THE NIGERIAN JOURNAL OF SOCIOLOGY AND ANTHROPOLOGY

ISSN: 0331-4111
E-ISSN: 2736-075X
Volume 23, No. 2 (November, 2025)

DOI: 10.36108/NJSA/5202.32.0280

Factors Influencing Care and Support for women with Vesicovaginal Fistula in Nigeria: A Comparative Study of Ebonyi and Plateau States

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Abstract
The study explores socio-demographic and contextual factors influencing care and support for women with Vesicovaginal Fistula (VVF) in Nigeria, with particular reference to Ebonyi and Plateau states. Employing a mixed-methods approach within a comparative cross-sectional design, data were collected from hospital records (Ebonyi (136) and Plateau (381), In-depth Interviews (IDIs), and case-studies. Quantitative data were analysed using descriptive and inferential statistics, while the qualitative data were content-analysed. Findings indicate that the likelihood and nature of support are significantly associated family support and the following variables: age (x^2 = 65.133, $p<0.05$), religion (x^2 = 32.383, $p<0.05$), educational attainment (x^2 = 33.396, $p<0.05$), marital status (x^2 = 134.021, $p<0.05$) and parity (x^2 = 42.971, $p<0.05$) variables such as state of residence, age, religion, educational level, marital status and parity. Although the factors affecting care and support were similar in the two thematic states, little variations were reported. For instance, in Ebonyi State, support was ascribed mainly to husbands, whereas in Plateau, support was offered more by relatives rather than the spouse. Factors such as community perceptions, number of repairs for VVF patients, marital status further influenced support dynamics. The results underscore the importance of ecology and socio-cultural context in shaping support systems for VVF patients. There is a need for public sensitization on the causes and treatment of VVF and emphasises a holistic approach involving medical, social, and educational interventions to improve the quality of life of affected women.

Keywords: Vesicovaginal Fistula in Nigeria, public sensitization on VVF, Ecology of VVF support system

Background

Effective coping mechanisms among individuals suffering from medical conditions is contingent upon the care and support they receive from significant others. For women living with Vesicovaginal Fistula (VVF), adequate support which involves giving attention to the medical, emotional, physical, educational and social needs is essential to improving their quality of life (Peter & Sunday, 2017). VVF, a maternal health issue, is characterized by continuous leakage of urine due to injury between the bladder and the vagina. The condition impacts the mental, social and physical well-being of affected women and girls (Barageine, *et al*., 2015; Nduka, Ali, Kabasinguzi, & Abdy, 2023). While some patients benefit from support from husbands, relatives, and friends thereby enabling them to navigate the condition effectively (Adeusi, Olujide, & Ebere, 2014), others experience neglect and abandonment (Okoye, Emma-Echiegu, & Tanyi, 2014; Nweke & Igwe, 2017; Fehintola *et al*., 2019). Factors associated to abandonment includes offensive odors, uncontrollable urine leakage, sporadic leakage even after surgical repair and challenges with sexual activity. Initially, significant others may demonstrate adequate concern, but as the conditions persist, care and support diminish, with patients increasingly blamed for their situation (Nsemo, 2014). Lack of emotional and financial support impedes the coping mechanism of VVF patients thereby leading to social withdrawal, depression and reliance on charity.

In response, Governmental and Non-Governmental Organisations (NGOs) as well as religious institutions have offered support through financial assistance for surgical repairs and relief materials (Ijaiya *et al.,* 2010). However, support from institutional sources may be insufficient without active involvement from close relatives. In African societies, particularly Nigeria, familial and spousal support are crucial for emotional stability. This study seeks to explore factors influencing whether a patient will receive care and support or not.

Theoretical Framework

The study adopted the Ecological Model of Health to explain how multiple level of influence (individual, interpersonal, community and institutional) interact to affect care and support for VVF patients. At the intrapersonal level, factors such as biology, knowledge and attitudes shape perceptions of VVF. At the interpersonal level, the attitudes of significant others can either promote or hinder supportive behaviours. For instance, when VVF is perceived as resulting from obstetric complications, significant others and community members may be more compassionate on the other hand, when viewed as a curse or a punishment for wrongdoing, patients may face rejection and abandonment. Surely, a social and structural environment that is not supportive can hinder a patient's ability to manage her condition. By implication therefore, improving community perception and engagement of significant others is key to enhancing care and support of VVF patients and ensuring better health outcomes.

Materials and Methods

The study adopted a comparative cross-sectional survey design within a mixed method research framework, combing both quantitative and qualitative approaches in eliciting primary and secondary data. The research was conducted in Ebonyi and Plateau states with recognized medical institutions specializing in VVF treatment. These centers were selected due to their extensive records of VVF cases and comprehensive services provided to patients. The target population comprised women diagnosed with VVF and receiving treatment or follow-up care and health care professionals (medical doctors and nurses). Primary data were elicited through In-depth interviews (Ebonyi (20) Plateau (20) States) and case studies (Ebonyi (4) Plateau (4) States).

Secondary data were elicited from hospital records (Ebonyi (136) and plateau (381) states). Ethical approval was obtained from the respective hospital ethics committees. Informed consent was secured from all participants, with assurance of anonymity, confidentiality and the right to withdraw from the study at any point. Quantitative data were analysed using descriptive and inferential statistics. The qualitative data were analysed using thematic content analysis for the purpose of deriving meaningful interpretations.

Results

Access to social support is crucial for the management of any health condition. To assess whether VVF patients received support from community members, data were retrieved and analysed from hospital records. The findings, presented in figure 1, indicate that the majority of VVF patients received support (94% and 81.8% in Ebonyi and Plateau state respectively). Overall, only 15.2% of patients lacked support. These results suggest that while most patients benefited from support systems, those in Plateau were less likely to receive family support compared to their counterparts in Ebonyi state.

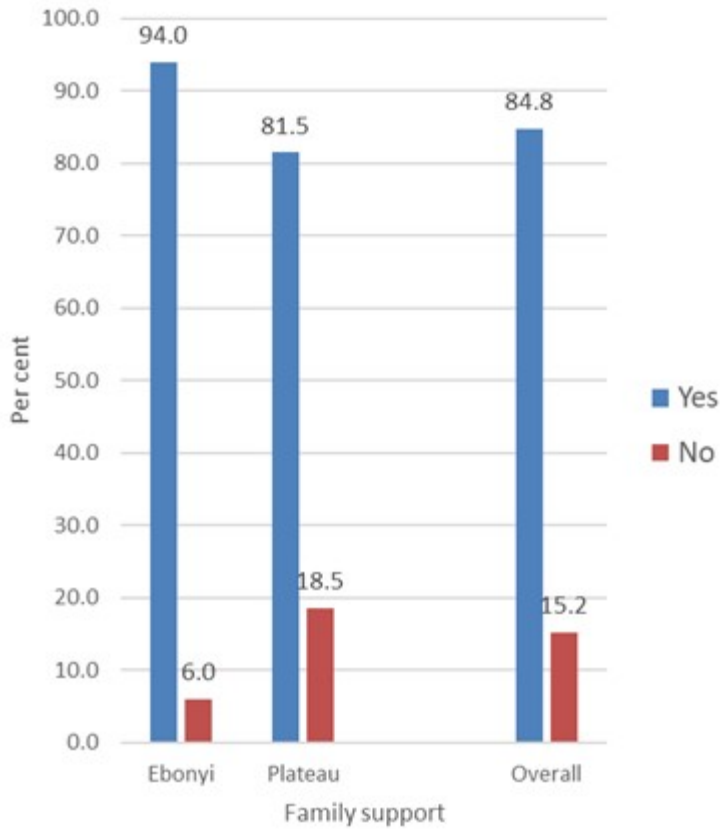

Fig. 1: Distribution of VVF patients by family support
Source: National Fistula Centre Abakaliki and Bigham Teaching Hospital Jos

Figure 2 presents a detailed analysis of the family members who provided support to patients with VVF. In Ebonyi state, the majority of support came from the patient's husbands (83.2%), followed by parents (10.7%) and other relatives (6.1%). In contrast, in Plateau state, over half of the patients (54.8%) reported receiving support primarily from other relatives, highlighting a notable difference from Ebonyi state, where husbands were the main caregivers. Although when aggregated, husbands and relatives provided nearly equal levels of support across both states. This data illustrates significant regional variations in the familial roles involved in caring for VVF patients.

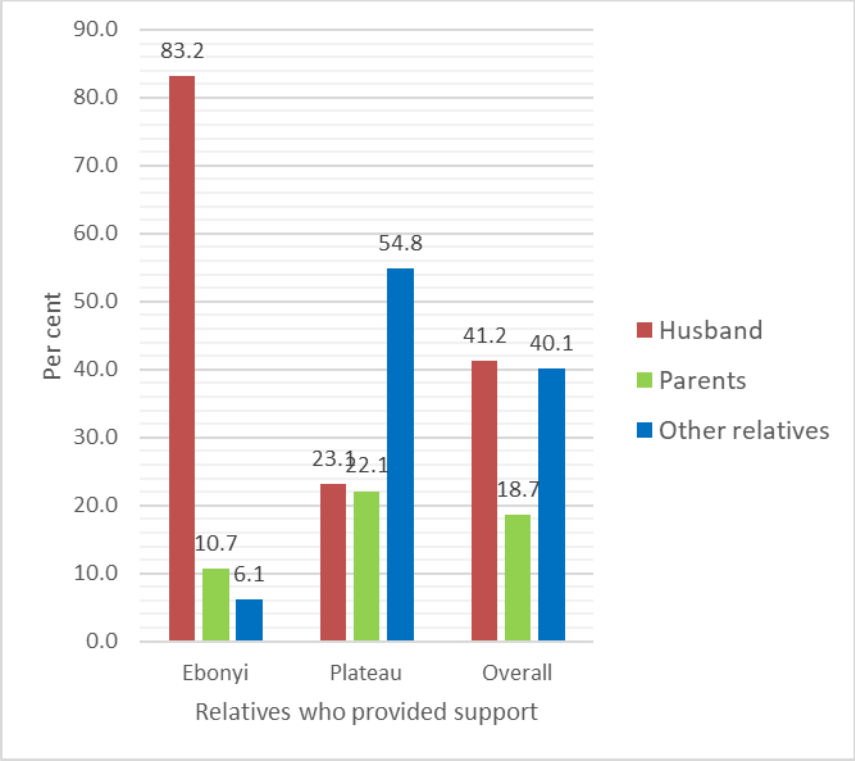

Fig. 2: Distribution of VVF patients by the relatives who provided support
Source: National Fistula Centre Abakaliki and Bigham Teaching Hospital Jos

Table 1 presents the cross-tabulation of family support across selected socio-demographic characteristics of VVF patients. The result indicates statistically significant association between family support and the following variables: age (x^2 = 65.133, p<0.05), religion (x^2 = 32.383, p<0.05), educational attainment (x^2 = 33.396, p<0.05), marital status (x^2 = 134.021, p<0.05) and parity (x^2 = 42.971, p<0.05). These findings suggest that the identity of the primary support provider – whether a husband, parent, or their relatives- is significantly influenced by the patient's state of residence, age, religion, education level, marital status the number of children. Additionally, these factors may serve as indicators of the strength and nature of social ties within the patients' families.

Table 1: Cross-tabulation of family support by socio-demographic characteristics

Socio-Demographic Characteristics	Response Categories	Who Provided Family Support			Chi Square
		Other Relatives	Husband	Parent	
State**	Ebonyi	8 (6.1)	109 (83.2)	14 (10.7)	x^2=138.952 P=0.000
	Plateau	166 (54.8)	71 (23.4)	66 (21.8)	
Age**	15 – 19	15 (8.8)	7 (3.9)	13 (18.6)	x^2=65.133 P=0.000
	20 – 24	27 (15.8)	23 (12.8)	27 (38.6)	
	25 – 29	35 (20.5)	33 (18.3)	15 (21.4)	
	30 – 34	31 (18.1)	41 (22.8)	7 (10.0)	
	35 – 39	23 (13.5)	36 (20.0)	5 (7.1)	
	40 – 44	8 (4.7)	21 (11.7)	3 (4.3)	
	45+	32 (18.7)	19 (10.6)	0 (0.0%)	
Religion**	Christianity	101 (58.4)	149 (83.7)	46 (58.2)	x^2=32.383 P=0.000
	Islam	71 (41.0)	28 (15.7)	33 (41.8)	
	Traditionalist	1 (0.6)	1 (0.6)	0 (0.0)	
Educational Attainment**	No formal education	89 (51.4)	50 (27.8)	27 (33.8)	x^2=33.296 P=0.000
	Primary	39 (22.5)	38 (21.1)	23 (28.8)	
	Secondary	35 (20.2)	71 (39.4)	28 (35.0)	
	Tertiary	10 (5.8)	21 (11.7)	2 (2.5)	
Marital Status**	Single	14 (8.2)	0 (0.0)	26 (32.9)	x^2=134.021 P=0.000
	Married	107 (62.6)	174 (96.7)	38 (48.1)	
	Separated	18 (10.5)	2 (1.1)	11 (13.9)	
	Divorced	19 (11.1)	0 (0.0)	3 (3.8)	
	Widow	13 (7.6)	4 (2.2)	1 (1.3)	
Parity**	0	3 (1.8)	1 (0.6)	5 (7.1)	x^2=42.971 P=0.000
	1	57 (33.5)	38 (22.5)	33 (47.1)	
	2	22 (12.9)	24 (14.2)	9 (12.9)	
	3	16 (9.4)	33 (19.5)	7 (10.0)	
	4	11 (6.5)	24 (14.2)	4 (5.7)	
	5	20 (11.8)	9 (5.3)	4 (5.7)	
	6+	41 (24.1)	40 (23.7)	8 (11.4)	

Significant at P<0.01**

Source: National Fistula Centre Abakaliki, and Bigham Teaching Hospital Jos

Factors Influencing Care and Support for VVF Patients

This section examines and documents the factors influencing care and support for VVF patients. Six emerging themes were generated, as highlighted below:

i. Community perception on VVF patients;
ii. Number of repairs for VVF patients;
iii. Marital status;
iv. The perceived cause of VVF;
v. Level of husbands' affection towards wife;
vi. Husband's decision.

Community Perception on VVF Patients

This study explored community perceptions and support for individuals affected by VVF. The findings revealed that community attitudes towards VVF patients is multifaceted. On the positive side, the research indicated that community members who have previous knowledge of VVF often provide emotional support and encouragement. For instance, one respondent recounted receiving empathetic remarks from her community, in the following statement:

> I use to receive words of encouragement and sympathy from people at the village, nobody was making mockery of me or rejected me, and they rather consoled me with examples of others that have had similar experience. I received encouraging words from my church members and women in the community. (*IDI/VVF Patient/34 years Old/Ebonyi*)

In another expression of positive perception, it was maintained by a participant that community members were good to her. As she noted:

> They are all good to me, especially my church members. They always pray and ask after me, even as am here now they use to call me and ask how am fairing. For other community members, most of them are not aware except a few close friends. Some people may have heard and spoken badly about me but I am not aware of any of such. (*IDI/VVF Patient/55 years Old/Ebonyi*)

In the expression of this participant who said she had no problem relating with the members of her church and community even with her condition, she noted that:

> I do not have problem with anybody, although is only a few of my church members that are aware of this problem, I stay in the town where everybody minds his/her business, nobody is aware of my condition, I don't even have much friends, I stay indoors all the time, except if I want to go to church or market to buy something. (*IDI/VVF Patient/36 years Old/Ebonyi*)

However, this positive attitude was not universal. Some participants reported experiencing negative reactions from community members, particularly due to the odor associated with VVF. These reactions led to feelings of shame and social withdrawal among affected individuals. One participant detailed how such stigmatization influenced her decision to avoid public spaces. She noted that:

> My relationship is normal with my family. And I am fine. I know I will be well after my treatment. I feel some people don't like me and are afraid of coming close to me because of the smelling related to urine leakage. Even my mother sometimes feels irritated. I stay at home without going out. I do not go to where people are so that I will not be disgraced. (*IDI/VVF patient/20 years Old/Plateau*).

From another patient whose mother expressed the reaction of community members towards the patient she cares for, it was revealed that community members stigmatize her. In her words:

> Her friends laugh at her because they feel a child of that age should not be urinating on herself. In the community she gets a lot of bad talks such as "*ki tashi mun anan me warin pisari*" (move away from me, you are smelling). However, she has some good friends especially those who know it is a sickness and not a habit. (*IDI/VVF patient/9 years old/Plateau)*.

Community perceptions of VVF significantly influence the level of care and support provided by spouses, family members, and the wider community. A positive societal perception of individuals living with VVF is often associated with compassionate care and emotional support. Conversely, when these perceptions are negative, patients are more likely to face neglect and social isolation. These perceptions therefore, play a crucial role in shaping the social experiences and recovery trajectories of affected women.

Number of repairs on VVF patients

The number of surgical repairs a patient undergoes has been shown to impact the nature of the support received. For example, one participant noted that although her spouse had been supportive during initial stages of treatment, this support diminished after subsequent repairs failed. As she explained:

> The care and support is not okay; when it started people were still around me, my husband gave me money to come for repair but after the 1st and 2nd repair did not work, I had to look for money (5000 naira) to come back for the third repair and till date, his one kobo has not been given for my treatment. The care taker my husband sent to bring me down the first time spent all the money he was given on drinks and meat and left me without food and toiletries. He was sent because he knew the place. When he got back, he was appreciated with chicken and cash gift of 10,000 naira after squandering my money. Subsequently I starting coming alone with no one to help. He has stopped showing care and concern. When I go to ask for funds, he will not even look at me

> talk less of answering me. I had to go look for money which was not even enough to come to Jos. After my checkup I could not go back home because I did not have money for transportation. I have to remain here until I raise money. I act as a care giver sometimes for other patients. Like today for instance, I could only get pap in the morning and that is all so I depend on people's food. Thank God I was allocated a space in the VVF hostel after complaining. Even my own family is not caring; for instance, my mother said her hands are not in this matter. (*IDIVVF Patient 30 years Plateau*)

Her experience suggests that repeated surgical interventions, particularly when unsuccessful, may lead to frustration among caregivers and family members, ultimately resulting to reduced support. In addition to this, another VVF patient explained that it was during her first repair the husband was very supportive but during the second repair, he was not. As she narrated:

> My husband has never pitied me; he did not care even though he is rich. He divorced me because of my situation. He only showed interest in the first surgery but left me when he noticed it was not successful. Had it been my father was alive I would have gotten good care; I have been the one taking care of myself with no support from anyone. Finance has been difficult; when I was told to go and come back after four months I could not, because there was no money. I stayed for a year before coming due to lack of support. (*Case study VVF Patient 30 years Plateau*)

These findings suggest that psychosocial support of those around the patient (especially significant others), plays a key role in determining the continuity and quality of care that they receive. When surgical repair is successful and limited to a single occurrence, relationships remain supportive. But multiple failed attempts may impact on the commitment of caregivers.

Marital Status

One of the critical factors influencing the care and support received by woman living with VVF is their marital status. Findings from this study suggest that married woman tend to receive more consistent emotional and material support from their spouses. One participant recounted how her husband provided continuous care and remained present though her experience. In her words:

> My husband always cares and supports me all the time. He took good care of me throughout the period, he always supported me financially, emotionally and otherwise. I do not have problem with him and his relatives. (*Case study/34 years Old/Ebonyi*)

In contrast, an unmarried respondent reported receiving no family support and had to rely on farm labour to survive until a traditional ruler in the community offered assistance. As she explained:

> No support from anybody, I use to farm for people in the village to pay me before somebody connected me to the traditional ruler am serving today. My father and mother died some time ago, none of my relatives is supporting me. No care from anybody, I am suffering to survive by myself. (*Case study/23 years Old/Ebonyi*)

These accounts suggest a significant disparity in the level of care and support based on marital status. Married women appear more likely to benefit from supportive networks, including spouses, in-laws and sometimes parents than there unmarried counterparts. This may reflect underlying cultural beliefs that associates marital status with social responsibility and worthiness. In some communities, married women with VVF may be perceived as victims of circumstances, while unmarried women may be unfairly stigmatized.

Perceived Cause of VVF

The etiology of the condition appears to influence how patients are treated by their loved ones and community members. A patient explained that her husband remained loving and supportive because her condition was perceived to be caused by childbirth complications. As she explained:

> My husband still loves me, and he cares for me. After all I was not the cause of the VVF, it was after childbirth I had the urine leakage. It was as a result giving birth to his baby even though I lost the baby. (*IDI/VVF Patient/36 years Old/Ebonyi*)

In a different perspective, a respondent who had lived with VVF from birth indicated that her mother assumed full responsibility for her care because that was how she had always been since birth. As she narrated:

> Even though her friends laugh at her, we have to take care of her because she was not the cause. That was how we gave birth to her and we have been taking care of her. She really needs our care and support. (*IDI/mother of VVF patient/9 years old/Plateau*)

This can be understood to mean that once the cause is perceived as natural, people's attitudes towards care and support will differ from when it was brought on by other circumstances.

Level of Husband's Affection towards Wife

Closely linked to marital status is the level affection a husband has for his wife. The finding revealed that care and support for VVF patients is influenced by

the level of affection from their spouses. Several participants highlighted how their spouses remained with them during their condition and provided emotional and financial backing. In support of the husband who cherished his wife, a respondent noted that her husband's consistent care led to a positive shift in how she was perceived by others in the community. As she stated:

> Care and support have been good. I have not been rejected. The way people feel about me has not changed. And I also do not feel withdrawn or sad. Look at me I would not have been this fat and happy if I was not getting support. Although my in-laws experience made them more supportive and understanding. (*Case study/25 years Old/Plateau*)

In contrast, women whose husbands were less affectionate or emotionally detached faced neglect, abandonment or divorce. One patient recounted that after developing VVF, her husband lost interest in the relationship and left her.

> Nobody cared for me, my husband only came to Parklane Hospital to carry the dead baby. After then, he never cared to ask about me again, I am now living with my mother in the village, I went to human right at that time, they locked him up and beat him, yet he did not repent, we went to the village to settle the matter but he insisted. I don't know what exactly happened or what he said I did to him (crying). He is the one who impregnated me, I never knew any other man ever since I married him, and now he left me with two of our children to suffer. (*Case study/31 years Old/Ebonyi*)

The fact that the woman experienced VVF and was rejected by her husbands added to the perception of a husband who did not love his wife. In the view of this respondent, it was explained that when she developed VVF, her husband left her. As she noted:

> My husband left me after I developed VVF; after I developed VVF I stayed in his house for 9 months before he said I should leave his house saying I smell and cannot have sexual intercourse with me. My friends laugh at me and do not like to stay around. (*IDI/VVF Patient/22 years Old/Plateau*)

The above narrations illustrate the vulnerability of VVF patients to marital breakdown, which in turn affects their social standing and access to support.

Husband's Decision

The decision of the husband also might affect how the patients are supported and cared for. One of the patients, for instance, stated that her spouse and family members decided what kind of treatment she would get. As a result, the

husband would make the decision regarding care and support. In her statements:

> My husband and family made the decisions of the kind of treatments I will get. From the traditional method to my first visit to the Fistula Center in Abakiliki. Maybe they felt traditional medicine was better and less expensive since they had wanted me to give birth at home. (*Case study/30 years Old/Plateau*)

This dynamic often places women in a position of dependence, limiting their agency in managing their own health and reinforcing patriarchal structures within the family unit in most African households, particularly in rural settings.

Discussion

Findings from this study on care and support for VVF victims indicated that the majority of VVF patients received assistance primarily from their immediate family members. Notably, patients from Ebonyi State were more likely to receive family supports compared to their counterparts in Plateau State. The primary family members providing support included husbands, parents and other relatives of the patients. This finding corroborates the result of a study by Adeusi, Olujide and Ebere (2014) which indicated that husbands, friends and extended family members offer adequate care and support thereby facilitating better coping mechanism for women with VVF. However, while many patients benefited from familial supports, others experienced a lack of such assistance, leading to feelings of frustration and dejection. This is corroborated by Okoye, Emman-Echiegu and Tanyi (2014), who documented that some VVF patients suffer neglect and inadequate care from husbands and friends.

Nsemo (2014), identified several reasons why victims are abandoned by their spouses. A key factor is the reduced sexual activity of the women, primarily due to the persistent stench, uncontrollable urine leakage and occasional post-surgical leakage which hinder sexual intimacy. These issues often result in emotional distress, depression, and a sense of resignation with many women relying on charity or begging for support. The current study further revealed that many women faced difficulties engaging in sexual relations due to pain and odor, which likely contributed to their husbands' withdrawal and abandonment.

Moreover, the study revealed significant associations between socio-demographic characteristics of VVF patients and the level of care and support received. Specifically, age, religion, educational attainment, marital status, parity were all significantly related to the degree of support from family members. These findings suggest that socio-demographic factors play crucial role in shaping the social bonds between patients, their spouses and their extended family members. It is anticipated that stronger bonds would exist between patient and their spouses compared to those with other relatives.

Several factors influencing care and support were identified, including community perception of VVF (whether positive or negative), the number of surgical repairs undergone, marital status, the perceived causes of VVF (whether biological or spiritual) and the level of affection from husbands as well as decision making authority within the family. The implications of patriarchal ethos in critical family decision making, including those that relate to the health of women have been documented (Nwokocha and Obioma 2016). In Ebonyi state, care and support were predominantly influenced by marital status and spousal affection. Conversely, in Plateau state, the number of repairs and family decision-making processes primarily determined the level of support. These variations highlight the influence of regional and cultural contexts on support systems for women with VVF, even during treatment.

Ultimately, care and support for VVF should focus more on prevention of the conditions that bring it about in the first place. Being proactive in dealing with medical condition is synonymous with tackling the root causes, which include early pregnancy, prolonged labour among others. Such appears to be ignored in the discourse even when it is the most sustainable approach to dealing with VVF. Thus, the critical role of sexuality education cannot not be overstated (Nwokocha and Taiwo 2012; Nwokocha 2010). Such education which has long been infused into primary and secondary school curricula in Nigeria embody issues such as awareness of physical developmental changes including those that relate to puberty, menarche, ovulation, mensuration, and assertiveness and the dangers of risky sexual behaviours among others (Isiugo-Abanihe *et al.,* 2015; Nwokocha *et al*., 2015; Udegbe *et al.,* 2015). Indeed, ensuring that adolescents and young people generally are equipped with these life-skills related factors will go a long to ensuring that the prevalence of VVF is reduced to the barest minimum in relevant Nigerian communities.

Conclusion

Considering the findings of this study, it is important to state that the process of recovery and restoration of dignity for women with VVF is closely linked to the level of familial support. Although the victim will interact with individuals outside their immediate environment, how well they are supported by their family members particularly spouses, largely determines how effectively they cope mentally, psychologically, physically and otherwise. In the present study, it has been revealed that the support dynamics vary significantly across different settings and are influenced mainly by socio-demographic factors. The findings underscore the importance of public awareness campaigns on the causes and treatment of VVF, which may foster more positive attitude and support networks. Furthermore, a holistic approach to care which include medical, educational, social and physical interventions is essential for improving the quality of life for women and girls living with VVF.

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