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# RELATIONSHIPS AMONG SOCIAL SUPPORT, COPING STRATEGIES, AGE AND PSYCHOLOGICAL WELLBEING OF VESICOVAGINAL FISTULA PATIENTS AT MURTALA MUHAMMAD SPECIALIST HOSPITAL, KANO, NIGERIA.

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**ABSTRACT:** The study investigated the relationships among social support and coping strategies and psychological wellbeing as well as the and age differences of Vesicovaginal Fistula (VVF) patients at Murtala Muhammad Specialist Hospital (MMSH), Kano State. Three hypotheses were tested. Survey research design was used for this study. A total number of 220 patients were purposively sampled as participants for the study. Three sets of research questionnaires named multidimensional scale of perceived social support (MSPSS), psychological wellbeing scale (PWB), and coping strategies scale were used as instruments for data collection. 220 questionnaires were administered and 216 were filled and returned for data analysis. Frequency count and percentages were used in organizing and describing the demographic information of the participants. t-test and pearson product moment correlation coefficient (PPMC) was used to test the hypotheses at 0.05 level of significance. The result revealed that social support ($r = 369$, $p<0.05$) and coping strategies ($r = 351$, $p<0.05$) have significant relationship with psychological wellbeing among VVF patients at MMSH Kano. The findings also revealed that young VVF patients report better psychological wellbeing than older VVF patients at MMSH Kan ($t (214) = 3.57$, $p<0.05$).. Based on the results, the study concluded that, social support. coping strategies and age differences influenced psychological wellbeing of VVF patients at MMSH Kano. It is, therefore, recommended that VVF patients especially older VVF patients should get more social support and knowledge of coping strategies from their family, community members as well as health workers in order to have better psychological wellbeing.

**Keyword:** Social Support, Coping Strategies, Psychological Wellbeing, Vesicovaginal Fistula,

## INTRODUCTION

In Nigeria and other developing nations, child and maternal health issues are constantly worrisome as a number of women have been found to die, lose their babies or get terminal deformation in the process of childbearing. Nevertheless, for every woman who dies during childbirth, nearly a hundred others service, albeit with a variety of short- and long-term physical, (Wall, 2000: Kabir, Iliyasu, Abubakar & Umar, 2004) psychological (Ahamed & Holt, 2007), and social consequences (Jones, 2007). The experiences are part of negative life events which have been found to prospectively predict increases in depressive symptoms among people of different ages. However, among those suffering these negative life events, a

certain number still succumb later to death due to serious complications arising from poor maternal health services prevalent in poor countries of the world. Most of these complications have, over the years, been diagnosed as vesicovaginal fistula (VVF) also referred more professionally to as obstetric vesicovaginal fistula or genitourinary fistula. Fistula primarily occurs when girls and women experience prolonged, obstructed Labor which accounts for between 79-97% of all vesicovaginal fistula cases (Murk, 2009). When these negative life event persist, VVF patients are known to suffer loss of social network, social support, isolation, rejection. (Alio, 2010). And associated bitterness and depression (Kabir, et al, 2004). VVF has globally been tied to many causes including: poverty, ignorance, early age at marriage, poor nutrition, illiteracy, female genital cutting (weather for purposes of circumcision or birth-related episiotomy) poorly performed abortions (i.e., if there could be anything like good abortion), unskilled maternity care, and insertion of caustic substances into the vagina with the intent to help the vagina return to its Nulliparous state (Lindsay, 2009: Kabir 2004; Alio, 2010). In Addis Ababa, Ethiopia; and Uyo, Katsina and Kano in Nigeria; showed that VVF is a disease related very much poverty, underdevelopment, harmful traditional practices, low status and educational level of women, lack of primary health care networks, maternal and child care networks as well as lack of accessible caesarean services. However, whatever may lead to the VVF condition in women the most common resultant psychological problem among such patients is the manifestation of depression basically from the trauma and shock of finding oneself in a hopeless and worthless life situation.

Women with VVF suffer severe stress and depression, secondary to being ostracized by their spouse, families and communities (Lindsay, 2009). According to Kabir, et al (2004), depression, loss of husbands' affection, divorce and social rejection are some of the psychological problems encountered by women suffering genitourinary fistula and the disease remains one of the commonest distressing conditions that bring remotely rural African women to the hospital. The problem of VVF in Nigeria has been found to be associated with young women who are denied or cannot afford skilled maternity care despite their high-risk pregnancies. Other Factors contributing to the high incidence if VVF Nigeria as also reported globally include; illiteracy, poverty, ignorance, home delivery, non-utilization of antenatal and intrapartum medical facilities and the habit of deprivation and neglect.

Vesico-vaginal fistula is a disease with tremendous socioeconomic and health implications and consequences. The uncontrolled urine leakage causing bad odour in public gatherings result in social stigma, neglect, and depression, other problem includes childlessness resulting most often from loss of viable foetus from pregnancies associated with VVF. Secondary infertility, vaginal stenosis by fibrosis and bands Amenorhea, high and unaffordable costs of repair and elective caesarean section among those who get pregnant later. Psychological problems of the patients include digression, loss of husband's affection, divorce and rejection by the society.

With regard to the afore-mentioned problems associated with vesco-vaginal fistula, this study became necessary to examine the influence of social support and coping strategies of psychological wellbeing among VVF patients. Based on the researcher experience while on field trip to the vesico-vaginal fistula Centre in Murtala Muhammad specialist Hospital, the Researcher was opportune to have a brief discussion with some of the patients and realize that most of their expression was about coping with challenges such as stigmatization, divorce, family abandonment other which has a significant contribution to their problem of psychological wellbeing.

## Statement of the Problem

It has been realized that the rate of occurrence of VVF is a serious life-threatening condition that is affecting the normal psychological and physiological functioning of reproductive women. Most of the research conducted is on physical aspect of the disease. As the women suffered of depression due to their loss of husband affection, and social rejection from the family and community. With this regard the research intends to study how social support and coping strategies could assist these patients to fully develop their psychological wellbeing. The has been increased due to increase in the incidence of prolonged or obstructed labour as well as other causes in our hospital as a result of inadequacy of the facilities for antenatal and post-natal care.

Utilizing maternal health services is very poor, 87% of Nigerian women deliver where they were attended by traditional birth attendant, who cannot identify the complication of obstetric labour or duration of prolong labour (Rochad, 2008.). In Hausa and Fulani communities, early marriage is their norms. Many girls become pregnant in their early teens before pelvis be fully mature. These girls have the higher risk of obstructed labour and ultimately VVF or maternal death.

The vesicovaginal fistula women become physically and morally offensive to their husbands, their families, their friends as well as their neighbours. Many of the VVF patients would have given birth to a stillborn baby, and thus leaving the women childlessness. Childlessness in Africa especially Nigeria is obviously an important factor in marital breakdown. (Marphy, 2017)

Since it has been realized that VVF has impacts on the normal physiological and psychological functioning of reproductive women (VVF) solution have to be provided for the prevention and eradication of vesicovaginal fistula in Nigeria. It is against this background that the research intends to study how social support and coping strategies could assist these patients to fully develop their psychological wellbeing.

## Research Questions

This study addressed the following research questions.

i. What is the relationship between social support and psychological Wellbeing of VVF Patients at Murtala Muhammad specialist Hospital Kano, Nigeria?
ii. What is the relationship between coping strategies and psychological wellbeing of VVF patients at Murtala Muhammad specialist Hospital Kano, Nigeria?
iii. What is the age difference in the psychological wellbeing of VVF patients?

## Objectives

This study is guided by the following objectives.

i. To examine the relationship between social support and psychological wellbeing of VVF patients at Murtala Muhammad Specialist Hospital Kano, Nigeria.
ii. To examine the relationship between coping strategies and psychological wellbeing of VVF patients at Murtala Muhammad Specialist Hospital Kano, Nigeria.

iii. To determine the age differences of VVF patients on psychological wellbeing.

**Hypotheses**

In an attempt to answer the research questions and achieve the research objectives as stated earlier, this study is tested by the following research hypotheses.

i. There will be a significant relationship between social support and psychological wellbeing of VVF patients at Murtala Muhammad specialist Hospital Kano, Nigeria.
ii. There will be a significant relationship between coping strategies and psychological wellbeing of VVF patients at Murtala Muhammad specialist Hospital Kano, Nigeria.
iii. Older VVF patients will significantly report better psychological wellbeing than younger VVF patients.

**Conceptual Clarifications**

**Social Support**

Social support is the perception and actually that one is cared for, has assistance available from other people and most popularly, that one is part of a supportive social network. (Racino, 2016: Albrecht). These supportive resources can be emotional (e.g., nurturance) informational (e.g., Advice), or companionship (e.g., Sense of belonging); tangible (e.g., Personal advice) (Racino, 2016: Albrecht). Social support can be measured as the perception that one has assistance available, the actual received assistance, or the degree to which a person is integrated in a social network (Racino, 2016: Albrecht). Support can come from many sources, such as family, friend, pets, neighbors, coworkers, organization, etc. Government provided social support may be referred to as public aid in some nations. (Wall, Karshima, Kirshehner, & Arrowsmith, 2014).

Social support is studied across a wide range of disciplines including psychology, medicine, sociology, nursing, public health, education, rehabilitation and social work (Wall, et al, 2014). Social support has been linked to many benefits for both physical and mental health, but social support (e.g., Gossiping about friends) is not always beneficial. (Uchino, 2014). Social support can be categorized and measured in several different way (Taylor, 2011). There are four common functions of social support:

i. Emotional support is the offering of empathy, concern, affection, love, trust, acceptance, intimacy, encouragement, or caring. It is the warmth and nurturance provided by sources of social support providing emotional support can let the individual know that he or she is valued.
ii. Tangible support is the provision of financial assistance, material goods, or services. Also called instrumental support this form of social support encompasses the concrete; direct ways people assist others.
iii. Informational support is the provision of advice, guidance, suggestions, or useful information to someone. This type of information has the potential to help others problem solved.
iv. Companionship support is the types of support that gives someone a sense of social belonging (and is also called belonging) this can be seen as the presence

of companions to engage in shared social activities. It is also referred to esteem support or appraisal support.

Researchers also commonly make a distinction between perceived and received support. Perceived support refers to a recipient's subjective judgment that providers will offer (or have offered) effective help during times of need receive support (also called enacted support) refers to specific supportive actions (e.g., Advice or reassurance) offered by providers during the times of need. (Vaux, 2018). Furthermore, social support can be measured in terms of structural support or functional support. Structural support (also called social integration) refers to the extent to which a recipient is connected within his or her social network family relationship, friends, and membership in clubs and organizations contribute to social integration. Functional support looks at the specific functions that members in this social network can provide, such as the emotional, instrumental, informational and companionship support listed above. (Uchino, 2014).

**Sources of Social Support**

Social support can come from a variety of sources, including (but not limited to): family, friends, romantic partners, pets, communities and coworkers. Sources of support can be natural (e.g., Family and friends) or more formal (e.g., Mental health specialists or community organizations). The source of the social support is an important determinant of its effectiveness a coping strategy (Racino, et al 2016). support from a romantic partner is associated with health benefits, particularly for men. However, one study has found that although support from spouses buffered the negative effects of work stress, it did not buffer the relationship between marital and parental stresses, because the spouses were implicated in this situation. However, work family specific support worked more to alleviate work-family stress that feeds into marital and parental stress. Employee humour is negatively associated with burnout, and positively with stress, health and stress coping effectiveness. Additionally social support from friends did provide a buffer in response to mental stress, because they were less implicated in the marital dynamic. (Walls, et al., 2014).

Early familial social support has been shown to be important in children's abilities to develop social competencies and supportive parental relationships have also had benefits for college-age students. Teacher and school personnel support have been shown to be stronger than other relationships of support. This is hypothesized to be a result of family and friend social relationships to be subject to conflicts whereas school relationships are more stable.

**Links of Social Support to Physical and Mental Health**

Social support profile is associated with increased psychological wellbeing in the workplace and in response to important life events. There has been an ample amount of evidence showing that social support aids in lowering problems related to one's mental health (Lakey, & Cronin. 2018). As reported by Cutrona, Russell and rose in the elderly population that was in their studies, their results showed that elderly individuals who had relationships where their self-esteem was elevated were less likely to have a decline in their health. In stressful times, social support helps people reduce psychological distress (e.g., Anxiety or depression). Social support can simultaneously function as a problem focused (e.g., Receiving tangible information that helps resolve an issues) and emotion-focused coping strategy (e.g., Used to regulate emotional responses that arise from the stressful event). (Lakey, & Cronin. 2018). Social support has been

found to promote psychological adjustment in conditions with chronic high stress like VVF rheumatoid arthritis, HIV, cancer, stroke, and canonry artery disease. Whereas a lack of social support has been associated with various acute and chronic pain variables. (Or more information, see chronic pain). People with low social support report more sub-clinical symptoms of depression and anxiety than do people with high social support. In addition, people with low social support have higher rates of major mental disorder than those with high support. These include post-traumatic stress disorder, panic disorder, social phobia, major depressive disorder, dysthymic disorder and eating disorder (Togrud, et al., 2014).

Among people with schizophrenia, those with low social support have more symptoms of the disorder. In addition, people with low support have more suicidal ideation and more alcohol and (illicit and prescription) drug problems. Similar results have been found among children. Religious coping has especially been shown to correlate positively with positive psychological adjustment to stressors with enhancement of faith-based social support hypothesized as the likely mechanism of effect. However, more recent research reveals the role of religiosity spirituality in enhancing social support may be overstated and in fact disappears when the personality traits of agreeableness and also included as predictors.

Lakey, and Cronin, (2018). Did a qualitative study of 34 men and women diagnosed with an eating disorder and used the health belief model (HBM) to explain the reasons for which they forgo seeking social support. Many people with eating disorders have a low perceived susceptibility, which can be explained as a sense of denial about their illness. Their perceived severity of the illness is affected by those to whom they compare themselves to, often resulting in people believing their illness is not severe enough to seek support. (Stice, Presnell & spangler, 2012). Due to poor past experiences or educated speculation, the perception of benefits for seeking social support often prevents people with eating disorders from getting the support they need to better cope with their illness. Such barriers include pear of social stigma, financial resources and availability and quality of support. Self-efficacy may also explain why people with eating disorder do not know how to properly express their need for help.

**Social Support Consequences on VVF Patients**

Fistula is considered a social calamity and women with VVFs are often ostracized by their husbands, families and communities. The condition is often considered as sexually transmitted disease and viewed as a punishment from God. (Ojanuga Onolemhemhen, & Ekwempu, 2009). Most women with fistula report disturbed socio-psycho-sexual lives and are usually deserted by their husbands. A study in Africa reported that immediately after the fistula occurred, 14% of new patients were divorced by their husbands; and only 14% continue to live with their husbands, if the condition persisted, 28% of the women were divorced and only 11% were allowed to stay. And among women affected with fistulas in Niger, 63% were divorced. Often, until they are cared, married women with fistula are sent back to their parents' home where they are not allowed to cook food, participate in social event, or to perform religious rituals. A study of how women with fistula perceive the societal reaction toward them in Nigeria fund that most (53%) consider themselves rejected. Our meta-analysis for the estimation of the mean percentage of women who are divorced or abandoned. A random- effect estimate shows that about 36% of the women (95%cl, 27%-46%) (47% With fixed effect estimate) were divorced or separated. (Ojanuga, et al 2009). Vesico-vaginal fistula Is so enormous and thus ravages Nigerian women that the country's federal ministry for women affairs and youth development estimated that the number of untreated VVFs in Nigeria stands

between 80.000 and 100,000. Majority of the victims are very young and without the basic elementary education. 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. (Ojanuga et al 2009).

Consequently, they are pushed away to their parents' homes or to seek refuge in mosques or churches, or VVF Centre's. In support of their coping strategies, a study by Fasakin on VVF and psychological wellbeing of women in Nigeria revealed that most VVF women in trying to cope fund begging easy for their condition. They sit at a junction and those who are kind drop some coins for them. (Ojanuga et al 2009). 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 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.

**Coping Strategies**

Coping strategies means to invest one's own conscious effort to solve personal and interpersonal problems, in order to try to master, minimize or tolerate stress and conflict. The psychological coping mechanisms are commonly termed coping strategies or coping skills. The term coping generally refers to adaptive an (constructive) coping strategy, that is strategies which reduce stress. In contrast, other coping strategies may be coined as maladaptive coping is therefore also described based on its outcome, as non-coping. Furthermore, the term coping generally refers to reactive coping i.e., the coping response which follows the stressor. This differs from proactive coping, in which a coping response aims to neutralize a future stressor. Subconscious or unconscious strategies (e.g., defence mechanisms) are generally excluded from the area of coping (Lazarus, & Folkman, 1994).

The effectiveness of the coping effort depends on the types of stress the individual and the circumstances. Coping responses are partly controlled by personality (habitual traits), but also partly by the social environment particularly the nature of the stressful environment (Lazarus, & Folkman, 1994).

**Types of Coping Strategies**

Hundreds of coping strategies have been identified. Classification of these strategies into a boarder architecture has not been agreed upon. Researchers try to group coping responses rationally, empirically by factors analysis or through a blend of both techniques. In the early days, Folkman and Lazarus split the coping strategies into four groups, namely problem focused emotional-focused, support seeking and meaning making coping. Welten has identified four types of coping strategies appraisal-focused (adaptive cognitive), problem focused (adaptive behavioural), emotion-focused and occupation focused-coping. Billing and Moos added avoidance coping as one of the emotion-focused coping. Some scholars have questioned the psychometric validity of forced categorization as those strategies are not independent to each other. Besides in reality people can adopt multiple coping strategies simultaneously.

Typically, people use a mixture of several coping strategies which may change over time. All these strategies can prove useful, but some claim that those using problem-focused coping strategies will adjust better to life. Problem focused coping mechanisms may allow an individual greater perceived control over their problem whereas emotion focused coping may sometimes lead to a reduction in perceived control (maladaptive coping). Lazarus notes the connection between his idea of defensive reappraisals or cognitive coping and Freud's concept of ego defences, coping strategies thus overlapping with a person's defence mechanisms

**Appraisal-Focused Coping Strategies**

Appraisal focused (adaptive-cognitive) strategies occur when the person modifies the way they think, for example employing denial or distancing oneself from the problem. People may after the way they think about a problem by altering their goals and values, such as by seeing the humor in a situation, some have suggested that humour may play a greater role as a stress moderator among women than men (Falkman, & Lazarus, 2019).

**Adaptive Behavioural Coping Strategies**

People using problem focused strategies try to deal with the cause of their problem. They do this by finding out information on the problem and learning new skills to manage the problem (Falkman, & Lazarus, 2019). Problem focused coping s aimed at changing or eliminating the source of the stress. The three problems focused coping strategies identified by Folkman and Lazarus are taking control, information seeking and evaluating the pros and cons. However, problem focused coping may not be necessary adaptive especially in the uncontrollable case that one cannot make the problem go away.

**Emotions-Focused Coping Strategies**

*It involves:*

i. Releasing pent-up emotions.
ii. Distracting oneself.
iii. Managing hostile feelings.
iv. Meditating.
v. Using systematic relaxation procedures.

**Emotion-** focused coping is oriented towards managing the emotions that accompany the perception of stress. The five emotion focused coping strategies identified by Folkman and Lazarus are:

i. Disclaiming.
ii. Escape avoidance.
iii. Accepting responsibility or blame
iv. Exercising self-control.
v. And positive appraisal.

**Emotion-**focused coping is a mechanism to alleviate distress by minimizing, reducing or preventing the emotional components of a stressor. This mechanism can be applied through a variety of ways such as;

i. Seeking social support.
ii. Reappraising the stressor in a positive light.
iii. Accepting responsibility.
iv. Using avoidance
v. Exercising self-control.
vi. And distancing.

The focus of this coping mechanisms is to change the meaning of the stressor or transfer attention away from it. For example, reappraising tries to find a more positive meaning of the cause the stressor (Falkman, & Lazarus, 2019). Avoidance of the emotional distress will distract from the negative feelings associated with the stressor. Emotion focused coping is well suited for stressors that seem uncontrollable (ex a terminal focused coping such as distancing or avoidance, can be determine when used over an extended period. Positive emotion focused mechanisms such as seeking social support and positive re-appraisal are associated with beneficial outcomes (Emotional approach coping is one form of emotion focused coping in which emotional expression and processing is used to adaptively manage a response to a stressor.

**Reactive and Proactive Coping.**

Most coping is reactive in that the coping is a response to stressor. Anticipating and reacting to a future stressor is known as proactive coping or future oriented coping. Anticipation is when one reduces the stress of some difficult challenge by anticipating what it in will be like and preparing for how one is going to cope with it (Falkman, & Lazarus, 2019).

**Social Coping.**

Social coping recognizes that individual is bedded within a social environment which can be stressful, but also is the source of coping resources, such as seeking social support from others (Falkman, & Lazarus, 2019). Humour used as a positive coping strategy may have useful benefits in relation to mental health and wellbeing. By having a humorous outlook on life, stressful experiences can be and are often minimized. This coping method corresponds with positive emotional states and is known to be an indicator of mental health. Psychological process is also influenced within the exercise of humour. For example, laughing may reduce muscle tension, increase the follow of oxygen to the blood, exercise the cardiovascular region and produce endorphins in the body (Falkman, & Lazarus, 2019). Using humour in coping while processing through feelings can vary depending on life circumstances and individual humour styles. In regards to grief and loss in life occurrences, it has been found that genuine laughs/smiles when speaking about the loss predicted later adjustment and evoked more positive responses from other people (Falkman, & Lazarus, 2019). A person of the deceased family member may resort to making jokes of when the deceased person used to give unwanted “wet willes” (term used for when a person sticks their finger inside their mouth then inserts the finger into another person’s ear) to any unwilling participant. A person might also find comedic relief with others around irrational positive outcomes for the deceased funeral service. It also possible that humour would be used by people to feel as a sense of control over a more powerless situation and used as way to temporarily escape a feeling of helplessness. Exercised humour can be a sign of positive adjustment as well as drawing support and interaction from others around the loss (Falkman, & Lazarus, 2019).

**Negative Techniques (Maladaptive Coping or Non-Coping)**

Whereas adaptive coping strategies improve functioning, a maladaptive coping technique (also termed non coping) will just reduce symptom while maintaining or strengthening the stressor. Maladaptive techniques are only effective as a short term rather than long term coping process (Falkman, & Lazarus, 2019).

Examples of maladaptive behaviour strategies include: Dissociation, sensitization, safety behaviours, anxious avoidance, rationalization and escape (including self- medication). These coping strategies interfere with the person's ability to unclean or break apart, the paired association between the situation and the associated anxiety symptoms. These are maladaptive strategies as they serve to maintain the disorder.

Psychological Wellbeing refers to inter and intra individual level of positive functioning that can include one's relatedness with others and self-referent attitudes that include one's sense of mastery and personal growth. Psychological Well-being is the experience of health, happiness, and prosperity. It includes having good mental health, high life satisfaction, a sense of meaning or purpose, and ability to manage stress, more generally well-being is just feeling well. (Layous, & Lyubomirsky, 2012).

Well-being is something sought by just about everyone, because it includes so many positive things feeling happy, health, socially connected and purposeful. Unfortunately, well-being appears to be in decline, at least in the U.S. and increasing your wellbeing can be tough without knowing what to do and how to do it. Well-beings, emerges most from your thoughts, actions and experience, most of which you have control over. For example, when we think positive, wanted to have greater emotional well-being. When we pursue meaningful relationship, we tend to have better social Well-being and when we lose our job or just hate it, we tend to have lower workplace Well-being (Layous, et al., 2012). These examples stand to reveal how broad Well-being is, and how many different types of Well-being there are. Because Well-being is such a broad experience, let's break it down into its different types.

The six factors model of psychological wellbeing is a theory developed by Carol Ruff which contribute to an individual's psychological wellbeing, contentment and happiness. Psychological wellbeing consists of positive relationships with others personal mastery, autonomy, a feeling of purpose and meaning in life and personal growth and development. Psychological wellbeing is attained by achieving a state of balance affected by both challenging and rewarding life events. These six components are considered key-elements of psychological wellbeing (Ryff, 2006).

**Psychological Well-Being on VVF Patients**

VVF is a condition that roots through multiple factors including physical, social, cultural, political and economic condition of the women. These all together established women's status and influences on their health, fertility, behaviour, nutrition and vulnerability to acquire VVF. (Kabir, Abubakar, & Umar, 2004).

In one study conducted in Zaria, Nigeria. examined that weather the presence of children was associated with the risk of divorce or separation. The findings suggested that, the presence of living children may reduce the risk of separation or divorce unless the mother has long been

affected with fistula. (Ojanuga, et al., 2009). A study in Addis Ababa fund that without well-being and support from their husbands and without the means of earning their livelihood 39% of the women with fistulas were dependent or relatives for foods and 22% bagged or lived on do nation. They are socially isolated (WHO, 2016). when suggested treating a blind woman with a fistula for her blindness first, she replied, cure my fistula first, if I am blind people will sit with me and talk to me, but no one will come near to me because I am wet and I smell. The reduction of stigma remains a major challenge for public health programs involved with the problem of fistula. (Fasakin, 2007).

**Vesico-vaginal fistula**

It is an abnormal connection between the urinary tract and the vagina such that there is an uncontrollable leakage for urine to the vaginal track. It is very unpleasant experience of the patients and it is considered as the most dehumanizing condition that afflicts women (Ejembi, 2018). Obstructed labour leads almost invariably to the death of the foetus during birth and is one of the leading causes of maternal death. When the woman survives, she is left with constant leaking of urine and often rejected by her husband, blamed by her community, and forced to leave her home (Hilton, 2013).

Vesicovaginal `fistula produces serious long term social, physically and psychological consequences for women; it leaves a woman permanently incontinent. it remains one of the serious maternal morbidities especially of teen or young mothers especially in the developing countries (Moronkola & Odu, 2013).

Many women are still unaware of the availability of treatment and it is estimated that 80% of women with fistula never seek treatment. The main reason for this is lack of knowledge (Ejembi, 2018). It is estimated that 80% of women never seek many live with condition for several years' treatment, yet when repaired by an expert, success rates are reported as high as 87-93%. it is therefore highly likely that most VVF cases remain undetected in the community and that burden is fair greater than has been estimated previously (Kabir, 2013). The obstetric vesicovaginal fistula is still largely neglected in the developing world; it has remained a hidden condition, because it affects some of the most marginalized members of the population; poor, young, often illiterate girls and women in remote regions of the world (WHO, 2018).

**Causes of Vesicovaginal Fistula**

The cause of vesicovaginal fistula include childbirth (in which case it is known as an obstetric fistula), when a prolonged labour presses the unborn child tightly against the pelvis, cutting off blood flow to the vesicovaginal wall. the affected tissue may necrotize (die), leaving a hole. Vesicovaginal fistula is a health condition caused by the inter-play of numerous physical, social, cultural, political factors as well as economic situation of women.

**Physical causes of VVF:** The basic physical factors that influence occurrence of obstetric fistula include:

**Obstructed labour:** The over whelming proportions of vesicovaginal fistula cases are complications of neglected obstructed labour prolonged obstructed labour puts a woman at risk for fistula and other serious injuries including death (Aboh, Nkwanko, Obi & Agu 2013) obstructed labour occurs when the presenting petal part cannot pass through the maternal bony

pelvis. The presenting part becomes wedge against the maternal pelvis bones, compressing the soft tissue in between. the uterine contraction forces the presenting part deeper in the pelvis, compressing the material soft tissues forcibly (Aboh, et al, 2013). During prolonged obstructed labour, the soft tissues of the vagina are trapped between the foetal head and the bony pelvis. If the compression is not relieved by surgical intervention, the blood supply is compromised, ultimately resulting in tissue death (necrosis). (Aboh, et al, 2013). Usually between 3-10 days postpartum, the necrotic tissue sloughs off and a fistula develops between the bladder and the vagina (VVF) or between the rectum and the vagina (RVF), or both. Factors predisposing to prolonged obstructed labour include mal presentation and cephalopelvic disproportion (CPD). Malpremal presentation can occur in any woman, but it is more frequent in grand multiparas with Lax uterine muscles. (Aboh et al., 2013).

**Gishiri cut (yankan gishiri)**: The practice of Yankan gishin is still commonly employed among Hausa, Fulani and Kanuri tribes of Northern Nigeria Gishiri is the Hausa world for salt; it also refers to a disease state in Hausa Ethno Medical System (Arrosmith, Wall, Briggs, Browning & Lassu 2016). there is belief that ingestion of too much self, sugar or similar substances (especially during pregnancy) will result in the vagina becoming encrusted, narrowed or covered with filmy membrane that will prevent the child from being born when this condition is diagnosed (obstructed labour) a traditional healer is consulted who makes a series of gishiri cuts in the vagina to relieve the obstruction. This often results in direct trauma to the urethra or bladder causing a fistula (Tahzib, 2017).

**Maternal mortality and vesicovaginal fistula**: The vast majority of VVF are due to obstructed labour, not surprisingly, VVF are most prevalent in area where maternal mortality is high and where obstructed labour is a major contributor to maternal death (Price, 2018).

Each year between 50,000 to 10,000 women worldwide is affected by obstetric fistula, an abnormal opening between a woman's genital tract and her urinary tract or rectum. The development of obstetric fistula is directly linked to one the major causes of maternal mortality. Worldwide more than half of a million healthy young woman die from complication of pregnancy and child birth each year (WHO, 2016). who estimated that globally, over 300,000 million women currently suffer from short- or long-term complication arising from pregnancy or childbirth with around 20 million new cases arising every year (Ahmed, 2016).

VVF is linked directly to maternal mortality. Maternal mortality is embedded in a complex network of social issues that have to do with the social status of women the distribution and availability of health care resources, perceptions about the nature and importance of maternal problem and the social economic and political infrastructures of developing countries. All these factors have been implicated in the ethnology of VVF (Carlson, 2014).

**Malignant fistula**: Excluding the effects of treatment malignance disease itself may result in a genital fistula cancer of the cervix, vagina and rectum are the most common malignancies to present in this manner. (Wall, 2016).

**Other Physical Causes of Fistula**

**Infection***:* The following infections have been implicated in some fistulas: Lymph granuloma venereal (LAV), diphtheria, measles, schistosomiasis, infected centipede bites, and so on. in Zaria study, there were 10 cases that were due to LGV, diphtheria, measles a boil in the vagina

that have rapture, and possibly a case due to schistosomia hematobivin 2 of 3 cases due to LGV were associated with RVF and they all involved total destruction of urethra (Murphy, 2017).

**Trauma:** VVF may also be caused by accident such as penetrating injuries to the vagina and the bladder involving cattle horns or implement by falling on a stick, foreign bodies, bladder calculi and so on.

**Malnutrition:** Nutrition is very important for all human being growth well and become healthy particularly for women who have begun menstrual cycle and for the woman who are pregnant. Women who are poorly nourished one most likely to suffer complication, severe bleeding and premature labour than those who are well fed (Balogun, 2017). It has been estimated that poor childhood nutrition, frequent infection and an early start childbearing. The study in Jos revealed that women with fistula tend to have married early often before monarch, to be short (80% less than 150 cm tall), and small (mean weight less than 44kg) (Wall, 2016).

**Cultural factors:** Some men are denied access to care or actually harmed due to cultural beliefs and traditional practices for example, if labour becomes obstructed and all local methods fail, a woman may be taken to the hospital only if consent is given by either her husband, the village chief, or sometimes her mother in-law. most times the decision comes too late. (Bimbola. 2013).

A barrier to women to available prenatal care and fistula treatment arises when women and or their family members resist necessary medical examination by the male doctors, and female doctors and suitable other health service providers are unavailable. Labour be unduly prolonged when available care is culturally un acceptable (Bimbola, 2013).

The timing of decision to go to a hospital has been linked to knowledge of the possible complications and mistrust on modern health care systems. Most of the women are examined by male doctors. This is one of the reasons, why many women keep away from seeking medical help early. (Murphy, 2017).

**Traditional surgical fistula:** In some parts of the world, harmful traditional practices are also responsible for fistula formation. Although there are few reliable statistics available, these practices may increase the like hood of complications by up to 7 times. These practices may explain as many as 15% of fistula cases in some parts of Africa. (Bimbola, 2013).

Most popular concern has focused recently on genital cutting practices commonly referred to as female circumcision or female genital cutting/mutilation (FGM) while obstetric fistula are common in communities where FGM are practiced in various forms in much of North Africa and Sudan. The most extreme form paranoiac circumcision or infibulations, involves the removal of the labia minor, most of the monsveneris, and often the clitoris, the introitus being reduced to pin hole size. Coitus itself may result in peripartum and may be the primary cause of fistula formation. Delivery will often necessitate wide episiotomy, often with an anterior incision. (Bimbola 2013)

**Early Marriage**: A woman who is given out in marriage as early as 12 to 14 years of age usually has a small and narrow pelvis. The likelihood of obstructed labour is increased in areas where early marriage and childbearing are common, the capacity of the bony pelvis normally continues to expand after the epephyseal growth plates of the long bones have fused. These

problems are worsened if girls have been under nourished throughout childhood and adolescence (Konje & Lapido,2018). Thus, although girls are capable of becoming pregnant at a relatively early age, their pelvis do not develop their full capacity to accommodate childbearing until much later and many will have their lives destroyed by obstetric injury before they have even crossed the threshold into true adulthood (Wall 2016). Age at marriage no doubt affects pregnancy and labour complication among Nigerian women hence likelihood of VVF.

**Poverty and Illiteracy**: Poverty often plays an important role in predisposing Nigeria women to the problem of VVF. Poverty is linked to illiteracy, malnourishment, living condition, accessibility to good obstetrics care and so on (Fasakin, 2018). As a result of poverty some part in Nigeria find it difficult to send their children to school. Some are even withdrawn from school so as to be given out in marriage to attract high bride prices, especially if they are still virgins (Balogun, 2017) also when the girls become pregnant, they are usually sent home to deliver at their parent's house and should there arise any complications the cost of procuring immediate and good obstetrics care might be too exorbitant for the parents. If and when VVF arise, victims equally find it impossible to afford medical services for repairs. The cost of transporting VVF victims to the hospital usually in major cities is also unaffordable by the family.

**Empirical Review of Literature**

**Social support and psychological wellbeing of VVF patients**

Obstetric fistula classic symptoms of faecal and urinary incontinences cause women to live with social stigma, isolation psychological trauma and lose their source of livelihood. In a study conducted in Kenya by Uchino (2016). Grounded theory methodologies were used to collect and analysed data from narrative of women during in patient stay after fistula surgery in three hospitals. Emergent themes contributed to the generation of substantive theory and conceptual frame work on the health seeking behaviour of fistula patients. A total of 121 participants (women with obstetric fistula) were recruited aged 17 to 62 years whose treatment path ways are presented. Gave their narratives of the experience of heath seeking behaviour during fistula illness. These narratives were used to construct the composite pathway. The demographic characteristics of 2 women whose narrative are included in the composite pathway were not obtained and consequently 119 women are presented. The participants' mean age were 33.2 (17 to 62 years). The mean age at fistula development was 23.2 years. Women generally had low level of education with 12.6% having no formal education, and further 54.7% had obtained primary education only. About a third of the women had no surviving child and half had developed fistula during their first pregnancy delivery. The participants described long episodes of labour at home under unskilled birth attendant. Staying with fistula illness entailed health seeking through seven key actions of staying home, trying home remedies, consulting with the private health care providers, nongovernmental organizations, prayers, traditional medicine and formal hospitals and clinics. Long treatment trajectories at hospital resulted from multiple hospital visit and surgeries. Seeking treatment at hospital is the most popular step for most women after recognizing fistula symptoms. It has concluded that the formal health system is not responsive to women's needs during fistula illness. Women suffer an illness with a chronic trajectory and seek alternative forms of care that are not lineally placed to treat fistula illness. The results suggest that a robust health system be provided with expertise and facilities to tract obstetric fistula to shorten women's treatment pathways. A study in Africa reported that immediately after the fistula occurred, 14% of new patients were divorced by their

husbands; and only 14% continue to live with their husbands, if the condition persisted, 28% of the women were divorced and only 11% were allowed to stay. And among women affected with fistulas in Niger, 63% were divorced. Often, until they are cared, married women with fistula are sent back to their parents' home where they are not allowed to cook food, participate in social event, or to perform religious rituals. A study of how women with fistula perceive the societal reaction toward them in Nigeria fund that most (53%) consider themselves rejected. Our meta-analysis for the estimation of the mean percentage of women who are divorced or abandoned. A random- effect estimate shows that about 36% of the women (95% cl, 27%-46%) (47% with fixed effect estimate) were divorced or separated. (Ojanuga, 2009).

**Coping strategies and psychological wellbeing of VVF patients:**

Coping is defined as a psychological process in which an individual attempts to manage external or internal demands. According to Elzubeir and Magzoub (2010) in the study on stress and coping strategies among vesicovaginal fistula patients, 275 women were used in the study, their age range between 30-40 years with a median of 25 years. 40% were emotionally disturbed (anxiety disorder) and 53% reported that they attend religious crusades and also visit pastors for counselling.

In a study conducted in Tanzania, fifty-four women receiving fistula repair at a Tanzanian hospital completed a structured survey. The study aimed to examine religious coping among women with obstetric fistula. Religious coping scale (RCOPE). was used to assess positive and negative religious coping strategies. Analysis included association between negative religious coping and key variables (demographics religiously. Anxiety, social support and stigma). Forty-five women also completed individual in-depth interviews where religion was discussed. Although participant utilized positive religious coping strategies more frequently than negative strategies (P<.001). 76% reported at least one form of negative religious coping (Nathan, 2010).

Similarly, in a study conducted in Tanzania among 144 vesicovaginal fistula patients, a BRIEF SCOPE was used to determine their level of coping skills. In the study, fistula patients were asked to rate the extent to which they used various strategies to deal with either a medical condition (when applicable) or with general stress. Majority of the respondents have shown resignation coping (Kelly, 2013).

According to (Teunissen, 2013) 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 drive great relief from being with their likes. United Nations population fund & engender health (UNPFA) 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 (Denise, et al. 2016).

Women's dignity project and engender health observed that following successful fistula repairs women resume normal lives and are able to work freely with their families, friends and communities. United States Agencies for International Development (USAID) has programs that support the social re-integration of women with fistula through teaching basic literacy and income generating skills to make them regain their self- respect and rebuild relationships towards the communities.

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 (Carlson & chamber, 2014).

**Age and psychological wellbeing of VVF patients**

Obstetric fistula is the most frequently found complication in the obstetric care facility in Bangladesh. In addition to physical illness, this lifelong complication is also associated with declined psychological wellbeing of the sufferers. This research study carried out in Bangaladash by Yeung (2017), in order to find out the associated factors in the occurrence of obstetric fistula and their effect on the psychological wellbeing of women of reproductive age group, by the use of cross-sectional design. A total of 108 women aged between 15 and 35 years were interviewed with a semi structural questionnaire to explore their sociodemographic, obstetric, and psychological wellbeing domains. Statistical Analysis Used: The frequencies of the different variables were analysed using statistical package for the social sciences (SPSS) 20 soft were, and chi-square test was done to observe the associations. The average age of the participants was 23 years. Over 40% of women had their first delivery between the ages of 16 to 18 years and the same percentage of them had never taken antenatal checkup during their pregnancy. Obstetric fistula was found in nearly 45% of the women after their first delivery. Over two thirds of the women were found to have a severe depression after the incident. Despite being common in the younger age group, patients older than 25 years were more prone to the severity depression and low psychological wellbeing. The present study strongly supports the association of having obstetric fistula with reduce mental health or psychological wellbeing ranging from having moderate to extreme depression. Yeung, (2017). Stated that, often associated with declines and loses of physical, cognitive and social domain, with many older people perceived as unhappy, lovely or depressed.

**Theoretical framework**

**Ecological models of health behaviour**

Emphasize the environmental and policy contexts of behaviour, while incorporating social and psychological influences. Ecological models lead to the explicit consideration of multiple levels of influences thereby guiding the development of more comprehensive interventions. Ecological models help us to understand how people interact with their environments. That understanding can be used to develop effective multi-level approaches to improve health behaviour. The model shows that human health behaviour is influenced by the interaction between personal, situational, social cultural and environmental factors, including the built environment. Inclusion of all these types of analysis provides an opportunity to see the influence of interpersonal (level of NBF individual knowledge, attitudes, and beliefs about obstetric care) and interpersonal (level of support from spouses, families, neighbours and traditional birth attendants) behaviour factors on women's health and social circumstances. It also helps to explain the influence of social cultural and environmental factors on women's health and circumstances. It also helps to explain the influence of socio-cultural and environmental factors on the occurrence and consequences of fistula (Keyser, 2014).

**Abraham Maslow's Hierarchy of Need Theory**.

Theory explained the psychological and social effects of vesicovaginal fistula. Maslow's hierarchy of need is a theory comes under theories of motivation in psychology, this theory proposed by Abraham Maslow in 1943. Maslow posited that human needs are arranged in a hierarch y, he described the need in a stratified layer: he identified the need as physiologic, safety and security, love a belongings, self-esteem and self- actualization and further stated that people are motivated to achieve certain needs, when one need is fulfilled then next one and so on.

One must satisfy the lover basic needs before progressing to meet higher level growth needs. Once these needs have been reasonably satisfied one may be able to reach the highest level called self-actualization. Unfortunately, progress is often disrupted by failure to meet lower needs. Life experiences including divorce and loss of job may cause an individual to fluctuate between levels of hierarchy, hence VVF patients finds it difficult to accomplish these needs.

**Physiologic needs:** Physiologic needs take precedence over other needs in Maslow's hierarchy of needs. They are considered basic needs are obvious and necessary for survival. These needs include breathing, human nutrition, water, homeostasis and elimination.

**Safety and security:** Coming immediately after physiologic needs are safety and security needs which form the second level. These needs include personal security, financial security health wealth being safety needs against accidents/ illness and their adverse impacts.

**Love and belongings:** The third level needs according to Maslow are love and belongings. This aspect involves emotionally based relationship in general e.g., Friendship and intimacy, family, human needs to feel sense of belongings and acceptance, people generally need to feel that they are loved by their family and accepted by their friends and other citizens. In the absence of these elements, many are susceptible to loneliness, social anxiety and clinical depression.

**Self-esteem needs:** All human has needed to be respected and to have self-esteem and self-respect. Esteem presents the normal human desire to be accepted and valued by others. Imbalances at this level can result in how self-esteem or an inferiority complex. People with low self-esteem need respect from others they may seek fame or glory which again depend on others. Psychological implicates such as depression can also prevent one from obtaining self-esteem.

**Self-actualization:** The highest level of human needs in Maslow hierarchy is self-actualization. This level of needs pertains to what person's full potential is and realizing that potential. Maslow describes this desire to belonging everything one is capable of becoming Similarly; theory of motivation was used; the researcher utilized the Abraham.

## METHOD

### Design

The design of this study was a survey research design wherein questionnaires were administered to the participants. Survey research normally gather factual information

concerning people's attitude, behaviour, opinions and feelings in their natural settings. Hence this study gathered information on the influence of social support, and coping strategies on the psychological well-being of VVF patients at Murtala Muhammad Specialist Hospital, Kano, Nigeria.

**Population, Sample and Sampling Techniques**

The population of the study include, 480 VVF patients from both ward and those attending outpatient of Murtala Muhammad Specialist Hospital (MMSH). Using Krejcie and Morgam (1970) to get sample size of 220 participants. The young patients were between the age of 13 to 34 years while the old age patients were between the age of 35 to 45 and above. most of the patients do not attends schools as such they are illiterate and also, they are from low social class level. Purposive sampling techniques were used in the selection of participants diagnosed with vesicovaginal fistula attending clinic and those on admission in the wards at Murtala Muhammad Specialist Hospital Kano, Nigeria.

**Method of Data Collection**

This study administered three sets of research instruments for data collection. They are described thus:

**Multidimensional Scale of Perceived Social Support (MSPSS)**

This is a 12 items instrument developed by Zimet, Dahlem, Zimet and Farley (1988). It was designed to assess how an individual perceive support from friends, family and significant others. The authors provided the reliability coefficient of the instrument to be .79. In items 1, 2, 5 and 10 are for significant other sub scale, items 3, 4, 8 and 11 are for family subscale whereas items 6, 7, 9 and 12 provides for friend's subscale. In terms of scoring of the instrument, the items in each of the subscale are sum up and divided by 4 each.

**Psychological Wellbeing Scale (PWB)**

This is a 12 items version of the Ryff psychological wellbeing. It was designed to purposely assess people's psychological wellbeing in six domains of autonomy, environmental mastery, personal growth, positive relations with others, purpose in life and self-acceptance. The 12 version of the instrument was developed by Ryff and Keyes (1995) and has a reliability coefficient of .84. Items 15, 17, and 18 measures autonomy, the environmental mastery is measured by items 4, 8, and 9 while items 11, 12, and 14 measure the personal growth of the scale. In addition, the positive relations with others domains are measure by items 6, 13 and 16 while the purpose in life have items 3, 7, and 10. Finally, the self-acceptance domain of the scale is measure by items 1, 2, and 5.

**Coping Strategies Scale**

The coping scale assesses cognitive, emotional and behavioural methods of dealing with problems. It is a 13 items scale developed by Hamby, Grych and Banyard (2013). In the present study, the internal reliability Cronbach's alpha for the scale's scores was 0.84. The questionnaire consisted of 13 items with a Likert Scale of 1 – 4: Not true about me, Of little true about me, Somewhat true about me and mostly true about me.

**Procedure**

Before the researcher proceed to the field of study, first and for most obtained an introductory letter from the Head of department of psychology, Nasarawa State University, Keffi, to the management of Murtala Muhammad Specialist Hospital Kano, Nigeria, for Permission to conduct the research study in the identified section of the Hospital. After permission was granted, the researcher established rapport with the participants and informed them the purpose of the study and the need for their participation. Also, they were notified that participation is voluntary and they can withdraw at any point in the course of the study without any harm to them. In addition, the researcher employed the use of an interpreter because of the participant have no formal education. At the end of the exercise, the researcher debriefed the participants and thanked them accordingly for their participation.

**Techniques for Data Analyses**

Since this study attempted to examine the relationship between and among the variables of interest, the researcher employed the use of Pearson product moment correlation and T-test for independent sample was used and determined the age differences of VVF patients on psychological wellbeing Murtala Muhammad specialist Hospital Kano.

**RESULTS**

**Table 1. Data Presentation**

**Table 1: Demographic Information of the respondents**

| Age | Frequency | Percentage |
|---|---|---|
| **15-24** | 25 | 11.6 |
| **25-34** | 43 | 19.9 |
| **35-44** | 93 | 43.1 |
| **45 and above** | 55 | 25.4 |
| **Total** | **216** | **100** |
| **Educational status** | | |
| **None** | 198 | 91.7 |
| **Primary** | 18 | 8.3 |
| **Secondary** | 0 | 0 |
| **Tertiary** | 0 | 0 |
| **Total** | **216** | **100** |

| | | |
|---|---|---|
| **Occupation** | | |
| **Self-employed** | 5 | 2.3 |
| **Civil servant** | 0 | 0 |
| **Unemployed** | 211 | 97.7 |
| **Total** | **216** | **100** |
| **Marital status** | | |
| **Single** | 0 | 0 |
| **Married** | 14 | 6.5 |
| **Widowed** | 5 | 2.3 |
| **Separated** | 0 | 0 |
| **Divorced** | 197 | 91.2 |
| **Total** | **216** | **100** |
| **Place of last delivery** | | |
| **Hospital** | 189 | 87.5 |
| **Primary health centre** | 11 | 5.1 |
| **Home** | 16 | 7.4 |
| **Total** | 216 | 100 |

Table 1 revealed that a total of 25 of the respondents representing 11.6% were between the age of 15-24 years, 43 of the respondents representing 19.9% were between the age of 25-34 years, 93 of the respondents representing 43.1% were between the age of 35-44 years while 55 of the respondents representing 25.4% were between the age of 45 and above years. The majority of the respondents were within 35-44 years of age. The educational qualification of the respondents is that 198 of the respondents representing 91.7% have no educational certificate, 18 of the respondents representing 8.3% have primary school certificate, none have secondary school while none have tertiary certificate. The majority of the respondents have no formal education. In terms of the occupation of the respondents, 5 of the respondents representing 2.3% are self- employed, 0 of the respondents representing 0% are civil servant while 211 of the respondents representing 97.7% are unemployed. Therefore, the majority of the respondents are unemployed. With the respect to the marital status of the respondents only, 14 of the respondents representing 6.5% are married, 5 of the respondents representing 2.3% are widowed, 0 of the respondents representing 0% are separated while 197 of the respondents representing 91.2% are divorced. Majority of the respondents are divorcee. In addition, the

place of last delivery of the respondents. 189 of the respondents representing 87.5% delivered at the hospital, 11 of the respondents representing 5.1% delivered at the primary health care while 16 of the respondents representing 7.4% delivered at home. The majority of the respondents delivered last at the hospital.

**Test of Hypotheses**

**Hypothesis 1:** There will be significant relationship between social support and psychological wellbeing of VVF patients at Murtala Muhammad Specialist Hospital Kano, Nigeria. This hypothesis was tested at 0.05 level of significant using the Pearson product moment correlation. and the results are presented in the table below

**Table 2:** Showed PPMC coefficient between social support and psychological wellbeing.

| Variable | N | Mean | Std | r. | P. Value | Decision |
|---|---|---|---|---|---|---|
| Social Support | 216 | 73.68 | 12.68 | .37 | .000 | significant |
| Psychological Wellbeing | 216 | 97.47 | 9.98 | | | |

**r= - .37, P<0.05**

The result in table 2 above shows that r. calculated.37 and p. value .000 which is less than alpha 0.05 level of significance, therefore the hypothesis of there will be significant relationship between social support and psychological wellbeing of VVF patients at Murtala Muhammad Specialist Hospital Kano, Nigeria is to be significant. This means that there is significant correlation coefficient between social support and psychological wellbeing.

**Hypothesis 2:** There will be significant relationship between coping strategies and psychological wellbeing of VVF patients at Murtala Muhammad Specialist Hospital Kano, Nigeria. This hypothesis was tested at 0.05 level of significant using the Pearson moment correlation. And the results were presented in the table below:

**Table 3:** Showed PPMC coefficient between coping strategies and psychological wellbeing.

| Variable | N | Mean | Std | r. | P. Value | Decision |
|---|---|---|---|---|---|---|
| Coping Strategies | 216 | 39.65 | 5.01 | .35 | .000 | significant |
| Psychological Wellbeing | 216 | 97.47 | 9.98 | | | |

**r= - .35, P<0.05**

From the above table 3, the result reveals that r. calculated .35 and p. value .000 which is less than alpha 0.05 level of significance, therefore the hypothesis of there will be significant relationship between coping strategies and psychological wellbeing of VVF patients at Murtala Muhammad Specialist Hospital Kano, Nigeria is significant. This means that there is significant correlation coefficient between coping strategies and psychological wellbeing.

**Hypothesis 3:** Older VVF patients will significantly report better psychological wellbeing than younger VVF patients at Murtala Muhammad Specialist Hospital Kano, Nigeria. This hypothesis was tested at 0.05 level of significant, using t-test. And the results were presented in the table below:

**Table 4:** Showed t –test on age difference in psychological wellbeing.

| Age | N | Mean | Std | S.E.M | t | df | P. Value | Decision |
|---|---|---|---|---|---|---|---|---|
| Younger | 68 | 101.3088 | 14.36440 | 1.74194 | 3.96 | 214 | .000 | Rejected |
| Older | 148 | 95.7095 | 6.46314 | .53127 | | | | |

**t (214) =3.957, P<0.05**

The t-test analysis from the above table 4.4 reveals that t – calculated 3.96 at df 214 and p. value .000 which is less than alpha 0.05, therefore, the hypothesis of older VVF patients will significantly report better psychological wellbeing than younger VVF patients is rejected. This reveals that younger VVF patients significantly report better psychological wellbeing than older patients at Murtala Muhammad Specialist Hospital Kano, Nigeria.

**Discussion of Findings**

The result of the hypothesis one revealed that there is significant relationship between social support and psychological wellbeing of VVF patients at Murtala Muhammad Special Hospital, Kano State. The result of Pearson product moment correlation was confirmed in this study which shows that there is significant correlation between social support and psychological wellbeing.

This implies that social support significantly influences psychological wellbeing of VVF patient at Murtala Muhammad Hospital Kano. This finding is in line with the research finding of Racino (2016), which stated that social support can be measured as the perception that one has assistance available, the actual received assistance or the degree to which a person is integrated in a social network. The finding also provide support from the work of Uchino (2014) which stated that social support has been linked to many benefits for both physical and mental health.

Also, the result of hypothesis two shows coping strategies has significance influence on psychological wellbeing of VVF patient at Murtala Muhammad Specialist Hospital Kano, the result of Pearson product moment correlation was confirmed in this study which reveals that there is significant correlation coefficient between coping strategies and psychological wellbeing. This implies that coping strategies significantly influence psychological wellbeing of VVF patient at Murtala Muhammad Specialist hospital. This finding is in line with the work

of Lazarus and Folkman (1994) which stated that the effectiveness of the coping effort depends on the types of stress the individual and circumstances coping responses are partly controlled by personality but also partly by the social environment particularly the nature of the stressful environment.

Similarly, the result of Hypothesis three using the t-test to determine the age differences in psychological wellbeing among VVF patients revealed that younger patients reported better psychological wellbeing than older VVF patients. This finding is in line with the work of Yeung (2017), which stated that, old age is often associated with decline and losses of physical, cognitive and social domain, with many older people perceived as unhappy, lonely or depressed.

**Summary**

The study on influence of social support and coping strategies on the psychological wellbeing of VVF patients at Murtala Muhammad specialist hospital was presented in five chapters: introduction, background to the study, statement of the problem, three research questions, three objective of the study and three alternative hypotheses were formulated for this study, significance of the study, scope of the study and definition of the term (operational) of the study as well. Chapter two consist literature review, on related variables as social support, coping strategies, psychological wellbeing and vesicovaginal fistula. Others include empirical review, theoretical framework and summary review. While chapter three was on research methodology, it consists of research design, population of the study, sample size, sampling techniques, method of data collection. A well-structured adapted questionnaire was used.

Three (3) hypotheses were formulated to establish the influence of social support and coping strategies on the psychological wellbeing of VVF patients at Murtala Muhammad specialist hospital Kano state. Data analysis procedures on the research question of the study were addressed with mean and standard deviation, while the bio-data variables were analyzed using frequencies and percentages. The sub-hypotheses were tested with Pearson product moment correlation (PPMC) and t-test analysis at 0.05 alpha level of significance.

The result of the findings from the analysed data were summarized as follows:

i. Hypothesis One: was confirmed that, there is significant relationship between social support and psychological wellbeing of VVF patients at Murtala Muhammad Specialist Hospital Kano, Nigeria.
ii. Hypothesis Two: confirmed that there is significant relationship between coping strategies and psychological wellbeing of VVF patients at Murtala Muhammad Specialist Hospital Kano, Nigeria.
iii. Hypothesis Three: was rejected that, in the study which stated the Older VVF patients significantly report better psychological wellbeing than younger VVF patients at Murtala Muhammad Specialist Hospital Kano, Nigeria.

**Conclusion**

This study investigates the relationship between social support and coping strategies on the psychological wellbeing of Vesical Vaginal Fistula patient at Murtala Muhammad Specialist Hospital, it concluded that there is significant correlation coefficient between social supports

and psychological wellbeing of VVF patients at Murtala Muhammad Hospital Kano, which means social support significantly influence psychological wellbeing of VVF patient at Murtala Muhammad Hospital Kano. The result also found that there is significant correlation coefficient between coping strategies and psychological wellbeing which means coping strategies significantly influence psychological wellbeing of VVF patients at Murtala Muhammad Hospital Kano, and also the result found out that younger VVF patients significantly reported better psychological wellbeing than older VVF patients at Murtala Muhammad Hospital Kano. In other words, the hypothesis was confirmed in this study. This implies that social support significantly influences psychological wellbeing of VVF patients at Murtala Muhammad Hospital Kano. Coping strategies significantly influence psychological wellbeing of VVF patients at Murtala Muhammad Hospital Kano. Younger VVF patients significantly report better psychological wellbeing than Older VVF patients at Murtala Muhammad Hospital Kano.

**Recommendations**

Based on the outcome of this study, the researcher recommends the following:

The VVF patients should continue to maintain good social support from their families, health workers as well as non-governmental organizations to keep their psychological wellbeing at Murtala Muhammad Hospital Kano.

VVF patients should also learn more coping strategies from significant people around them like families and health workers to maintain their good coping strategies at Murtala Muhammad Hospital Kano.

It is also recommended that older VVF patients as well, needs their families, health workers and other non-governmental organization to provide more social support to them for the better psychological wellbeing. Old age VVF patients should be encourage to engage themselves into religious activities so that their faith will increase to cope with the situation, and boost their psychological wellbeing like the younger VVF patients at Murtala Muhammad Specialist Hospital, Kano State.

Lastly, the Government should provide a conducive center in each of the hospital in the state, so that VVF patients should at least get peace of mind and contentment that will boost their social support and coping strategies for a better psychological wellbeing.

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