Moderating Influence of Intervention Programs on the Relationships between Psychosocial factors and Therapeutic Behaviour of Obstetric Fistula Patients in North-west Nigeria: A Proposed Conceptual Framework

Faruk U. Abubakar*, Muhammad Anka Nasiru#

Department of Nursing Sciences, College of Health Sciences, Usmanu Danfodiyo University Sokoto, Nigeria

Abstract—The strategic objective of this study is to make available a visual framework that graphically describes some selected constructs of intervention programs, psychosocial factors, and therapeutic behavior among obstetric fistula patients in northern Nigeria. Explicitly, this study proposed a research framework that, when authenticated, it will go further to assess the seeming association among the key constructs under study. In order to offer a solution to the research problem stated by this paper, this study will, in due course, employ mixed methods research design (pragmatism). The research consists of five basic constructs in the proposed framework that, when validated, the constructs will be used to evaluate the influence of intervention programs, combined with psychosocial factors in motivating obstetric fistula women to participate in therapy. In the proposed conceptual framework, the key constructs that strive for validation comprise therapeutic behavior, intervention programs, decision-making, the attitude of health personnel, and social support.

Keywords: Therapeutic behavior, intervention programs, decision-making, attitude of health personnel, social support.

I. INTRODUCTION

Obstetric fistulas come about mainly because of prolonged obstructed labor ([35]-[39]). Labor becomes prolonged when a woman takes longer than 24 hours to deliver a child [35]. A significant complication of prolonged labor is the occurrence of birth-related injury communicating the vagina and urinary bladder (VVF or vesicovaginal fistula) or vagina and rectum (RVF or rectovaginal fistula), leading to uncontrolled escape of urine and feces through the vagina, aggressive odor, and other social, physical, medical, and psychological problems ([6], [12]-[35]).

Worldwide, obstetric fistula disease distresses more than 2-3 million women ([35]-[6]), with an estimated 50,000-100,000 afflicted individuals with the disease every year, generally in unindustrialized nations including Nigeria ([25]-[35]). In the case of Nigeria, an estimate shows that there are about 800,000-1,000,000 victims of the obstetric fistula disease, with nearly 20,000 new cases suffering from the condition annually ([35]-[25]). Northern Nigeria alone has more than 700,000 cases of obstetric fistula, accounting for nearly 70 percent of the figure of the disease in Nigeria, with an average 2 to 5 cases occurring among every 1,000 delivery compared to 0.44 cases for every 1,000 birth in Southern Nigeria ([16]-[24]).

It is important to note, despite an enormous number of patients with obstetric fistula in Nigeria, only around 4,000-5,000 repairs were carried out each year, which further makes the disease situation worse ([16]-[24]). In recent times, a report from the Federal Ministry of Health, Nigeria, shows that the inability of most significant number of states in northern Nigeria to eradicate obstetric fistula could be related to several psychosocial factors, such as reduced health infrastructure, inadequate training of health professionals, and ignorance on the treatability of the disease on the part of the victims among others [16]. Furthermore, and more importantly, obstetric fistula may have persisted in Nigeria perhaps, because most victims of the disease were unable to try to find help from competent health professionals; which could be due to some fundamental issues, such as decision-making ([35]-[16]), attitude of health personnel [20], social support [36], and transportation [1]. Conversely, several scholars ([5]-[23]) contend that the factors mentioned in the preceding discussion are not related to the inability of the obstetric fistula patients to seek for healthcare services.

According to references[8]and [20],a moderator variable can be introduced in a study if the relationships between independent and dependent variables are inconsistent, weak or if there is evidence that previous intervention programs have not been active or are weak. Therefore, the above scenarios created a "gap" in knowledge, which will be filled by this study through the introduction of a "moderator" to strengthen the relationship between the predictors and outcome, which will be the first contribution of the subsequent study.

Based on the preceding discussion, there are few studies
patients, are beginning to appreciate the construct as an
important part of their way of life. Additionally, the
significance of therapeutic behavior was discovered by
reference [36], who contends that the health personnel must
understand various psychosocial factors, and more
importantly, the moderating factors which influence peoples’
decision to seek therapy.

2.2 Psychosocial factors and therapeutic behavior:

The Psychosocial factors imply to those psychological and
social elements that can influence the therapeutic behavior of
the individuals in the society ([18]-[4]). Furthermore, the
concept of psychosocial factors is also defined as essentials
that could positively influence people with specific health
challenges to take part in therapy. According to reference [9],
among the most significant prominent perceived psychosocial
factors that positively influence therapeutic behavior include
but are not limited to decision-making, the attitude of health
professionals, social support, and transportation.

As a result, based on the numerous definitions of the
concept of psychosocial factors influencing therapeutic
behavior in the preceding discussion, this study examined the
influences the construct may have when combined with the
moderator (rehabilitation and campaign) to motivate women
who contract obstetric fistula disease to seek cure in the
selected states of north-west Nigeria.

2.2.1: Decision-Making:

Decision-making entails to a situation where women and
men have relatively equal chances in engagement into
discussions concerning matters affecting them and the family
([11]-[23]). Women’s participation in decision-making has a
remarkable advantage, in that, in a society where women
participate in important decisions affecting their lives and
families; there are high chances of improving the health and
economy of that society ([11]-[23]). Conversely, reduced
decision-making power available to women may result in the
violation of their health and other fundamental human rights
[23].

Several studies have examined the influence of decision-
making on therapeutic behavior of obstetric fistula patients
([11], [19]-[25]). For example, in Tanzania, lack of decision-
making power available to women was observed to have
inhibited women’s participation in health intervention
programs. The preceding study further observed that in most
rural communities where bulk of the patients came from they
could not take decisions regarding their health or that of their
children. That, for the patients to seek health care services;
they have to seek permission from the husband or his family,
even in dire situations [19]. Furthermore, investigation by
reference [16] shows that VVF disease is preventable but the
problem is getting worse because majority of the rural women
in Nigeria are powerless; whose fortification of rights is not
sufficient but were left to face the rage of gender disparity
especially while determining on when and how to access
health care facilities.
Furthermore, studies that examined the impact of women's decision-making power on therapeutic behavior among patients have reported inconsistencies in their findings. So, for instance, reference [7] stated that in Nigeria, only 10-12 percent of women in northern Nigeria participate in decision-making affecting their health, compared to 50 percent in southern Nigeria. Conversely, reference [29] stated that the majority of women in Nigeria lack decision-making power to participate in treatment. Also, reference [23] reported mixed findings in their studies concerning decision-making in four nations, which reveals that the majority of women in India and Nepal controlled decision-making autonomy to partake in cure treatment. On the other hand, in Kenya and Namibia, the study shows that a majority of women in rural communities do not have decision-making power, which affects their participation in seeking healthcare facilities.

In line with the previous studies, reference [7] in his examination of decision-making as a factor that inhibits seeking for healthcare services suggested further studies to focus on how problem of decision-making affects participation in health intervention programs in another social context, as well as the necessity for evaluating the development in health inequalities in such new environments. Again, the majority of the previous studies employed either qualitative or quantitative methods to examine decision-making, which creates a methodological gap, which can be filled using mixed-method research design, in line with the views of references [14] and [28].

Thus, this study employed decision-making as one of the study's construct to discover its relationship with therapeutic behavior among obstetric fistula patients in northern Nigeria. Moreover, the construct of the attitude of health personnel involves relating with the patients through being friendly, respectful, and polite, among others ([20]-[26]). On the other hand, the concept involves behaving negatively towards the patients in a manner that depicts staff as being cruel, abusive, and rude as well as staff discharging their duties without fairness [26].

The attitude of healthcare personnel as a concept is essential for a positive attitude aids to promote interpersonal communication among the patient and the healthcare providers; this ultimately helps to offer quality healthcare facilities to the sick persons [20]. On the other hand, the negative attitudes of healthcare personnel create an unhealthy gap and barrier to seeking treatment [21]. Also, poor relationships, particularly between health care providers and women patients, could hamper the transfer of information that such pregnant women may require for healthy development and that of the unborn child ([20]-[26]). The information might include one about nutrition, family planning, pre and post-delivery preparations among others ([20]-[26]). Also, showing negative attitudes by the health personnel might result in further social and psychological injury to people with health issues; subsequently, this could have adverse consequences on their therapeutic behavior [20].

Several studies on the attitude of health personnel show some inconsistent findings. For example, a study comparing attitudes of trained staff midwives in government and private missionary hospitals in Oyo, Nigeria, reported contradicting findings [2]. The result of the study shows that because of the staff's positive attitude in the private missionary hospital, women frequently visit the clinic for delivery: although the clinic is not well equipped [2]. Conversely, the study found that because of the staff's negative attitude in a government hospital, only a few people visit the clinic for delivery. The decline in participation at the health center happened even though the government hospital is more equipped than a private missionary hospital. What is perplexing is that these staff received training at the same school, so the inconsistency is baffling [2]. Additionally, reference [18] indicated that negative staff attitude prevents the participation of pregnant women in treatment in rural Pakistan.

Furthermore, a study in some selected Zambian hospitals utilizing 86 sampled women for antenatal care, labor, and those undergoing abortion indicated that the attitude of most of the healthcare providers in the area is positive [22]. Similarly, a study in Bangladesh suggests that health personnel attitude is right because the workers continually assess the health conditions of the sick in the hospital; they serve medicine at the right time and sometimes offer financial assistance to the clients [3]. Similarly, a study in four South African regions using 187 sample size reports that over 65 percent of the respondents reported that they visit the antenatal care unit to seek for treatment because the health workers are friendly [33]. Again, the respondents stated that anytime they are visiting the health center, they feel relaxed.
community among others ([34]-[37]). Social support is provided to an individual by the fellow’s family, friends and community among others. Social support denotes the material and emotional support between the attitude of health personnel and therapeutic behavior. H4: Intervention programs moderate the relationships among obstetric fistula patients in northern Nigeria.

H3: Attitude of health personnel is positively related to therapeutic behavior among obstetric fistula patients in northern Nigeria.

H5: Social support is positively related to therapeutic behavior among obstetric fistula patients in northern Nigeria.

H6: Intervention programs moderate the relationships between social support and therapeutic behavior among obstetric fistula patients.

III. RESEARCH FRAMEWORK

The Literature reviewed related to the constructs of interest to this study proposed a relationship between psychosocial factors and therapeutic behavior among obstetric fistula patients. Precisely, earlier studies ([7],[11],[23],[18],[29],[33], [3],[12],[21],[15]-[36])...
hypothesizes the direct relationships between decision-making, attitude of health personnel, and social support, as seeming factors that influences therapeutic behavior as specified in figure 1. Likewise, the scholars hypothesized the moderating effects of intervention programs on the relationships between the predictors (decision-making, the attitude of health personnel & social support), and the outcome (therapeutic behavior). Additionally, the theory of planned behavior (TPB) and the health beliefs model (HBM) made assumptions concerning direct and indirect associations between the constructs of the study. In the direct relationship, the TPB suggests that the more favorable the attitude (A), subjective norms (SN) and perceived behavioral control (PBC) the robust the therapeutic behavior among obstetric fistula patients. On the contrary, the less favorable the individual’s attitude to seek for a cure, the less favorable the opinions of significant others and the less than individual beliefs about their abilities, power, and control over the search for medical help the lesser the patients seek for therapy. Furthermore, in the indirect relationship, the HBM argues that the threat of disease and perceived benefits of therapy push the individual patients to address psychosocial factors, utilize appropriate intervention programs, which further boost therapeutic behavior.

Consequently, as soon as the five adapted constructs proposed by this framework (as shown in figure 1), are validated in this study, they will be employed for further study in a new social context in northern Nigeria. Also, the successive study will use a robust methodological orientation (pragmatism) and method (quantitative and qualitative) as well as the introduction of a moderator (intervention programs) in a single study in order to assess the influence of a moderator when combined with psychosocial factors in strengthening the therapeutic behavior of vesicovaginal and rectovaginal fistula patients in northern Nigeria.

IV. CONCLUSION AND RECOMMENDATION

Finally, this study intended to assess and validate the constructs on the subject of moderating effects of intervention programs on the relationships between psychosocial factors and therapeutic behavior among the obstetric fistula patients in northern Nigeria. Meanwhile, this study has provided a theoretical framework that could serve as a model for reference to researchers that aspire to carry out a study in the future concerning how intervention programs combined with psychosocial factors could strengthen medical help-seeking among patients with obstetric fistula in Nigeria. As a result, when this proposed conceptual framework is endorsed, its results will make available critical contributions to literature for policymakers on health, health practitioners and researchers among others to make the right decisions for the overall improvement of human society.

For the time being, the drawback of the other conceptual framework of this study is its inability to include a mediating relationship coupled with its use of few psychosocial variables. Consequently, the study recommends that mediators and additional psychosocial variables be included in the existing model for more authentications.

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REFERENCES

and India. International journal of women's health, 2012; 4,
role of gender inequities in women's access to reproductive
providers in interactions with clients: a systematic review.
[24] Newswatch VVF prevalence soars in Nigeria. 2013, pp. 3-4
[34] Upton, D. & Upton, P.Friends, and social support: psychology of healing. 2015, pp. 56-61