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Influence of Abandonment, Stigmatization and Social Isolation on the Coping Strategies of Women with Vesico Vaginal Fistula in Akwa Ibom State, Nigeria

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Abstract

Women in the developing world are experiencing "unimaginable suffering" due to lack of effective care during pregnancy and childbirth as many end up with debilitating injuries such as Vesico Vaginal Fistula (VVF). VVF is an abnormal communication between the urinary bladder and the vagina that results in the continuous involuntary discharge of urine. Most women affected are living in shame and isolation, often abandoned by their husbands and relatives. The aim of this study was to assess the extent to which abandonment, social isolation and stigmatization significantly influence the coping strategies of women affected by VVF in Akwa Ibom State, Nigeria. The study adopted Ex- post Facto design using mixed method of quantitative and qualitative approach. Transactional model of stress and coping directed the study. A sample of 120 VVF women (inpatients and outpatients), 18 VVF women coming back for follow-up care after repairs and 3 key informants were purposively selected for the study. Instruments for data collection were structured interview guide and in-depth (unstructured) interview. Regression analyses was used for quantitative data analysis and verbatim transcription/coding for qualitative with result presented in themes. The results showed that the three independent variables were significant predictors of coping strategies of VVF women in the area of study, with abandonment and stigmatization having a high influence though with a negative coefficient while social isolation exerted a weak influence. This implied that the more abandoned and stigmatized the VVF women, the less active their coping abilities while social isolation exerted less influence on their coping strategies. The study concluded that there exist a significant influence of abandonment stigmatization and social isolation on the coping strategies of VVF affected women.

Keywords: Abandonment; Stigmatization; Social Isolation; Coping Strategies; Women; Vesico Vaginal Fistula

Introduction

Women in the developing world, are experiencing "unimaginable suffering" due to lack of effective care during pregnancy and childbirth. Non-fatal maternal childbirth injuries such as Vesico Vaginal Fistula (VVF) often have devastating psychological and social consequences with an impact greater than maternal death. Vesico Vaginal Fistula is an abnormal communication between the urinary bladder and the vagina that results in the continuous involuntary discharge of urine [1], leaving the victims with tremendous psycho-social and health consequences. The uncontrolled urine leakage causing unpleasant odour results in social stigma and consequent neglect. Most women affected are living in shame and isolation, often abandoned by their husbands and excluded by their families and communities [2].

According to UNFPA [3], in Sub-Saharan Africa alone between 3,000 and 130,000 of women giving birth develop fistula each year. Other estimates indicate that there are approximately 73,000 new cases per year. Adequate population-based epidemiological data on obstetric fistula is lacking due to the historic neglect of this condition since it was mostly eradicated in developed nations. Available data are estimations that should be viewed with caution [4]. The prevalence of VVF is much lower in places that discourage early marriage, encourage and provide general education for women, and grant women access to family planning and skilled medical teams to assist during childbirth [5], hence the burden of VVF rests largely on the women poor rural communities of the world and its severe nature puts a serious toll on the lives of those affected. This condition is so enormous and thus ravages Nigerian women that the country's Federal Minister for Women Affairs and Youth Development estimated that the number of untreated VVFs in Nigeria stands between 80,000 and 1,00,000 [1]. Majority of the victims are very young and without the basic elementary education [6]. Most of them find it difficult to engage in any economic activity, surviving the hardship is very complicated and pathetic as coping is done in isolation and loneliness.

Dejong [7], observed that despite the severity of this health condition, most studies on fistula focus on treatment and repair, therefore limiting knowledge on the magnitude, psycho-social consequences and their influence on the coping strategies of the women affected. This study was therefore designed to specifically address the following questions; is there any significant influence of abandonment, social isolations, and stigmatization on the coping strategies of women affected by VVF in Akwa Ibom State, Nigeria?

Various studies reviewed have confirmed that most women living with VVF are faced with various psychological and social consequences. They may have to cope with pain, abandonment, isolation and stigma, not only from the community but also from their loved ones [8,9]. According to Teunissen et al. [10], two main strategies have been identified by which affected victims adopt to effectively cope with life. These are: Active coping and passive coping.

In active coping, victims engage in close associations with people whom they share stigma problem(s). They derive great relief from being with their likes. UNFPA [11] refers to this as "a sisterhood of sufferings". This circle gives them a high sense of belonging to live with their disabilities. Some resort to fighting the disease rather than losing hope. Some also engage in various trades and crafts for survival. They may spend months or years saving money in order to pay for medical care. Women's Dignity Project and Engender Health [8] observed that following successful fistula repairs women resume normal lives and are able to work freely with their families, friends and communities. USAID has programs that support the social reintegration of women with fistula through teaching basic literacy and income generating skills to make them regain their self-respect and rebuild relationships towards reintegration into their communities [12]. Passive coping is when VVF victims adopt the principle of subtlety (or passively) hiding themselves away from the others because of humiliation. Some who suffer from stigma would rather be alone until they are able to find treatment. This might lead them into deep physical and emotional decline and may resort to suicide [11].

The transactional model of stress and coping propounded by Lazarus [13], adopted to direct the study, is a framework for evaluating the processes of coping with stressful events. According to same source, stressors are demands made by the internal or external environment that upset balance, thus affecting physical and psychological well-being and requiring action to restore balance [14]. This is mediated firstly by the person's appraisal of the stressor and secondly on the social and cultural resources at his or her disposal (p20). Secondary appraisals address what one can do about the situation. Actual coping efforts aimed at regulation of problem give rise to outcomes of the coping process [15].

Methodology

Design

The study adopted Ex-post Facto research design, using mixed method approach. Ex-post literally means "after the fact". This design is considered most suitable as the researcher identifies events that have already occurred or conditions that are already present and then collects data to investigate a possible relationship between these factors and subsequent behaviours. In this study, Vesico Vaginal Fistula (VVF) had already occurred and the psychosocial impact on the women affected already experienced hence the independent variable cannot be manipulated. The study which spanned over the period of three (3) months (90 days) provided an in-depth exploration of the influence of abandonment, stigmatization and social isolation on the coping strategies of the women affected by VVF.

Study setting

The study was conducted in Family Life Centre and Hospital, Mbribit Itam in Akwa Ibom State. It is faith-based, established and managed by the Roman Catholic Church. The centre offers treatment and care to VVF victims across the country. Administratively, the centre is managed by the medical missionaries of Mary in Drogheda, Ireland. They are the principal donor for the survival of the centre.

Population

The population of study comprised 120 women (selected from in-patients and out-patients) coming to seek VVF treatment in the centre. They were engaged in the structured interview. Interview was most appropriate for this study because majority of the respondents were illiterate, hence questions were read out to the respondents and responses recorded. 18 discharged VVF women coming for follow-up were engaged in an in-depth interview and 3 key informants (matron in charge of administration, outpatient department and the ward) who had served in the centre for not less than three (3) years were also involved in the study. They gave information based on their experiences in the centre.

Sampling

Purposive sampling was employed to select the participants. This type of sample is based on the judgement of the researchers, in that a sample is composed of elements that contain the most characteristics, representative or typical attributes of the population that serve the purpose of the study best [16-18]. Selected participants fulfilled the inclusion criteria which in this case were those who had suffered VVF for not less than six (6) months and were willing to share their experiences relating to coping strategies [19].

Data collection

Data collection was through structured interview schedule (quantitative) and in-depth (unstructured) interview guide (qualitative). The structured interview schedule consisted of 3 sections. Section A covered the demographic characteristics of the respondents and comprised nine (9) items. Section B comprised nine (9) items which elicited responses on the respondents' reproductive history. Section C elicited responses on psychological consequences of VVF and comprised nine (9) items for abandonment, five (5) items for stigmatization and eight (8) items for social isolation. Section D was further divided into two sub-sections (passive and active coping) comprising eight (8) items each and 4-point Likert Scale type was used to elicit responses on respondents coping strategies. All positively worded items were scored 4 to 1 for Not Agreed to Strongly Agreed, while all negatively worded items were scored 1 to 4, with the mean score expected per variable being 8 and 32.

Validity of the instrument

The instruments for the quantitative data were constructed by the researchers, validated by one of the authors (A professional Measurement and Evaluation expert) and scrutinized by the ethical committee of Family Life VVF Centre, based on the relevance of the item to the objective of the study.

Reliability of the instrument

Reliability refers to the degree of consistency with which an instrument measures what it is supposed to measure over time [20]. The reliability of the structured interview schedule was determined through a trial testing. This involved administering the instruments to ten (10) in- patients (those who went through prolonged obstructed labour) in post natal ward of St Luke's hospital, Anua, Uyo. After one week interval, copies of the same instrument were administered on the same respondents. The indices of the test-retest reliability estimate of

the scale on the instrument was 0.9 and this was adjudged high enough for generating actual data for the study.

The in-depth interview guide was used to collect qualitative data. The researchers explained the purpose and format of the interview to each participant and consent obtained for the interview and the use of a tape-recorder. The BATH technique model was adopted in the interview process with the respondents. This model is a brief psychotherapeutic method that addresses the individual's background issues, affects and most troubling problem, followed by a demonstration of empathy by the researcher [21]. Each interview took approximately sixty minutes [22]. The interview guide for the (3) key informants explored the psychosocial consequences VVF women were exposed to in the centre, their coping strategies and the coping mechanisms in place in this centre to assist them.

Trustworthiness

Trustworthiness in respect of the qualitative interviews was enhanced by the fact that the interview guide was reviewed after the first interview, which also served as a pre-test and was excluded from the study. Following the transcription by the researcher of the tape-recorded interviews, each participant was given the opportunity to review the transcription and was asked to confirm whether that was a true reflection of what she had recounted to the researcher.

Credibility was protected by the prolonged engagement of the researchers in the field, for a period of 90 days. The researchers maintained an audit trail in order to secure procedural dependability by keeping a meticulous record of the raw data in the form of field notes and audio-tapes of each interview. All memorandum and notes were kept safely for future reference.

Data analysis procedure

Quantitative data were coded and scored using SPSS (Statistical Package for Social Sciences), then analysed using tables, percentages, and Regression. The independent variables for this study were abandonment, stigmatization and social isolation while the main dependent variable (coping strategy) was further grouped into two: Active coping and Passive coping. Those whose mean score was between 8.0 and 15.0 were considered not completely abandoned, while those with mean score between 16.0 and 32.0 were severely abandoned.

Tesch's eight-step procedure was applied in the qualitative data analysis. The first step entailed the transcription of the taped interviews. Following transcription, the researcher read the transcripts and compared with the audio-taped interviews. This process allowed the researcher to become familiar with the interviews and 'to get a sense of the whole'. Furthermore, notes were made in a memorandum, setting out thoughts and ideas on the overall meaning of the interviews. A list was made of all the main topics that emerged. Similar topics were clustered [23] and coding was the next process. The descriptive codes were written out in each participant's own words [24] and interpretative codes were made in addition. The emerging themes in the study were linked to the BATHE technique model framework as reflected in Table 6.

Results

From Figure 1, it could be inferred that VVF cuts across the entire Nigerian nation and beyond to the Camerouns. During the period of survey, majority of the respondents came from Cross River State (19.2%), followed by Ebonyi State (17.5%).

Figure 1: Respondents' distribution by area of abode.

Age of Respondents	No. of Respondents	Percentage (%)
12- 20 years	28	23.33
21 – 39 years	49	40.83
31 – 40 years	36	30.00
41years and above	7	5.83
Total	120	100%
Marital Status		
Married	33	27.50
Single	2	1.70
Divorced	80	66.77
Widowed	5	4.17
Total	120	100
Educational Level		
No formal education	27	22.5
Primary	40	33.30
Secondary	38	31.70
NCE/OND	13	10.80
HND/BSC	2	1.70
Total	120	100
Occupation		
House wife	20	16.70
Student	22	18.33
Self-employed	14	11.67
Farmer	31	25.83
Trader	12	10.00
Civil servant	9	7.50
Unemployed	12	10.00
Total	120	100

Table 1: Socio-Demographic Characteristics of Respondents Variables.

From Table 1, it could be observed that most of the respondents developed VVF between the early ages of 12 and 30 years. Majority of the respondents 80 (66.7%) were divorced, 33 (27.5%) were married. On education qualification, most of the respondents 40 (33.30%) were

primary school leavers and 38 (31.79%) secondary school leavers which implies that majority of those who develop VVF are of very low educational background. Majority of the respondents 31 (25.83%) were farmers, 20 (16.7%) were house wives, 22 (16.3%) were students, 14 (11.7%) were civil servants and 12 (10.0%) were traders, 9 (7.5%) were civil servants 12 (10.0%) were unemployed. This confirms the role of socio-economic factor in maternal morbidity such as VVF.

No of children	Number	percentage
None	57	47.5
1 – 2	44	36.67
3 – 4	13	10.83
5 and above	6	5
Total	120	100
Age at Marriage		
<12 years	1	0.83
13 – 18 years	45	37.5
19 – 24 years	38	31.67
25 -30 years	32	26.67
31 years and above	4	3.33
Total	210	100
Duration of Labour Resulting in VVF		
6 – 12 hours	3	2.5
13 – 19 hours	21	17.5
20 – 26 hours	33	27.5
2 – 3days	40	33.33
4 days and above	23	19.27
Total	120	100
Place of Delivery		
Modern Hospital	22	18.33
Traditional birth attendant	65	54.17
Home	21	17.5
Church/mosque	12	9.99
Total	120	100
Duration of VVF		
6months-1year	55	46.83
1 – 5 years	49	40.83
6 – 15 years	16	13.33
Total	120	100
Length of stay in hospital		
Within 1 week	1	0.83
2 weeks to 1 month	5	4.17
Within 2 months	76	63.33
2 months & above	38	31.67
Total	120	100

Table 2: Obstetric History of Respondents.

From Table 2, it could be deduced that most of the VVF affected women had no child 57 (47.5%) of the total sample. 44 (36.67%) had between 1 and 2 children, 13(10.83%) had 3 to 4 children, while 6 (5.0%) had up to 5 children and above. This result confirms the findings of most studies that VVF occurs mostly during the first pregnancy. It could also be observed that majority of the respondents 45(37.5%) got married between the ages of 13 and 18years. From this result, it could be drawn that early marriage could contribute significantly to the development of VVF. Majority of the respondent were in labour for many hours with those who suffered the highest impact labouring for 4 days and above at 23 (19.17%). Majority of VVF affected women 65 (54.17%) sought the assistance of Traditional Birth Attendants, 21(17.5%) preferred to give birth at home while 12 (10.0%) preferred churches. Most of the respondents 55 (46.83%) suffered from VVF within one year, 49 (40.83%) lived with the ailment for 1-5years, while 16 (13.33%) have lived with VVF between 6 and 15 years. As regards the length of stay in the hospital, majority of the respondents 76 (63.33%) stayed in hospital between 2 weeks to 1 month, 38 (31.67%) lived in the centre for up to and beyond 2 months while only 1(0.83%) stayed for only 1 week.

Hypothesis

Only one null hypothesis was used in this study.

H_0

Abandonment, stigmatisation and social isolation are not significant predictors of the coping strategies of VVF women.

To test this hypothesis, data from the field survey were extracted from the data bank and summarised into means (x) and standard deviations (SD), then subjected to multiple linear regression statistics of the SPSS version 20. The results is presented in Tables 3-5.

Model	R	R-square	Adjusted R – square	Std. Error of estimate
1	0.344a	119	.096	2.59758

Table 3: Model summary of regression

a. Predictors: (constant), social Isolation Abandonment, stigmatization

Model	Sum of squares	df	Mean square	F	Sig.
1 Regression	10.5285	3	35.088	5.200*	.002b
Residual	782.702	116	6.747		

Total	887.987	119			

Table 4: Summary of ANOVAa of the regression N=120.

a. Dependent variable: Copingstrat.

b. Predictors: (constant), social Isolation, Abandonment, stigma.

Model	Unstandardized coefficient			T	Sig.
	B	Std. Error	Beta		
1 (constant)	16.915	3.241	-.221	5.219	.000
Stigma	-.257	.107	.281	-2.394*	.018
Abandonment	-.324	.103	.143	-3.156*	.002
Social isolation	.365	.234		1.558	.122

Table 5: Summary for regression coefficients.

*Significant at P<.05, df = 118, crit – t=1.968 (2-tailed)

From Table 3, which shows the summary of results (for the "enter" model) of regression analysis procedures, a R-value of .344a, R2 – value of .119 and adjusted R2 – value of .096 were given off, with a standard error of 2.597. This means that 34.4 per cent by weight of predictive factors of VVF coping strategies were predictable by stigmatization, abandonment and social isolation.

From Table 4 (summary of one-way ANOVA for the estimation of amount of variability), a calculated Fisher's value of F=5.200* was recorded; this was found to be greater than the critical F – value of 3.00, needed for significance at .0.5 alpha level with 3 and 119 degrees of freedom. The null hypothesis was therefore rejected; meaning that the social predictive factors of stigmatization, abandonment and social isolation are significant predictors of VVF patients' coping strategies in the area of study.

To determine the extent of influence of each of the predicting variables, the summary of Beta coefficients (Table 5) was presented. This table reveals a Constance of 5.219, and calculated t-values of –2.594* for stigmatization; -3.156* for abandonment and 1.558 for social isolation. Of these,– 2.594* and - 3.156* were found to be greater, while the value 1.558 was lower than the critical t-value of 1.968 needed for significance at .05 alpha level with 118 degrees of freedom. This result further empowered the authors to reject the null hypothesis of the study.

On the basis of the b-coefficients results, the regression equation that emerged was given as: $Y=\beta0 + \beta1\ X1 + \beta2\ X2 + \beta3\ X3 + E$ (where Y = criterion variable (VVF coping strategies), β0=the regression constant, β1 to β3=regression coefficients and X1 to X3 are the predictors.

Hence: Coping strategies of VVF women = 5.219 -3.156 abandonment, +1.558 social isolation, –2.594 stigmatization.

This implied that the more abandoned and stigmatized the VVF women, the less active their coping abilities (denoted by the negative coefficient), while social isolation exerted less influence on the coping strategies of the women affected.

From the qualitative analysis, themes emerged as presented in Table 6 using BATHE Technique model framework.

BATH Technique	Sample question and statements	Corresponding themes emerging from the study
Background	Tell me what's happening? What's going on with your body?	"I am constantly wet because of leakage of urine and faeces, giving offbad odour".
Affect	How do you feel about what is going on? How is that affecting you?	"Very sad and hopeless" "It would be better I die"
Trouble	What worries you most about this situation?	"Nobody visit or support me since I was admitted" "My husband rejects me and choose another wife" "My relatives abandoned me" "I lack money to feed, becoming a problem for the nurses" "My husband sent me away blaming this condition on me" There is no joy anymore in being with others, loneliness takes over" "I don't feel comfortable having sex with my husband" "Most of my friends don't like visiting me anymore" "My husband forced me out of the main dwelling into a separate hut" "Customers do not buy my goods anymore" "I am labelled a witch because of my condition" "Everybody says it is because I committed adultery that I have this problem"
Handle	How are you handling this situation? How are you managing this?	Passive coping "I am distasteful in the eyes of others.It is God's will" "I resign to fate" "I try to suppress my sexual feelings"

		"I hide my problem from people" "I pretend nothing is wrong" "I withdraw from people and learn to do my things alone" "I become 'born again" giving my life to Christ" Active coping "I become harden about shame of rejection" "I learn to live on charity and beg for survival" I take menial jobs for survival" I bath, change pads, cloths and use perfume regularly" "I try to be modest and kind to hide my feelings" "I live by the arts/craft skills learnt at the VVF centre" "My husband and relatives still support me". "People make fun of me, so I decided to seek treatment somewhere else". "In the centre we try to be happy in our group of "sisterhood" where we assist ourselves and share ourstory"
Empathy	I can understand how that would make you feel. That must be difficult for you.	

Table 6: Stages in BATHE technique framework and corresponding themes emerging from the qualitative data [21].

Discussion

Testing of the hypothesis using multiple linear regression statistics to determine the influence of each of the predicting variables revealed a Constance 5.219, and calculated t-values of– 2.594* for stigmatization;-3.156* for abandonment and 1.558 for social isolation. Of these, – 2.594* and - 3.156* were found to be greater, while the value 1.558 was lower than the critical t-value of 1.968 needed for significance at .05 alpha level with 118 degrees of freedom. Hence, the null hypothesis was rejected (Coping strategies of VVF women = 5.219 -3.156 abandonment, +1.558 social isolation, –2.594 stigmatization). This implied that the VVF women who were abandoned and those who experienced stigmatization found coping very difficult, hence they tend to be more passive in their coping than their counterparts who were not (denoted by the negative coefficient), while social isolation exerted less influence on their coping strategies. Whether sick or healthy, normal or abnormal, Nigerian people are known for developing various strategies to manage whatever unfortunate situations they find themselves. It is not surprising that Victims of VVF in the study area also developed survival strategies in the face of their calamity.

Findings from the quantitative analyses were in line with the themes that emerged from the in-depth interview (qualitative), where most of the respondents abandoned traced the rejection by their spouses to inactive sexual life due to painful coitus and occasional leakage of urine even after surgical repairs. They expressed difficulties in coping due to lack of support (emotional and financial), so they tend to be withdrawn, frustrated and resorted to spirituality and resigned to fate, living on charity and even begging. Some resorted to menial jobs like farming and fetching firewood for people for survival. One of the respondents, during the study survey told her story as thus:

"----seeing that my situation is not improved, my husband rejected me and choose another wife and little by little, the entire village turn its back on me. Since then I and my mother have lived in a hut at the edge of the village. We subsist on charity, but my health was becoming a little more precarious every day. When it became obvious that my life was at stake, the Rev. Sister is the Catholic Church my mother worships, brought me to this hospital for treatment. They are the ones providing for my care and treatment since then. That is how we have been coping". (oral interview – 23yr old VVF victim).

Another respondent said:

"I believe my condition is the will of god"

In support of this, one of the key informants reported:

"For those abandoned patients while in hospital, the hospital take charge of them from donated items by philanthropic organization and women groups from the Catholic Churches….Also some patients from the communities are brought to the centre by good Samaritans. They overstay after discharge, they lack money to feed and become dependent on the nurses."

To corroborate the views of other victims who beg for alms in order to survive the hardship of VVF, one of the respondents recounted:

"It has been very difficult for me but I must survive, so I beg for money sitting at a busy road and church corners. Begging is easy for me and I don't have to walk up and down" (27yr old VVF woman).

These findings are highly in consonance with the findings of study by Wall [25], which revealed that more than 60% of VVF affected women are abandoned or divorced for the reason that they can hardly satisfy the conjugal and consummative obligations of marriage. Consequently they are pushed away to their parents' homes or to seek refuge in churches or VVF centres. In support of their coping strategies, study by Fasakin [6] on VVF and psychosocial wellbeing of women in Nigeria revealed that most VVF women in trying to cope found begging easy for their condition. They sit at a junction and those who are kind drop some coins for them. Same source (p48) revealed that most of them reported finding solace in being active in the church, for that was where they were shown love, prayed for, given gifts and not treated as outcasts even when their problem is known.

However, VVF women who were not abandoned could cope better and very actively too. A respondent under this category reported thus:

"-----my husband supports me. He brought me to this hospital and do visit always. I use pad, change always and bath at all times to minimize odour. I also use good scented body cream, soap and spray" (30yr old VVF woman).

In support of this, an analysis of patients at the Addis Ababa Fistua Centre, Muleta and Fantanhun [26] found that women who are influential and rich are usually not abandoned, instead they are pampered supported and encouraged to stay in intact homes so that her wealth will be used in sustaining the other family members. Coping becomes easier for these ones.

The findings that stigmatization greatly influenced the coping strategies of VVF women though with a negative coefficient implies that the more they were stigmatized, the less their coping abilities. This finding correlates with the findings from the in-depth interview where some respondents from (Ebonyi, Kogi States and the Cameroun) sought treatment and care far from home to avoid stigmatization. One of them verbally expressed her experience as thus:

"Everybody says it is because I committed adultery that I have fistula. Some make fun of me. I could not bear remaining there… I had to seek treatment elsewhere (oral interview: 32yr old woman from the Cameroun).

Some hide their condition from people thereby shying away from treatment thus prolonging the duration of the condition. One of the respondents said:

"I hide my problem from people so that they do not mock at me---"

Nevertheless, others still withdrew from social gatherings and tend to hide themselves from others due to stigmatization. About 10% of the women interviewed, confirmed they benefitted from the free machine donated to them from the VVF centre and the skills taught them, which served as their source of livelihood since discharge. Some verbalized being very happy at the centre meeting others of their likes, sharing their stories and learning to cope by forming groups where they assisted one another.

A respondent recounted:

"The hospital helps me from the donations from churches and other charitable organizations. I can't tell my end" (38 years old VVF woman, Yala – Cross River State – (oral interview).

In support, another had this to say:

"I want to have friends.I want to share my story" (19 years old girl Ebonyi State: Oral interview).

Nearly all the women who were stigmatized but had gone through a successful repairs described feeling like a "normal human being" and were able to return to their ordinary lives. Some indicated the ability to re-engage in economic activities and perform daily chores with little difficulty, with improved self-esteem; as they could now attend community and family gatherings. Others claimed having served as community level educators for the prevention and treatment of VVF and promoters of maternal health and safe delivery. A respondent interviewed verbalised thus:

"I tell them what I have been through so they don't have to suffer as I have" (30 years old woman Kogi State oral interview).

These findings are consistent with findings of Akpan [27], in her work "early marriage in Eastern Nigeria and health consequences of VVF among mothers", which revealed that VVF is a shameful and degrading condition and women affected are highly stigmatized. When they discover they are many, they soon cope with their lives by forming association of Sisterhood, which helps them cope and cater for one another. Some of them loose hope of getting well again, so to cope, they seek refuge in churches, Non- Governmental Organizations (NGOs) and centres managed by missionaries for care and support.

From the regression analyses result, it could be inferred that social isolation exerted less influence on the coping strategies of VVF women (as reflected in their regression coefficient +1.558). This implies that other psychosocial factors must have contributed to the influence of social isolation on the coping strategies of VVF women. From the findings of this study, it became obvious that other psychosocial factors precede social isolation. For instance, majority of the respondents were married before the occurrence of VVF, only to be rejected, abandoned and some divorced by their husbands. They faced stigmatization from the so called "normal" people and even ostracized out of their communities. For these reasons they withdrew to themselves, stayed away from social functions, feeling very lonely and sad. Some respondents confessed that being isolated served as a motivator for them to devise ways of coping and getting on with their lives. Isolation is based on the superstitious belief that VVF is caused by either evil forces or a curse for the level of promiscuity purportedly engaged by the victim. The researcher during the in-depth interview captured these facts verbalism as thus:

"There is no joy anymore in being with others, loneliness takes over. I lose my habit for cooking, visiting others – and all these make me sad (38 years old VVF woman).

"I sleep in separate bed from my husband; I don't feel comfortable having sex. I refuse my husband sometimes" (30 years old VVF woman).

They expressed different ways of coping with the situation to include: "resigning to fate", "withdrawing from others", "accepting it as the will of God or punishment from God", " forming groups of sisterhood". Some resorted to living on the margins of the society due to the smell for fear of embarrassment and ostracism from the community. Some tend to depend on charitable bodies like churches and NGOs.

One of the respondents who saw social isolation as a motivator to her coping had this to say:

"It is better to be on your own than to be with people who will constantly remind you of your problems" (29years old VVF woman).

Another respondent recalled:

"If I need to be with anyone, it is better with those we share the same condition. They understand how I feel. Since I came to this centre, I feel better because we share the same story" (VVF woman-34years).

A respondent who still enjoy some form of relationship confessed thus during the oral interview:

"My friends and relatives relate with me from a distance. With the little money I have, I try to change my sanitary pad regularly, wash my cloths and wrappers very clean and also use perfumes and good scented body creams to be able to say close to people" (30 years old VVF woman, Uyo).

Results of survey studies by Beuching and Jeter and Verdell [28], is in congruence with these findings. The studies revealed that there is a high tendency in these women to exhibit avoidance behaviours in trying to cope passively due to social embarrassment, hence personal isolation which may end up in extreme depression, suicidal tendencies and even death. Also findings of study by Fasakin [6] revealed that VVF victims feel happy and relaxed being with their likes. They organized themselves into "sisterhood of suffering" which enables them to survive the unwelcoming and anti-social attitude of the "normal" people towards them.

On the whole, the findings of this study strongly agree with the findings of earlier reviewed studies. Physical consequences of VVF lead to severe psychosocial stigmatization for various reasons. In most African communities, people believe that fistula occurs as a divine punishment or a curse for disloyal or disrespectful behavior [29]. Most cultures in Nigeria view offspring as an indicator of a family's wealth and any woman who is unable to successfully produce children as assets for her family is believed to make her and her family socially and economically inferior [27]. A patient's incontinence and pain render her unable to perform household chores and childrearing as a wife and as a mother, thus devaluing her worth. Other misconceptions about VVF are that it is caused by venereal diseases or that it is divine punishment for sexual misconduct [30]. As a result, many girls are divorced or abandoned by their husbands and partners, disowned by family, ridiculed by friends, and even isolated by health workers [4]. According to McKinney [31], some women have formed small groups and resorted to walking by foot covering long distances to seek medical help. Same source posit that women are sometimes forced to turn to begging, hawking as a means of survival because the extreme poverty and social isolation that result from VVF eliminate all other income opportunities.

Conclusion and Recommendation

The study concluded that there is a significant influence of abandonment, stigmatization and social isolation on the coping strategies of VVF women in the area of study. VVF reveals how poverty and gender inequality limits women's exercise of their reproductive rights. The psychosocial impacts this condition exerts on the unfortunate victims pose enormous influence on their coping strategies, thus, the study recommended that by addressing gender inequality, girls' education and strengthening health systems – particularly in, access to family planning and maternal health services, Vesico Vagual Fistula can become a history in every community in Nigeria. For the women affected, promotion of strategies for their rehabilitation and reintegration into communities after VVF repair can improve their socio-economic situation and alleviate financial dependency on others. This should include training in literacy and income – generating skills, loans and grants for micro business etc.

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