mass-media campaigns through radio messaging have been shown to have significant impact on community mobilization for action against obstetric fistula (54-56). Nurses and midwives need to publicly declare their position on women's rights through gender activism and advocacy for empowerment of women and girls. Nurses and midwives can expand efforts to reach women and girls in their community by collaborating with and mobilizing traditional leaders, village heads, local women's groups, local government council's chairmen and religious leaders towards community action against obstetric fistula. Midwives particularly should engage men and extended families in perinatal interventions for women. Men need to recognize the important stake that they have in the health of their wives, and midwives ought to include men throughout the childbearing cycle from pre- to post-natal periods.

### **Women Empowerment**

Women themselves are a human resource to improve their social status and resist oppressive norms; this needs to be explored further. Women's voices and agency for activism to institute change in decision making for their reproductive health need to be recognized (57). Wall sheds light on the potential for collective action to resist the forces that perpetuate OF. He noted that Hausa women use 'praise songs' to build collective identity and group solidarity amidst struggle—a form of sisterhood in using their common voice to establish self-worth. By singing and maintaining persistence while waiting in line outside obstetric fistula centers these women demonstrate resilience in aiming to restore their dignity (17). The collective power of women can be used as a cultural basis for action to eliminate obstetric fistula (23, 45, 51). Nurses

and midwives have a strong advocacy role to address and question mainstream gender roles and utilize the expertise of grassroots women's organizations in promoting the rights of affected women and girls.

Change in the social system is needed to address the spatial and socio-cultural limitations against providing optimum maternal and reproductive healthcare to women and girls. The spatial limitations, which include constraints to reach a health facility due to lack of transportation, and the limited decision making power of women, can be addressed through empowerment and provision of prompt transport services for women living in the rural communities. This is not only necessary to remove economic barriers against access but is also an important tool to help women re-integrate after obstetric fistula repair. The United Nations General Assembly in 2014 put forward the idea that the best way to link marginalized women back into civil society and overcome social exclusion is to empower them with self-sustaining skills that can generate income (26). Suggested strategies include literacy workshops for basic reading and writing, vocational training, and material aid to women (24). Grassroots women's groups and fistula survivors can contribute to institutionalizing the movement against harmful traditional practices related to obstetric fistula. Local community activism groups such as that of the Federation of Muslim Women's Associations in Nigeria (FOMWAN)(58) can be expanded across communities and more women can be recruited through snowballing.

### **Policy Implications**

Obstetric fistula is a rights-based issue that requires change in the social and hegemonic hierarchal order of communities. For this to happen, women's health issues need to rise higher on the social and political agenda of Nigeria (15). Firm laws need to be put in place in northern states that protect the social and legal status of girls and women. The Childs Rights Act (that puts the age of consent for marriage at 18) should be enforced in the 13 northern states that have yet



to adopt the Act (59) so that child marriage becomes criminalized. The Nigerian constitution needs to be reformed to prohibit child marriage and harmful traditional practices that put women at risk for obstetric fistula (51). There is need for an increase in healthcare personnel in underserved regions in the northern parts of Nigeria. A useful strategy could be to further support girls and women in Nigeria to complete educational programs in nursing and midwifery in northern Nigeria. This would include educating the community, both men and women, on the vital importance of education for girls and young women. Systemic barriers such as insecurity and low job satisfaction (6) that prevent midwives from practicing in these areas need to be addressed. Policy should enable a structured, community-focused strategy for the supervision and planning of budgets and interventions for obstetric fistula prevention and management. In the meantime, while the Nigerian government plans for improvement in the supply of trained midwives to the north, an improvised remedy for the situation of midwifery shortages is required to ensure that no woman gives birth to her baby alone. This strategy could include regularizing the practice of traditional birth attendants so that they are equipped with knowledge to identify danger signs when a woman falls into labour and to make prompt referrals to appropriate health centers before complications occur (60). Midwives currently working in these communities can be a useful resource for training traditional birth attendants in the needed competence to assess women in labour in order to substitute for the shortage of health care workers (10, 61).

International work on obstetric fistula in Nigeria has centered on ad hoc measures to reduce the backlog of women and girls awaiting surgery for obstetric fistulas by providing funding for development of obstetric fistula centers and training of repair experts (48). These efforts have not been effective in addressing the broader issues related to the rights of the girl child and the need to end harmful traditional practices that perpetuate obstetric fistula. An obstetric fistula management plan that is based on long-term, sustainable interventions that are

coordinated and well-resourced requires collaborative effort. This means that international project efforts need to be diverted into the creation of inclusive international health policy networks where all nations speak with one voice on the need to develop policy to abolish gender-based inequality, child marriage, and traditional practices that are harmful to women and girls in marginalized communities. The Health and Development International model in Norway (2), already being used by the Government of Niger, could be implemented in Nigeria as part of its National Program of Reproductive Health to end obstetric fistula.

The practice of child marriage undermines international development plans and international health policy interests, and threatens the economic stability of countries where it is prevalent by extending poverty, violence, insecurity and a disregard for the rule of law. A human development perspective to ending child marriage is needed that raises the ‘end child marriage’ campaign as a priority in international diplomatic relations with Nigeria. Concerted effort is required where countries, UN agencies, the Africa Child Policy Forum, the international ‘Girls Not Brides’ campaign, ministries of health, and international organizations develop global partnerships and cooperative relations to intensify global awareness on obstetric fistula and mobilize support for action against obstetric fistula (62). Legal clarity needs to be established in the international bill of rights on the minimum age of consent for marriage across nations. This bill of rights should include policies to ensure that competent care is provided to women and girls during pregnancy and birth, and that the rights of women during pregnancy and birth are respected. Obstetric fistula prevention programs need ombudspersons that maintain operations at best levels with regular audits and monitoring to ensure ethical administration of programs and disbursement of funds (19). There should be increased funding, monitoring and evaluation of ‘end child marriage’ programs (63). Humanitarian response efforts to aid girls in crisis zones, such as in northern Nigeria, are necessary. Further research, investments and external aid are

needed to improve the sexual and reproductive health of girls in internally displaced camps who have fled from Boko Haram terrorism to other regions of Nigeria.

### **Conclusion**

Based on this review, it can be seen that obstetric fistula is a leading maternal health issue in sub-Saharan Africa, not only as a result of high levels of poverty but also because of cultural practices peculiar to these areas. The Hausa community presents a good example of a community in which women's health is challenged by multiple but understated norms and traditions of society. These practices include, but are not limited to, early marriage, early childbearing, unsafe birthing practices, and constraints to health seeking for women in labour. To address these issues from a preventative point of view, we recommend that the Childs Rights Act (59) be adopted and domesticated as state law in northern Nigeria. Community-oriented initiatives based on emancipatory models of prevention that focus on empowerment and self-liberation of women should be promoted. Nurses and midwives can and should be involved in the legalization and regulation of the practice of traditional birth attendants, by being involved in training and enlightening traditional birth attendants in the required competencies for handling childbirth emergencies. Measures should be put in place to address the terrorist crisis situations that limit human health resources in northern regions of Nigeria. Primary healthcare services should be strengthened to meet the reproductive health needs of women in Hausa communities. A moral revolution is required on the part of public health agencies and governments. Greater political attention is needed to meet the needs of women by addressing the barriers to healthcare and developing comprehensive strategies to reduce the occurrence of obstetric fistula. A genuine renewal of political commitments towards equal access to quality maternal health care for women across the globe is required in order to meet the UN's sustainable development agenda.

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## Chapter 3

### Obstetric Fistula Policy in Nigeria: A Critical Discourse Analysis

#### Abstract

##### Background

Nigeria developed a National Strategic Framework for the Elimination of Obstetric Fistula (NSFEOF) for 2011-2015. The framework has lapsed and there is no real evidence to demonstrate that the goal of eliminating obstetric fistula (OF) was met. To further inform future policy directions on obstetric fistula in Nigeria, this paper explores how the OF policy conceptualized OF issues in Nigeria to identify possible gaps in the discourse.

##### Method

A critical discourse analysis of the National strategic framework for the Elimination of Obstetric Fistula in Nigeria (NSFEOF) (2011-2015) was done. I analyzed four policies in addition to the Strategic Framework. I used the three phases of CDA as recommended by Fairclough including textual analysis, analysis of discourse practice and analysis of discursive events as instances of sociocultural practice.

##### Results

Findings from this critical discourse analysis revealed that the policy's title of elimination did not align with the content of reduction within the policy document. The overall orientation of the policy was downstream with minimal focus on prevention. Control of policy operations is centralized in biomedicine with an absence of voices of midwives in the role of prevention. OF was conceptualized as a biomedical problem rather than a social one. The style of language suggested a victim blaming and behaviour change strategy; a strategy that appeared to model the

parent Safe Motherhood Strategy. Although the policy is said to be based on social justice and equity, several rhetorical positions suggest that the Nigerian constitutional environment and justice systems makes no real provisions to protect the reproductive rights of girls in accordance with the agenda to have a justice attentive framework to eliminate obstetric fistula.

### **Conclusions**

This analysis revealed that the Nigerian constitutional environment and justice systems may be unprepared to accommodate a genuine strategy to end OF. Particularly, the constitution and Marriage Act of Nigeria needs to specify an age of consent that is consistent with the agenda of preventing obstetric fistula. Similarly, the strategies to end OF must be revolutionized with a refocus on prevention rather than reduction. A new perspective to OF must consider affected women as people capable of self-emancipation. Midwifery led community services are needed to provide skilled birth attendance for women during labour.

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<sup>2</sup> For submission to BMC journal

## Background

The most severe long-term complication of prolonged obstructed labour is obstetric fistula (OF). OF is a hole which forms in the vaginal wall linking into the bladder (vesico-vaginal fistula) or the rectum (recto-vaginal fistula) or both [1]. This condition results when labour does not progress normally, and the fetal presenting part becomes impacted within the birth canal. The vaginal soft tissue is compressed against the bony pelvis of the laboring woman for an extended period and if there is no timely intervention (such as emergency caesarian section), blood supply is cut off, and the vaginal tissue becomes necrotic. The necrotic tissue sloughs off usually within 3 to 10 days post-partum, and a hole develops in the birth canal. The result of this is uncontrollable leakage of urine, feces or both through the vagina post-partum. This condition may be further complicated by infection, vaginal ulcers, scarring and stillbirths as seen in 78-95% of cases [2-4]

Obstetric fistula disproportionately affects women and girls in low-resourced parts of the world. While precise figures are not available, it is estimated that more than 2-3.5 million girls and women live with untreated obstetric fistula with an added incidence of 50,000-100,000 new cases each year, mostly occurring in Sub-Saharan Africa and Asia. Obstetric fistula continues to affect the poorest of the poor; women and girls living in the most under-served populations till date [5, 6]. Obstetric fistula (OF) has been a maternal health concern in Africa since 2050 BC when physicians of ancient Egypt first reported the condition in literature [7]. The continued existence of this condition particularly in sub-Saharan Africa represents the failure of the global community to address the sexual and reproductive health and rights of women and girls, and to achieve equity in the distribution and access to reproductive health resources.

Nigeria is said to account for close to half of world-wide OF prevalence rates. Nigeria is said to have the highest population of child brides in Africa. About 43% of girls marry before 18 years and 17% marry before 15 years [8]. Child marriage is more popular in the North-West Region, with figures as high as 76% [9]. There are various factors that determine advancement of maternal health initiatives in many countries. These determinants are dependent on the policy environment in which obstetric fistula initiatives are operationalized. Although policy has been developed to tackle the issue, the fistula incidence has not been curbed and there has not been comprehensive strategy to measure actual progress or to analyze if interventions were appropriate within the sociopolitical context of countries. Accountability to mobilize resources, political and social systems and to reform policy initiatives to become one that is practical and workable requires an in-depth enquiry.

### **History of Global Policy on OF in Africa: The Nairobi and Cairo Agenda for Maternal Health**

The current intervention schemes to eradicate OF in Africa is historically linked to two landmark conferences. In 1987, at an international conference in Nairobi, the Safe Motherhood Initiative (SMI) was launched to deliberate the appalling state of maternal health in developing countries. The goal was set to reduce maternal mortality by three-quarters between 1990 and 2015. The second conference was held in Cairo, Egypt in 1994 - the International Conference on Population and Development (ICPD) substantiated deliberations on women's health by bringing global recognition to the reproductive rights of women and girls, declaring that it is in fact, at the heart of sustainable development. The Millennium Development Goals (MDG), particularly, MDG-5 emerged, premised on the ICPD principles and a prominent part of this agenda was the elimination of OF in Africa [10-12]. However, the goal of MDG-5 was not accomplished in many African countries and OF incidence still continue to rise.



In 2003, FistulaCare conducted a 6-year facility-based needs assessment and policy intervention project in 9 sub-Saharan African countries funded by the United Nations Population Fund (UNFPA) and implemented by EngenderHealth, in Partnership with IntraHealth International. This assessment was conducted to expound knowledge on the OF situation in each country in Africa [13]. What the assessments revealed is that OF is a culture based problem that is rooted within issues of national development and social policy. United Nations (UN) agencies and partners then motivated each country to take ownership of their respective policy agenda for eradication of OF. This meant inculcating the policy on OF within broader national development plans and poverty reduction strategies of African nations. The ultimate goal of this agenda was to establish country-specific “levels of care” model where prevention is factored into all levels of the health system in each country [14, 15]. Nigeria, Guinea, Uganda, Mali and Bangladesh are one of the first countries to develop a national framework.

Results of the mid-term evaluation of the Fistula Care project by UNFPA showed that the success in creating a collaborative network model in these countries will shape future direction of fistula prevention in other countries. However, country specific OF initiatives shows that these initiatives were modelled after the parent SMI and MDG -5 principles which basically focuses on awareness and education on reproductive health services and technical improvement in biomedical maternal and obstetric care services. These initiatives were vertical running parallel to local social and health system functioning within the countries, hence there was no true ownership of interventions and capacity building for sustainability was not achieved. The United Nations agencies made a paradigm shift from safe motherhood type initiatives that was considered weak to a more sustainable approach that is based on action for social justice and development approach which advanced into Sustainable Development Goal 5— to achieve gender equality and empower all women and girls by 2030 [16]. While global policy on maternal

health continues to shift in theory, the administration of these ideas are generically abstract as the local channels for delivering interventions to grassroots in Africa have serious challenges that are hidden from global view. Nigeria's OF policy was one of the first in West Africa, and has been a model for other African countries. Limited studies have been done on the policy context of obstetric fistula prevention and management in Africa, including Nigeria. This paper focuses on obstetric fistula policy in Nigeria, specifically through a critical discourse analysis lens.

### **Historical perspective on OF policy in Nigeria**

Nigeria is the most populous country in Africa with about 180 million people [17]. The World Health Organization currently positions the Nigerian health system at the 197th place of 200 WHO countries evaluated. Nigeria accounts for 10% of the world's maternal mortality rate in child birth whereas it constitutes only 2% world's population [18]. It is the country with the largest economy in Africa [19]. Maternal health initiatives began in Nigeria in 1990 after the Nairobi conference when Nigerian attendees organized a national Safe Motherhood conference convened by the Society for Obstetrics and Gynecology in Nigeria. After the country transitioned from military to civilian rule in 1999, political space was somewhat created to address some of the social issues related to maternal morbidities and mortalities however, this transition concurrently diffused political power making it easier to siphon public funds into private purses [20, 21].

Global attention was drawn to the obstetric fistula situation in Nigeria in 2003 when UNFPA launched the landmark campaign to End Fistula. The initiative largely focused on improving treatment supplies and supporting existing fistula centers. UNFPA collaborated with the International Society of Obstetric Fistula Surgeons (ISOFS) to develop an initial framework; a National Strategic Framework for Eradication of Fistula (NSFEOF) established between 2005 and 2010, an unpublished guideline and initial step in the establishment a cohesive Obstetric

fistula taskforce in Nigeria. ISOFS also simultaneously started the formulation of competence based training manual for fistula repair experts. This was done with a goal to reduce the incidence of obstetric fistulas by 80% and to have a 300% increase in fistula repair services between 2005 and 2010 [22]. In this period, a community screening model for OF was developed in Nigeria that was incorporated into the Nigeria Demographic and Health Survey to have a community based incidence rate calculator. Within a decade, fistula treatment rate increased from 2,000 in 2003 to 6000 repairs in 2013 [23].

After the initial framework lapsed in 2010, the Federal government developed a new policy targeted at a comprehensive approach to eliminating obstetric fistula. The policy titled National Strategic Framework for the Elimination of OF in Nigeria (2011-2015) was developed to scale up access to prevention, treatment and rehabilitation services. Although this policy initiative is a giant step in Nigeria owning its own initiative to address obstetric fistula, recent report by the UN Country Representative, UN Population Fund (UNFPA) News Agency of Nigeria (NAN) heralds that around 800,000 women still suffer from obstetric fistula and about 20,000 cases occurs yearly outnumbering the limit of the 5000 repairs done yearly.

The failure of the local policy to eliminate OF within a 10-year span demonstrated that there are intervening challenges to successful implementation. The continued rise in OF incidence indicates that the extant policy and political context of Nigeria may be unprepared to assimilate and accommodate an agenda for obstetric fistula management because of a polarized government focus. This state of affairs engenders a need for a critique of the obstetric fistula policy discourse in Nigeria within the context of related social policies to better understand the root causes of failures in policy operations. The global agenda for obstetric fistula is to strengthen country specific frameworks, and reinforce country ownership, sustainability and accountability for OF policy development and solution building for toward 2030. In line with

this agenda, this analysis, uses the existing framework for obstetric fistula in Nigeria [24], as a gateway to uncover the broader social issues related to obstetric fistula in Nigeria and to understand how the legislative environment in Nigeria and the National Reproductive plan on which the OF Policy is premised constitutes the reality of obstetric fistula in Nigeria. Using critical discourse analysis as a method, this study analyzes the language and dominant paradigms in these policies and presents a discussion on how this dominant rhetoric in discourse constructs reality of obstetric fistula in Nigeria. This study aims to explore how the language and structure of policy discourses on OF in Nigeria conceptualize the issue of OF, specifically, how the dominant paradigms in the policy text constructs the social reality of affected women.

### **Methods**

A critical discourse analysis of National Strategic Framework for the Elimination of Obstetric Fistula 2011-2015 was done. The aim of the analysis is to explore how the social reality of obstetric fistula are constructed through policy discourse. Specifically, to explore how the language of policy discourses on OF in Nigeria conceptualize the issue of OF. Critical discourse analysis (CDA) is used to examine how existing policies are used to empower or to disempower. Critical discourse analysis uses text, writing or speech as data to understand society. This approach looks at how language of text constitutes aspects of social reality and how text engages different sets of rhetorical devices that positions claims within it as authoritative [25]. Reality is assumed as multiple because it is constructed by people and social relations. Truth is subjective and meaning evolves from diverse contextual backgrounds. CDA is used to observe how language is used to justify inequality. It looks beyond the technical aspect of language and places the pieces of text in a wider political and social context [26]. It tries to establish how society is interconnected with standard ways of knowing or discourse. It also

examines how text is used to create versions of reality that allow power elites to sustain social injustice and inequality.

The language of current policy on OF in Nigeria served as a representative dataset to explore rhetoric that can provide a direction for understanding how the discourse, the problem of OF in Nigeria have evolved concurrently. The main OF policy I analyzed was written by the Vesico-Vaginal Fistula (VVF) Technical Working Group and is premised on existing National Health Development Frameworks including the National Strategic Health Development Plan 2010 to 2015 and the National Reproductive Health Policy (2001). The guiding principles of the policy is social justice and equity as declared in the 1999 constitution of the Federal Republic of Nigeria and comprehensive strategy. The policy components include an introduction to obstetric fistula in the context of maternal mortality and morbidity in Nigeria, a discussion on global policies on obstetric fistula, the policy environment in Nigeria, a situational analysis of obstetric fistula in Nigeria, problem statement and priority action areas for 2011-2015, a highlight of expected results, coordination and feedback mechanisms for tracking implementation and a monitoring and evaluation plan.

Analysis of the policy began at textual level as recommended by Fairclough [27]. (Fairclough, 2001). The initial analysis (micro-level or linguistic analysis) focused on text of the main policy on elimination of OF. I immersed myself into the policy and identified the ideas in the policy that made certain perspectives persuasive. The set of rhetoric tools on which the authoritative claims in the discourse are based was identified. Themes were identified based on emphasis or de-emphasis. Second, discourse analysis was done which involves deconstructive analysis of how the text produces situational meaning in intertextual context. At this level, I focused on word choices, semantics and grammar as rhetorical techniques of meaning making. At the macro levels (dialectic analysis), I did a social policy analysis by looking broadly into

four other policies which created the enabling environment for the main policy to be enacted. I examined trends across these 5 policies: The Nigerian constitution, the Marriage Act which is related to policy on OF, the Matrimonial Causes Act, the National Health Policy (2010-2015) and the National Reproductive Health Policy published in 2001. These social policies were used as a gate way to broaden understanding of the issues surrounding OF. This was done to reveal where undue silence or power struggles exists within texts and effects of this particularly, examining how discursive hegemonies is produced.

Methodological rigor was maintained through process of thinking and finding information from multiple sources for triangulation purpose. I met with some members of ISOFS in order to obtain some information around stakeholder involvement. Systematic analysis of text as recommended by Fairclough was done. Sampling was purposive [28] and policy text selected was a representative data indicating current policy discourse on OF. Narratives derived from text was buttressed with quotes from social policies and extant texts were selected based on relevance to the research question [29].

Critical discourse analysis acknowledges that truth is multiple. Texts were quoted verbatim within the analysis and I used contextual quotation to recover all the nuances of the discourse and the antecedents and contextual elements of the text that can contribute to its interpretation in the best possible manner to support the multiple meanings derivable from the analysis. Tools were selected and used based on research objectives [30]. For the purpose of this study, I dwelt on the dominant themes that arise from the discourse analysis, then discussed in light of my specific research questions. I did not go beyond the insights that my analysis provided and I examine findings in-depth [31]. Abstractions derived from text analysis were related with discourse in Africa.

## Results

Critical analysis of the Strategic Framework for the Elimination of Obstetric fistula in Nigeria revealed a number of rhetorical positions and discursive regimes. The main discourse identified includes: the policy seemed to have a misguided title related to elimination of obstetric fistula which did not align with the content of reduction; the approach was medicalized and was represented as targeting treatment by the Minister for health. A discourse identified is victim blaming with a focus on behavioral change. Textual analysis revealed contradiction in policy goals, misconceptualization of OF as mainly a health access issue, and the overall approach of the policy came across as a downstream approach rather than upstream.

### Downstream Approach to OF Management

The frameworks' success was measured using the yardstick of 'number of repairs done' (p. 25). Even though the framework claims to be inclusive of prevention and rehabilitation, the real focus seems to be treatment of existing cases. In this policy, this fact is conceded when it is highlighted that states do not have a uniform agreement on what reintegration entails. Similarly, in the foreword of the document the Minister for health states that:

*“the goal of this document is to provide a standard reference material that can be used to train health workers and also guide them in the provision of holistic, respectful, simple, affordable, quality and evidence-based care for obstetric fistula women that will guarantee improved quality of life for these women and their families”.* [24] (p.2)

By using the pre modified noun 'obstetric fistula women', the minister emphasizes that this framework was designed for women after they have developed OF and not for women who are yet to develop the condition.

The policy states that one of the principles on which the framework is based is: *“inter-sectoral cooperation and collaboration between the different health-related Ministries,*

*development agencies and other relevant institutions shall be strengthened*” (VVF Technical Working Group, 2012 p. 31). However, there seemed to be an over dependence on the National Health Plan’s philosophy which is hinged on health paradigms without consideration for broader social policies related to obstetric fistula, as stated in the policy: *“the National Health Plan... was developed in a fully participatory manner that involved all the key stakeholders in health – Federal, State, LGA, international and domestic partners, and civil society organizations”* [24] (p. 19).

We see here that civil society is subsumed under the umbrella of *‘stakeholders in health’* hence civic participation is used to refer back to stakeholders in health sector. The pre-modified adverb *‘fully participatory’* here is a bombastic rhetoric that appears inclusive but in practice maintains stakeholders within the realm of health sector, and global development partners. The question arises in what capacity does state governments and civil society organizations function to influence mainstream health sector and development agencies’ decision making. The lack of specificity in role of civic organizations is further explicated on another hand where the NSFEOF policy states that: *“In the last 5 years of implementation of this lapsed strategy, the Federal Ministry of Health remained in the lead in coordinating the work of multiple actors at the Federal, State, Local levels, Civil Society and international partners”* [24] (p. 13). With this statement, the framework makes the Ministry of Health the authority with the power to regulate the work of administering the end OF framework. Hence, civic participation, according to this policy, may not imply public sector participation as it maintains control of policy operations within the realm of federal government and federal ministry of health.



## Contradictions in policy Goals

### Constitution mal-aligns with OF Policy goals

Although there is a plethora of policies that the developers claimed they consulted in developing this human rights based end obstetric fistula policy, there is uncertainty as to what extent the policies align with the goals of eliminating obstetric fistula. For example, the Nigerian constitution is said to provide a foundation of social justice and equity to support the NSFEOF. However, there is a huge query on social justice provisions in the constitution.

The OF policy states: *“The Nigerian Constitution makes some provisions under sections 17 and 33-45 that are relevant to the promotion and protection of reproductive health rights”*. [24] (p.18). The use of ‘some’ here connotes vagueness in the extent that the Nigerian constitution protects the reproductive rights of girls and women.

The Nigerian constitution makes no set arrangement to prevent child marriage. The federal government is constitutionally detached from the said responsibility for protecting rights of minors, and its role is not clearly defined in the context of elimination of OF. Queries in the constitution include provisions to protect girls from early marriage.

#### Review of Nigerian Constitution

In the constitution of Nigeria, the Sharia judiciary system presides over marriages at sub-national levels particularly in Northern states of Nigeria

*262. (2) For the purpose of subsection (1) of this section, the Sharia Court of Appeal shall be competent to decide -*

*(a) any question of Islamic personal law regarding a marriage concluded in accordance with that law, including a question relating to the validity or dissolution of such a marriage or a question that depends on such a marriage and relating to family relationship or the guardianship of an infant;*

*(b) where all the parties to the proceeding are Muslims, any question of Islamic personal law regarding a marriage, including the validity or dissolution of that marriage, or regarding family relationship, a foundling or the guardianship of an infant.”*

Also, in 29(4) (b) the constitution states that: *“any woman who is married shall be deemed to be of full age”* [32].

At the same time, constitutional laws do not control regional regulations. In particular, Northern States rulings on child marriage do not align with the Federal constitution. In northern Nigeria, Islamist jurists believe that a minor can be married if she has attained menarche under Sharia law [33]. There is a concept known as ‘ij bar’ or ‘fatherly power’ where a father can force a daughter to be married [34,35] (p.10) for the purpose of preventing sexual freedom and also states that men can take up to four wives but women can have only one husband [36]. Marriage can occur at any time but, according to Sharia, consummation should only occur when the girl is matured [37]. Hence girls are given in marriage to men with the hope that these men will wait till the girls are ‘of age’ before they consummate, although men often rape the girls after being married [38].

The practice of forced marriage is popular in northern regions of Nigeria, girls are betrothed under customary law to older men as seen in the story of Wasilat Tasiu who was married off at the age of 14 years to a 35-year-old man in north east Nigeria [38]. The man raped her after tying her to a bed and releasing her the next day. She was placed on death roll after supposedly murdering him [38]. During this period, in one state in Northern Nigeria, including one girl who ran away from home the week before she was to be married and another who attempted suicide, there were 54 pending cases related to child marriage. Another girl was on death roll for a decade after setting her acclaimed husband on fire due to similar circumstances.

In sharia courts, female defendants do not have legal representation to prosecute men for rape unless there are up to four male witnesses [39]. The first Bill for juvenile justice to set age of marriage at 18 years was rejected in October 2002 [40] and also in 2016 the bill for gender parity and ending child marriage met stiff resistance from the National assembly of Nigeria on the grounds that it contradicts Islamic traditions and culture.

The use of reproductive rights serves to reconstitute the NSFEOF strategy as one that is justice attentive but it is not specific on what laws are applied to do justice. In the framework, it was stated that the legislation in particular, the Nigerian Labour Law, the Marriage Act and the Matrimonial Causes Act and constitution are controversial in the provisions they make related to reproductive health and rights of women in Nigeria as seen in the following excerpt:

*“Section 54 of the Nigerian Labour Law, Chapter 21 and Part 5 of the Criminal Code, and sections 18 of the Marriage Act as well as section 3 of the Matrimonial Causes Act contain relevant but controversial provisions related to reproductive health and rights”. [24] (p.18)*

Although the framework does not expand on what controversies there are, investigation into the Marriage Act and the Matrimonial Causes Act revealed that several rhetorical devices were also contradictory as it relates to the provisions made to protect the reproductive rights of minors especially with reference to age of consent for marriage. The Marriage Act does not stipulate and neither does the Matrimonial Causes Act prescribe a specific minimum age of consent for marriage of minors. Under section 18 of the Marriage Act there is no limit to the age given as long as there is parental approval.

***Marriage Act: Consent to Marriage in certain cases necessary section 18***

*(18) “If either party to an intended marriage, not being a Consent widower or widow, is under twenty-one years of age, the written consent of the father, or if he be dead or of*

*unsound mind or absent from Nigeria, of the mother, or if both be dead or of unsound mind or absent from Nigeria, of the guardian of such party, must be produced annexed to such affidavit as aforesaid before a license can be granted or a certificate issued”.*

***Marriage Act: Preliminaries to Marriage***

*11(b)” that each of the parties to the intended marriage (not being a widower or widow) is twenty-one years old, or that if he or she is under that age, the consent hereinafter made requisite has been obtained in writing and is annexed to such affidavit”;*

The Federal Government operates a federalist political structure and does not claim responsibility fully for the reproductive legislation at sub-national levels (protection of reproductive rights of girls by state). It gives legislative power to State House of Assemblies to proceed on matters related to Islamic and customary marriages in section 35 of the Marriage Act makes reference to native marriages stating that: *“nothing in this Act contained shall affect the validity of any marriage contracted under or in accordance with any customary law, or in any manner apply to marriages so contracted” (Section 35: Marriage Act)*. Thus, the Act legitimizes any marriage that is contracted under customary law.

In the case of Wasilat, she was tried for murdering her husband under the judiciary system and it took the intervention of the women’s rights organization for her to be released after years of being on death roll [41]. The Nigerian justice system perpetuates marriage of underage girls and the provision it makes for rights of girls is highly queried.

**Early childbearing versus Forced childbearing**

There is something fundamentally wrong with the discourse strand that attempts to detach early childbearing from early marriage as was accomplished by the rhetoric below:

*“Possible factors in the formation of obstetric fistula include static gender norms...; poverty, ignorance, illiteracy, preference for home delivery and the desire to avoid*

*Caesarean section, early childbearing (as opposed to early marriage); harmful traditional practices like “gishiri cut” low social status of women coupled with poor access to and utilization of EMOC services are other reasons proffered for the higher incidence of obstetric fistula in Nigeria. [24] (p.22)*

In the above statement the author makes it appear that conditions related to early childbearing is somehow an entity different from early child marriage when in fact within the Nigerian system, the case is the opposite. There is higher population of unwilling child brides pregnant than willing ones. In the case of Wasilat, if she had been willing to be married, she would not have to be raped. And this is the same for many other girls given in marriage without their consent.

It is important to pay attention to how issues related to early children births in Nigeria is conceptualized across other policies. Gendered causal narratives are common with issues of women’s health. In the national reproductive health policy, reproductive health problems are reduced to adolescent’s personal subscribed sexual frivolities. This is seen in the reproductive health policy which states:

*“The reproductive health status of the Nigerian adolescent is poor. Paramount among the factors responsible for the current high levels of reproductive ill- health among adolescents are the observations that for many reasons, the average age at first intercourse has declined and there is greater practice of unprotected sexual intercourse with multiple and casual partners by both boys and girls.” [42] (p. 3)*

“For many reasons” first suggests that there is multiplicity of factors and then subsequently shifts rhetoric to ‘*practice of unprotected sexual intercourse with multiple and casual partners by both boys’ and girls’* [42] (p. 3).

The reason for poor adolescent reproductive health is depicted as being a result of high rates of casual unprotected sex among adolescents. The picture is painted that girls/adolescents have chosen to have unprotected sex outside of a marriage context, with boys (like in the form of juvenile delinquency). Said this way, it appears that adolescent girls are blamed for their poor health while nothing was said for instance, about the forced child marriages and forced sexual intercourse that exist between teenage girls and older men in the northern regions of Nigeria. For example, in 2010, the Zamfara state governor in Nigeria refused to allow constitution against child marriage to be passed in the House of Assembly because he had plans to marry a 13-year-old Egyptian girl; the family of whom he paid a dowry of \$100,000 [37, 43, 44].

This ideology is listed as one of the justifications of the national reproductive health policy thus:

*“Increasing high risk behaviour of adolescent leading to premarital sexual encounters, early marriage, unintended pregnancies, unsafe abortions, and the social consequences such as school drop out with subsequent negative inter-generational effects”* (Section 1.3) [42] (p.4)

This narrative is discursively represented in the OF policy also. In the first national strategic framework 2005-2010 (an unpublished framework), it states that the policy was developed to have an integrated effort to *“improve sexual and reproductive health in the country”* p.8. While in the newer NSFEOF, gender norms are indicted for women’s poor health seeking behaviour.

*“Possible factors in the formation of obstetric fistula include static gender norms that require women to seek approval from their husbands before seeking medical care during labour; poverty, ignorance, illiteracy ...”* [24] (p.22)

Similarly, the reproductive health policy in Nigeria states that terminologies were changed from ‘maternal health’ to ‘reproductive health’ in order to have a more comprehensive

approach to maternal health issues. Sexual and reproductive health is a catchphrase that has been overused in the Safe Motherhood initiatives and has watered down the complexity of the issues. According to the frameworks, this shift to ‘reproductive health’ is an aphorism that serves to broaden the issue of women’s health but somehow the language gives primacy to more biologic definitions of women’s health. Of course when the problem is conceptualized as biologic, the solution will be viewed more from a linear biomedical perspective which will be counterintuitive to the holistic aims that the framework recognizes. Ryan states “Individuals with fistula are defined by their suffering bodies and biological existence” [45] (p.17).

These biologic conceptions of the problem have informed safe motherhood type plans which stalled because they often include technical measures to address women’s ‘suffering bodies’ with services such as emergency obstetric care supplies and fistula repair. These do not bring long-term results because the context in which these issues occur are way more complex than what linear strategies can address.

### **OF conceptualized as a health behavior issue and victim picture as image of affected women**

In the NSFEOF policy there is an emphasis on poverty and ignorance as a factor leading to OF with use of absolute statements like: “*The typical OF patient in Nigeria is best described as young, married at an early age, illiterate, poor, rural, and lacking access to ante-natal care*” [24] (p.22). This trend is seen across other the literature [7, 46-48]. This gendered stereotyping is used to establish a new hegemony in the order of discourse of OF that portrays affected women as defenseless victims who cannot access care because of ignorance.

In the opening remark by the Minister for Health (executive summary), the issue of obstetric fistula is signaled as an access issue in the statement:

*“Improving service delivery by increasing the uptake of family planning, delaying marriage and early births, increasing access to quality maternal health services are also important in the national response” [24] (p.8).*

In analyzing the rhetoric, it is difficult to comprehend how increasing ‘uptake’ translates to improving ‘service’ delivery. This statement shifts responsibility from the service provider to the user of the service; making it appear that the shortage of service provision is somehow a result of women not accessing the services. According to this statement, demand of maternal services is the problem of supply. This is a form of Gerrymandering that has gone wrong and renders itself to fallibility on many fronts. Going by the literature, within a context of Nigeria, women’s needs grossly outweighs the services available. Except, we are examining the issue from a cost accessibility point of view, in which case, services are surplus but the women cannot afford it (which is not the case in Nigeria). The case is there is limited health service, limited supplies and maternal health infrastructure. Many women do not patronize medical services because of the unsatisfactory antenatal and obstetric care they receive from grossly under motivated staff particularly working in rural areas in Nigeria [48, 49].

Again, within the framework, OF is expounded within the context of women’s access to maternity services. It combines the metaphor ‘access factor’ with ‘education factor’ to depict the reason for poor maternal health access among women.

*“Lack of education has been the bane of women in many parts of Nigeria, fueling a vicious cycle of ‘ignorance, disease and death’. The result is a compounding of the ‘access factor’ (geographic, economic and social) by the ‘lack of education factor’ which increases the risk of poor maternal outcomes in these societies” [24] (p. 28).*



## Discussion

The NSFEOF is titled elimination however, there is no data to support that the goal of elimination was being targeted. The idea of a holistic plan to eliminate OF seems idealistic but impractical given the discrepancy between the title which states ‘elimination of OF’ and the content which states ‘reduction’ of OF incidence by 50% from current level. It is not definite if the intent of the ministry of health was elimination of OF or an ad-hoc measure to curb OF prevalence in the short-term. There is a gendered victim blaming perception in the policy with a recommendation to have behaviour change programs. The introductory orientation of the policy states that the goal of the document is to guarantee improved quality of life for the ‘obstetric fistula woman’. This description and recommendation seems less ambitious and has more of a remedial tone to it.

The framework emphasizes the need for a shift from a ‘medical paradigm’ to a ‘multidisciplinary’ and ‘multisectoral’ approach to OF, as stated thus: “*The developers of the strategy noted a general desire to move from a medical paradigm for addressing fistula to a more multidisciplinary and multi-sectoral approach*” [24] (p.13). However, the general orientation of the framework suggests a medical focus and multidisciplinary perspectives were generally not evident from discourse analysis. Biomedical rationalizations of OF sustain reproductive generalizations about the causal narrative on OF. Medicalization of reproductive health can potentially make medicine an institution of social control and displaces the midwives’ role in prevention of OF. Medicalization in women’s health care is a monopoly of professional interventions, and resources by authorities who possess ‘linguistic capital’ [50]. Linguistic capital means having the power to sanction and impose a particular definition of a concept because of one’s social legitimacy. By emphasizing medical solutions as the supreme way, medicalization of OF sanctions a one-sided definition of OF and obscures potential for

solution building at social and policy levels. It blinds the analysts from seeing gendered oppression and inequality perpetuated by forces beyond the woman's reproductive body [51, 52].

This medicalized philosophy on OF positions OF within the common narrative of women's access to maternity services and fistula repair. It combines the metaphor 'access factor' with 'education factor' to depict the reason for poor maternal health access among women. In the policy, 'access' is mentioned 47 times in the context of uptake of maternal health service. The emphasis on health access fuels the motives of institutions that have interest in sustaining the discussion as a clinical issue associated with health care accessibility. This creates a medicalized hegemony wherein health care funds are diverted into new fistula market schemes. These rationalizations in the discourse gives more credibility to suggestions to improve standard of practice for fistula repair experts, medical personnel setting the nexus of research and policy development and implementation at macro levels, in the realm of biomedicine and shutting out other perspectives that may be relevant for the holistic improvement of the OF situation. This medical dominance is not an invention of this framework — it has been indicated as a trend in the global maternal health policy discourse [53-56].

In Nigeria, pockets of fistula repair camps are conducted intermittently where certain numbers of fistulas are repaired [57]. The curative fistula sites are only promising for reducing the number of women awaiting treatment but it is not a reliable strategy for elimination of OF problem. More so evidence suggests that many of the trained repair experts tend not to be committed to this field of fistula treatment for reasons related to professional development. In addition, these short-term medical treatment campaigns produce a form of inequality for those women who are in faraway communities where pocket fistula repair camps do not reach [58]. In many cases the women's voices are never heard because of the shameful and marginal circumstances they find themselves [59].

The use of stereotype language in NSFEOF associates poor health seeking with ignorance on the part of women. The use of rhetorics like “obstetric fistula woman”, “uneducated” and “ignorance” serves to pathologize women’s role and knowledge in the scheme of things; suggesting that their intellectual deficit is at the core of their OF calamity. This label connotes perpetual subjection. This labelling obscures understanding of the unique experiences of affected women and arguably shuts out other factors that constitute the woman’s subjection to OF; further disenfranchise the emancipatory capacities of affected women. Newer studies in Africa, however, challenge this common instrumental narrative of women with obstetric fistula [60-62], they suggest a need to look into the problem of obstetric fistula purposefully to describe it contextually, rather than to label it

Critical feminists [63-65] warn us to be weary of gendered ideologies on women’s health that reduce the complex nature of women’s health issues to a biologic issue. Particularly, those that point to sexual frivolity and reproductive role to rationalize women’s health. These conceptions although appeal to common-sense may be manipulated in such a way that readers do not see the cryptic forces of social oppression that play a critical role in maintaining these women’s problems as they are. For example, the language of the NSFEOF isolates early child marriage from early child birth in the Nigerian context- removing the hegemony of forced marriage from the situation of early births/adolescent pregnancy. Similarly, the reproductive health policy suggests that girls and boys in Nigeria are having casual unprotected sex. These narratives foreshadow other aspects of woman’s health especially the non-biologic understanding of maternal health challenges on how systemic oppressions and abuse are perpetrated. Further, these narratives water down the complexity of women’s health issues to mundane conceptions and limit understanding of the problem by blaming the victim and supporting linear interventions/linear intervention focus like behaviour change and awareness programs.

Victim blaming can be a tool used by government to re-embed systemic hegemonies and focus on the victim as the one who needs a behaviour change. By giving an oppressed group label to women, attention shifts from justice considerations on the issue to behaviour change model of intervention. This behaviour change model has become a gospel of safe motherhood in Africa [66-68]. Behaviour change programs are a toothless strategy when it comes to dealing with the pervasive authorities that have historically constrained reproductive power and freedom of women in African communities. In particular, the forces of paternalism in government and in law that sustain gendered discriminations against women. For example, in Nigeria, as of 2016, only 23 states of the 36 states of Nigeria have made drastic measures to sign the Child Rights Act into Law [8]. Nigeria has the highest absolute number of child brides in Africa of about 43% [69] and this has been implicated in its high rate of OF incidence especially in northern regions. The practice of child marriage has been endemic in Nigeria and there are stiff cultural and ideological supporters of the practice. As I had earlier mentioned that the Nigerian constitution and marriage act, systematically promotes early child marriage and hence early child bearing.

Sub-Saharan Africa has the highest rates of early marriage in the world. Although legal and policy interventions to outlaw early marriage and protect the girl child have been put in place by global task forces to try and set a minimum age for marriage [70], these interventions have failed to win the leadership agreement of many African countries. Many countries like Nigeria, Sudan and Guinea still have not set a minimum age of consent for marriage with parental consent [71]. Child marriage is a global problem that cuts across countries, cultures and religions. This practice hinders the attainment of the MDGs and the SDGs. It also creates barrier to international policy and diplomatic goals [72].

Detaching child marriage from childbearing is disingenuous. The uncertainties in age of consent and minimum age for marriage in the Nigerian constitution and the Marriage act is the

primary evidence that Nigerian legislative environment is inconsistent with the agenda to eliminate OF. Nigeria may be wasting public funds on strategy to eliminate fistula whilst child marriage still predominates the nation and is maintained by cultural and political hegemonies [73] (p.105).

Within the context of obstetric fistula among girls in Nigeria, it is vividly a case of married adolescents, married to older men, giving birth to babies before their reproductive organs have matured [48, 74, 75]. The literature shows that nuptial relationships are arranged under the precedence of paternalistic norms and may not have gotten consent from the girls involved [76, 77]. There is high risk of abuse because of the older husband's dominance [78] although the judiciary process makes this seem normal. Within the discourse on obstetric fistula, early child marriage is usually a precursor to early childbearing and cannot be portrayed as opposing variables within the discussion of causation of obstetric fistula among young girls especially under the notion of reproductive justice as in the case of Wasilat Tasiu and the seeming silence about the injustice to her, one authors described it as the 'victimization of victims'. A strategy that must end early childbearing has to address early child marriage with equal if not greater resolve.

Given the incoherence in the policy goals and the fact that there is no clear alignment of OF goals with the constitutional and customary law on reproductive rights of girls, the enabling legislative environment on which the NSFEOF was founded on is doubted. Likewise, there is ambivalence on what extent sub-national stakeholders in government and health systems were engaged in decision making process for developing this policy. Previous reports have shown that due to the multi-party system of government and constant reshuffling of political cabinet, and, weak health care systems, maternal health development programs lack coherence and consistence [79-81].

## Implications of Analysis

OF is more than a medical problem. It is a social problem related to rights abuse and women oppression. There is need to first deliberate how vulnerability and subjectivity of women and girls is constructed by intermeshing political and cultural practices in Nigeria that predate this new regime of reproductive rights. Future policy in Nigeria needs to consider the broader social policy and constitutional laws in Nigeria. Particularly, a specific age of consent needs to be agreed upon by the global organizations who aim to attain an end OF agenda. According to Ban Ki moon girl child marriage and gender based violence gets in the way of attaining the 2030 goal 5 of the SDGs [82]. Age of consent to marriage is key to consider for attaining policy goals because it is a reflection of education, narrowing gender gaps and economic independence. Female education should become priority in Nigeria and there needs to be equal gender representation in leadership positions and in judiciary especially in the northern states where mainly men preside in the Sharia courts.

Accessibility to fistula repair need to be defined regionally in line with the disparity in the wealth index of the country. Obstetric care services need to become concentrated in areas where women are least likely to have access to reach care. The policy to end OF needs to be aligned with other national health policies and constitution of Nigeria. A review of social policies in Africa needs to be done in order to better situate the end OF agenda into a national development agenda in African countries. Focus of funding commitment should be to mobilize political and social systems for the cause prevention of OF including developing midwifery led clinics in rural communities, training of local women to become trained as midwives. Practical steps to implement the child's rights act should be taken to protect the rights of girls and women. Stories of stereotyping are popular about African women especially on the passivity of the victims, sexually bound, and thoroughly oppressed. However, new policy analysis needs to be

done on customary laws and constitutional laws. Research into the disparate experiences of women is needed to provide valid evidence for policy planning. Also to create new definitions of reproductive emancipation for women.

Although the OF policy claims to desire a paradigm shift to social justice model, the tone of the policy appears discursively palliative rather than emancipatory. Due to the paucity of information and accurate reporting, this study was limited in its capacity to delineate who stakeholders were and in what capacity they contributed to the policy development. Likewise, the study's methodology could not shed light on how this policy was distributed to inform health decisions. There is a weak reference in the NSFEOF policy on women as stakeholders themselves in terms of resisting social injustices and oppression. A biomedical inclination is suspected in the NSFEOF policy method especially because of the medical domination and the sidelining of the midwife's role. Approaches to OF should be decentralized and should engage midwives, nurses and, women. Community based nurses and midwives should be engaged in preventive efforts towards the elimination of OF in Nigeria. It is not known how this policy has informed care of women with OF in actual reality. Media interview [83] granted by UNFPA country representative indicated however, that the federal government failed to release the budget approved for up to 3 years into the span of the policy. Owing to the temporal contingency of discourse [29], reanalysis into discourse context in Nigeria may result in a different finding but core analysis of content remains the same because the texts were quoted verbatim and detailed hence the analysis is reproducible by other analysts.

### **Conclusion**

OF is a childbirth injury that has become a global health concern. Most of the issues relate to ineffective maternal health policies and by polarized leadership and paternalistic customs in society, in government and health systems. UNFPA recommends individual country

ownership of policies to end OF in Africa. Nigeria was one of the first countries to develop an end OF policy called NSFEOF. Analysis of the NSFEOF policy however revealed some dichotomies between the OF policy to eliminate OF and the local policy situation in Nigeria. These include: a downstream approach to OF rather than an upstream approach, ambiguity in the level of participation of civic stakeholders, contradictions in policy goals, focus on curative solutions, downstream approach rather upstream; contradictions between constitutional law and customary law in the provisions they make to protect the reproductive health and rights of girls and to prevent OF. There is ambivalence in the frameworks plan that aims to address OF as a rights issue when strategies are limited to a behavior change model of intervention and poor health seeking among women rather than a problem of defective social and political relations of power. In order for global interventions to end OF to be sustainable and effective, priority prevention strategy should be the enforcement of laws against child marriage and for development of policy to educate and empower girls and women. The UN initiative to have country ownership of the OF policy has kicked off with an unclear alignment in policies. Nigeria's health systems and constitutional environments are not prepared to accommodate a comprehensive end OF agenda.



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## Chapter 4

### Conclusion

#### Introduction

Obstetric fistula is a maternal morbidity that is particularly high in sub-Saharan Africa because patriarchal traditions and androcentric policies preclude women's ability to control their birthing experiences and exercise reproductive autonomy. Women with OF experience extreme vulnerability in many aspects due to their marginal social status and the offensive reek associated with the pathology (Ijaiya et al., 2010). As a part of Safe motherhood mission, United Nations Population Fund (UNFPA) have supported OF repairs in African countries for up to two decades (EngenderHealth, 2016). In spite of series of interventions and campaigns, the incidence of OF continues to rise. A landmark study conducted in 9 sub-Saharan African countries revealed that each country's social and political atmosphere shape the OF situation (Valez, Ramsey & Tell, 2007). UNFPA then motivated each country to develop individual policies to eliminate OF that fits with national development plans and programs.

Nigeria, a country with one of the world's largest incidence of OF (Oduah, 2015) was first to own this vision in West Africa. Nigeria's northern region has disproportionately higher incidence of OF than southern regions owing to cultural practices that predispose girls and women to OF (Muhammad, 2011). Nigeria developed its first National OF policy in 2005. The second policy was developed between 2011 and 2015. This policy was titled National Strategic Framework for the Elimination of Obstetric Fistula (NSFEOF). In spite of having this policy, Nigeria continues to record high incidence of OF of about 20, 000 cases a year (VVF Technical Working Group, 2012). The sociopolitical discourse on which the OF policy is operationalized in Nigeria is not explicated in literature. In line with the global agenda to strengthen country capacity for eliminating OF, this study utilized two approaches to explore the policy context of

OF. First, a literature review was done to explore some of the cultural practices and beliefs that are associated with higher incidence of OF among Hausa ethno lingual community in Northern Regions. Implications for policy, for nurses and midwives and for women were discussed.

Following this, a critical discourse analysis of the NSFEOF was conducted. This purpose of this analysis was to explore how the policy discourse shapes the OF situation in Nigeria.

### **Key Findings**

From the review of the literature on predisposing factors to OF among Hausa women and girls in Northern Nigeria, it was found that gendered beliefs on how a woman or girl should go through pregnancy and childbirth in general contributed to the threats to maternal health and safety of Hausa women. These ideologies were paternalistic in nature. Early marriage was a predominant practice that is notorious for causing OF. In addition, folklore practices including '*yankan gishiri*' (female genital cutting), '*purdah*' (wife seclusion) all constitute ideological and spatial barriers to health care accessibility for Hausa women during labour, inadvertently predisposing women to OF.

The results of the critical discourse analysis of policy documents revealed similar but broader, more complex issues. There were several interesting dichotomies between the policy discourses related to OF in Nigeria. Analysis revealed victim stereotyping of women similar to the common narrative of subjection and powerlessness associated with the discourse on maternal problems in Africa. Medical dominance was speculated with a focus on OF as a 'reproductive health' issue rather than a social problem. There was noticeable silence on the role of midwives in prevention of OF. Dialectic analysis revealed conflicting associations between social policies and agenda to eliminate obstetric fistula. The policy language was palliative rather than emancipatory, this contradicted the social justice aims of the policy initiative. There were obscurities in the social justice provisions of constitutional law, the Marriage Act and

Matrimonial Causes and Customary law in Nigeria. A most outstanding finding was the deliberate detachment of early marriage from early childbearing in the discourse on predictors of OF (VVF Technical Working Group. 2012, p.22). This stylized gerrymandering along with other contradictions in discourse demonstrate that the discourse of child marriage which has been implicated in OF globally is being sidelined in the OF policy discourse. There is need for further investigation on this.

The general trend on OF management in Nigeria does not currently seem promising. The results of this research project supported findings from the literature that child marriage is an important risk factor to obstetric fistula. It also demonstrated that OF policy discourses did not highlight this aspect of the issue, instead, it focused on gendered stereotyping of affected women. Most of what was emphasized included limitations to health access, ignorance on the part of women and the need for a behavior change approach to OF. This approach is typical of the Safe Motherhood doctrine of maternal health initiatives in Africa. Contrary to general belief that OF is a problem of low socioeconomic status and ignorance of women in Africa, this study revealed gendered power differentials in the policy arena in Nigeria that skews the causal narrative of OF in a medicalized direction and marginalizes the broader social determinants related to OF. The overall challenges are broad and women and girls have no voice in the discourse.

### **Implications**

There is need to change the approach to OF from a downstream palliative approach to a holistic social justice based approach that measures to all the understated issues that marginalizes women's voices and violates the reproductive rights of women and girls in Nigeria. This foreseeable change has implications for research, for policy and for nursing practice.

## **Research**

There is need for further research on how policy discourses shape broader societal discourses on maternal health in Nigeria and the rest of Africa. Community based participatory action research that engages multidisciplinary team members, community members and religious leaders can serve as a cultural basis for action to be tapped on to improve maternal health in Northern Nigeria. Relevant research should be commissioned to evaluate outcomes of previous policies, and identify gaps and challenges of implementation systems for OF policies and to determine future directions of the post 2015 OF policy for Nigeria. A comprehensive needs assessment and stakeholder engagement should be done regionally to develop an evidence based intervention and evaluation strategy for policy. An evidence based approach to address the multiple social determinants of health from a preventative perspective is crucial to ending OF.

## **Policy**

Several lapses exist in the Nigerian policy context (as identified from policy analysis), particularly on the provisions it makes to protect the rights of girls. Based on existing literature on forced marriage of girls in northern Nigeria and the contradictions between Sharia law and the reproductive justice for girls, it is imperative to take a human rights approach to the problem of OF and to policy development on the issue. International research committees, legal scholars and global human rights organizations should jointly support the transformation of constitutional laws, legal and judiciary systems in Nigeria. The Nigerian government should over ride all customary laws within all states that violate the rights of young girls and women. Also important, is the need to have more women in leadership and government offices in Nigeria to avoid biased laws from being endorsed by the predominantly male members of the National Assembly in Nigeria. The Marriage Act, Matrimonial Causes Act and the Constitutional law in

Nigeria need to be reformed to make appropriate provisions to protect girls and women from sexual, reproductive and maternal injustices.

### **Nursing practice**

The preventive aspect in obstetric fistula care is lacking. There is a huge opportunity for nurses to influence change in maternal health policy in Nigeria. Nurses and midwives should become active in interdisciplinary work with the VVF Technical Working Group to mobilize fistula survivors and grassroots organizations in civil society to begin a social movement for placing the bill for ending OF and related maternal morbidities on the national agenda. Critical education and research is recommended to leverage nursing knowledge for the purpose of challenging dominant social practice and to query entrenched hegemonies that perpetuate gender based subjection, economic subordination and social vulnerability of women in Nigeria. Family centered care is recommended involving participatory framework with husbands, in-laws and women that provides opportunity for nurses to develop trusting relationships with families and educate families on importance of having professional maternity care for women during labour.

In summary, the androcentric influences in northern communities in Nigeria and medicalized and politicized hegemonies in OF policy discourse needs to be counterbalanced by the voices and resistance of affected women themselves and the actions of global human rights advocates. A strategy to monitor funding provisions and to ensure accountability of all stakeholders particularly government leaders to direct funds to appropriate women's needs is recommended. The post 2015 strategy to end OF should be towards public policy advocacy on issues of power and agency of affected women and how this can create a basis for action. The road to building country capacity to end OF and related maternal morbidities requires the global human rights advocacy community to address the patriarchal elements in African states legislature that compromise reproductive health and sexual freedom of girls and women.

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