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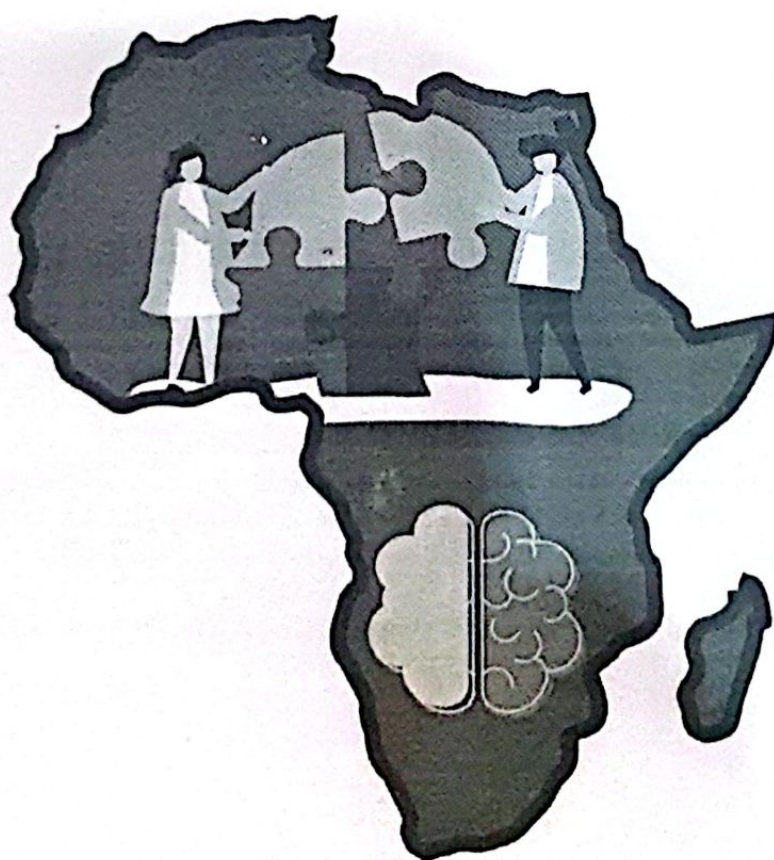
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Contents

Page

Relationship between Parenting Styles and Academic Procrastination of Tertiary Institution Students in Nigeria

Hussein Abdulkareem Bibire, Ph.D, Rakiya Maiwada Abubakar, Ph.D,
Ibrahim Arobo Dauda, Muhammed-Sanni Abubakar, Ph.D

1

Predictors of Perceived Quality of Life among Residents of an Emerging Settlement in Ogun State, Nigeria

Emmanuel Etim Uye, Peter O. Olapegba PhD

11

Confirmatory Analysis for Religious Life and Orientation Scale among Nigeria Police Academy Cadets

Ibrahim Arobo Dauda, Haruna Karick, Samson Olowo Kolawole,
Bibire Hussein Abdulkareem, Sabo Saleh Dagona

20

Access to Medical Care during an Emergency in the Primary Health Care Centre Vwang District of Jos South Local Government Plateau State, North-Central, Nigeria

Choji Davou Zakka

30

Menstrual Pattern and Blood Pressure as Predictors of General Health among Undergraduates

Tamuno-Opubo Addah Temple, Baba Ahmed Karatu Adepoju,
Adedamola Paul-Adeleye Hadassah, Yekeen Omolola Kikelomo,
Anuoluwapo Blessing Adeleke, Aborisade Temitope Emmanuel

41

Psychoactive Substance Use among Students in Some Selected Public Secondary Schools in Ilorin, Kwara State

Obasanjo Solomon Balogun

50

Social Media Dependence, Mobile Phone Usage and Demographics Factors OSAMIKA, Bamidele Emmanuel

Babarinde, Adekunle, Odusanya, Adedeji, Balogun, Omoniyi

60

Domestic violence against women in Udu Local Government Area of Delta State, Nigeria

Veta, Oghenechoja Dennis PhD

74

Personality Traits, Gender difference and Domestic Violence among Gudi Residents, Nasarawa State, Nigeria

Emmanuel Onu Alhassan PhD, Blessing Stephen Akwaden, Faith Monday Ajodo

83

Cigarette Smoking Disorders among Adolescent Students in Nigeria Tertiary Institution: Implications for Social Work Practice

Atiku Abdullateef Abiodun, Abdulhameed Abdussalam,
Sunday Evaristus Abonyi, Titi Olamide Arinde-Simeon

95

<i>Reliability of 3-Items Orgasm Subscale of Female Sexual Function Index among Women within Jos Metropolis</i> Dauda Akwai Saleh, Gloria Samuel Karuri, Zubairu Kwambo Dagona	103
<i>Sports Bet Advertisements on Television and its Influence on Betting Participation among Youths in Makurdi Metropolis, Benue State, Nigeria</i> Isaac, Ejiga; Anthony, Ijeh Omirigwe; Iteji Omale Nelson	111
<i>Spirituality in Social Work Practice: Views and Beliefs of Social Workers in Ilorin, Kwara State</i> Kelani Karamat Ayotola, Mohammed Abdulganiyu Harun, Adekola Olufunmilayo Theresa	124
<i>Explorative Study of Perceived Life Purpose among Male Convicts in Correctional Centres in Lagos State</i> AJALA, Muniru Alimi	133
<i>The Role of Psychological Intervention in the Management of Traumatic Experiences as a Result of Covid-19 Global Pandemic</i> Isaac Peter Chingle, Ph. D	145
<i>Effects of Social Support on Wellbeing of Vesicovaginal Fistula Patients in Sokoto, North Western, Nigeria</i> Kelani Karamat Ayotola, Mohammed Sanusi Yusuf, Rebecca Oluwaseun Oke, Daniel Damilola Oladeinde, Addullahi Akinwale Olunlade	155
<i>Influence of Underemployment and Perception Pay Equity on Unethical Work Attitude among the Non-Commissioned Officers in the Nigerian Army</i> Atafo, Dennis O., Ishola, Ajibola A.	163
<i>Personality Traits and Perceived Social Support on Cognitive Functioning of Elderly Attending Adeoyo Maternity Teaching Hospital (AMTH), Yemetu, Ibadan</i> Jackson. I. Osuh, Ajibola. A. Ishola	175
<i>Socio-Cultural Environment and Personality Correlates of Anti-Social Behaviour among Youths in Lagos Metropolis</i> Ajala, Muniru Alimi	186
<i>Cognitive Control and Psychodynamic Therapies on Academic Self-Handicapping Behaviour among Distance Learners</i> Ibraheem Adedayo Adediran	195
<i>Demographic Factors Moderating the Influence of Career Growth on Unethical Behaviour among Personnel of Nigerian Customs Service</i> Akeem A. Kenku Ph.D, Ajibola A. Ishola	209

<i>Service Quality and Self-Efficacy as Factors Influencing Acceptance of Online Learning among Undergraduate Students in Private Universities in Southwestern Nigeria</i> Okunade, Bosede Abidemi, Kazeem, Ajibola Rasheed, Asiyanbi, Mutiat Sola	223
<i>Adolescent Sexual Behavior: Implications for School Social Work Practice</i> Oyeleke Ajiboye Isaac PhD, Ajibola Ishola	234
<i>Environmental Adaptation and Prevalence of Domestic Violence among People of Coastal Communities in Ondo State, Nigeria</i> Popoola, Olusoji David (PhD)	241
<i>Ethical Leadership not Likeness Engenders Subordinates' Affective Commitment to Squad among Police Cadets</i> Odunayo Oluwasanmi Oluwafemi, Valentine Ayo Mebu, and Grace Ohunene Legbeti	253

Effects of Social Support on Wellbeing of Vesicovaginal Fistula Patients in Sokoto, North Western, Nigeria

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Abstract

The problem of Vesicovaginal fistula amongst young mothers in the northern part of Nigeria is alarming with its consequences on their physical and social wellbeing. This study examines the effects of social support on wellbeing of vesicovaginal fistula patients in Sokoto, North western, Nigeria.

The study adopted a non-experimental descriptive research design with the use of purposive sampling which involved the recruitment of 80 out of 120 VVF patients attending Maryam Abacha Women and Children Hospital, Sokoto. Correlation and multiple regression were used to test hypotheses one and two respectively.

The results indicate that all the study participants were Muslims. Approximately, 97.5% of the respondents are Hausa/Fulani by tribe. The first hypothesis reveals that social support significantly correlates with general wellbeing ($r=.260$; $P<.05$). The second hypothesis shows that marital status, ($\beta = -.341$; $t = -3.303$; $P<.05$; and social support ($\beta = .287$; $t = 2.778$; $P<.05$) have significant independent prediction on the general wellbeing of VVF patients.

We therefore concluded that social support (spousal, family and informational support) are vital for wellbeing of VVF patients. Therefore, intervention for people with VVF should include social support. Also, social workers and other healthcare providers should be involved in counselling the patients.

Keywords: Vesicovaginal Fistula, Social Support, wellbeing,

Introduction

Vesicovaginal fistula (VVF) is a subtype of female urogenital fistula (UGF). VVF is an abnormal fistulous tract extending between the bladder and the vagina that allows the continuous involuntary discharge of urine into the vaginal vault (Spurlock, 2016). It comes with an excruciating pain and abnormal communication that translates into physical impairment and agony (Rajaian, Pragatheeswarane, & Panda, 2019). Also, women having VVF are embarrassed

and unable to control their bodily functions; they are constantly soiled, wet and smell (Okoye, Emma-Echiegu, & Tanyi, 2014). Notwithstanding that VVF is a global issue, it has a polar epidemiological dominance. It is less found in the industrialized countries compared to the less developed countries. In developed countries where few cases of VVF are seen, it is often caused by a malignant disease, prolonged obstructed labour, hysterectomy, surgical injury, or long-term radiation therapy (Shazly & Laughlin-Tommaso, 2020). In contrast, in the developing world such as Africa, besides the factors responsible for VVF in the developed countries, child marriage, rape, sex trafficking are other causes of vesicovaginal fistula (Apara, Iscoluwa & Omomen, 2020; Ellis, Elledge, & de Chesnay, 2019; Aye, Robinson, Eze, Eze, & Oforka, 2018). In Africa, age of involvement in sexual activity is 18 years. However, it is not ratified among all African countries (Wado, Sully & Mumah, 2019). In fact, in Nigeria, Sexual Offenses Bill enacted in 2015 upholds the age limit of 18 years predominant among African countries. Unfortunately, eleven northern states of Nigeria have not adopted the Child Right Act of 2003 (Brimah, 2014) and as a result, child marriage is rampant in these regions, a risk factor for vesicovaginal fistula. It is wonderous that Nigeria with just three percent of the global population recorded 20% of maternal mortality worldwide (between 2005 and 2015) World Health Organization, (WHO), 2019).

Furthermore, the aetiology of VVF in Nigeria is multifaceted. Risk factors such as, poverty, early marriage, illiteracy, rape, and girl-child neglect spearhead other proximate causes of vesicovaginal fistula (Alawari & Maureen, 2020). Over the years, studies in fistula care management have revealed that prolonged obstructed labour is a major trigger of VVF in Nigeria and other Sub-Saharan African countries. Precisely 96.5% cases of vesicovaginal fistula are caused by obstructed labour and gynaecological operations (Pradhan, Basnet, Thapa, & Regmi, 2019; Wall, et al. 2004). It can therefore be safely said that obstructed labour is the leading cause of VVF in Nigeria. The presence of unskilled health attendants in labour rooms and diabolical beliefs during childbirth also cause VVF in Sub-Saharan African countries (Erinosho, 1998) cited in Archibong, Enang and Bassey (2017).

From a clinical standpoint, VVF genres are grouped into categories based on size, congenitally wired, or acquired, cystoscopy, clinical examination, and involvement of continent mechanism. The initial and prompt diagnosis of VVF helps to rapidly select treatment procedures (Shazly & Laughlin-Tommaso, 2020). Although, these treatment procedures are available in Nigeria, VVF is still quite common in the Northern part of Nigeria. The prevalence level of VVF is higher in rural areas than urban centres in Nigeria because of inadequacies in antenatal and postnatal care facilities and supplements. Sadly, studies conducted in Nigeria on VVF have reported that more than 2 million women in Nigeria have VVF and about 1 million have died of this troubling health condition (Daru, Karshima, Mikah & Nyango, 2011). The statistics of VVF patients and those that have died of it may be understated as many girls and women are afraid and sceptical about reporting because of fear of stigmatization.

The effects of VVF are not physical manifestations of pains only. Psychological, social, and economic consequences are also apparent among VVF patients. In many instances, the victims are labelled as unclean and smelly (Nweke & Igwe, 2017). They are labelled as such because of their uncontrollable urge to urinate. Socially, the victims of VVF are restricted to live alone in isolation and social distancing from others. Also, young girls with VVF often lack friends and more worrisome is the attitudes of their husbands and other family members towards them; they are ignored and blamed for their misfortune. Study by Oluwasola and Bello

(2020) revealed that patients with VVF experience Post Traumatic Stress Disorder (PTSD) and emotional disorder, fear of death, truncated life plans, and panic attacks. In addition, many studies also assert that VVF causes death when diagnosed late (Di, 2008; Singini, 2017). More so, VVF can have a long-lasting effect as it affects the reproductive health of women which in turn creates possibility of barrenness and social exclusion (Singini, 2017). Although many studies have been done on medical implications of VVF, there is dearth of literature about social support for VVF patients, especially in Nigeria. Therefore, this study seeks to investigate effects of social support on wellbeing of VVF patients in the Northern region of Nigeria.

Research Hypotheses

- There is no significant relationship between social support and the general wellbeing of the VVF patients at VVF Centre Sokoto.
- There is no significant relationship between marital status and social and the general wellbeing of VVF patients at Maryam Abacha Women and Children Hospital,

Materials and methods

The study location was Maryam Abacha Women and Children Hospital, VVF centre Sokoto, Sokoto state in Nigeria. The research uses a non-experimental descriptive design. The target population was all VVF patients at Maryam Abacha Women and Children Hospital, VVF centre Sokoto. The technique used for this study was purposive and convenient. The inclusion criteria for the study was all patients diagnosed with VVF attending Maryam Abacha Women and Children Hospital, VVF centre Sokoto and willing to participate in the study. At the time of conducting the survey for the investigation, 120 patients have been diagnosed with VVF and only 80 patients were willing to participate in the study.

Data were collected using a self-administered questionnaire adapted from the general wellbeing scale, family support scale and informational support scale (Fazio, 1977; Procidano & Heller, 1983; Schwarzer & Schulz, 2004). The questionnaire was divided into three (3) sections: Section A investigated the socio-demographic characteristics of the respondents. Section B was on the general wellbeing of the respondents while Section C elicited information on the emotional, family, and informational support for VVF patients. The items on the questionnaire place respondents on a Likert-scale format ranging from 1= (strongly disagree) to 4= (strongly agree). The validity of the instrument was ascertained by experts in the field of tests, measurement and evaluation and colleagues in the Psychology Department for its content, relevance and clarity of thought; for its content, relevance, and clarity of thought; corrections were made, and the tool was adjudged valid. The reliability of the questionnaire was done using the test-retest method; the questionnaire was administered to 10 in-patients at the VVF ward and the same instrument was administered again to the same set of patients. The responses were analysed using the Cronbach Alpha Model to measure the internal consistence and the outcome was 0.85 as the correlation coefficient which was significant. Hence, the instrument was adjudged reliable. Although, standardized scales were used for the study, test for validity and reliability was necessary because the scales were modified to achieve the objectives of this study.

Before data collection, an approval was sought from the Ethical committee of the Maryam Abacha Women and Children Hospital, VVF centre Sokoto. Written and verbal informed consent were sought and obtained from the respondents before the administration of

the questionnaire. Participation was voluntary without coercion or inducement. Questionnaires were administered to 80 patients that met the inclusion criteria and that were willing to participate; all the questionnaires were retrieved immediately after completion. Data gathering was from 8th to 21st of June 2018. The data gathered were analysed using statistical package for social sciences (SPSS) version 22.0. The descriptive statistics was done using frequencies and percentages while zero order correlation was adopted for testing composite relationship of the independent variables, and multiple regression analysis was adopted for predictions.

Results

The results of the data collected and analysed are presented below. Specifically, the study provides answers to research hypotheses. The statistical tests used include zero order correlation for testing composite relationship of the independent variables, and multiple regression analysis for predictions.

Table 1: Sociodemographic characteristics of respondents

Variable	Frequency	Percentage
Age		
10-20 years	22	27.5
21-30years	35	43.8
31-40 years or more	23	28.8
Religion		
Islam	80	100
Occupation		
Employed	0	0
Unemployed	80	100
Ethnic Background		
Hausa/Fulani	78	97.5
Yoruba	0	0
Igbo	0	0
Others	2	2.5
Marital status		
Married	69	86.2
Divorced	11	13.8

The sociodemographic characteristics of the women are presented in Table 1. The age of the women reveals that majority of the women falls between the age of 21 to 30 years 35(43.8%) while only 22(27.5%) falls between the age of 10 to 20 years. All the women are Unemployed Muslim 80(100%) and majority are from Hausa/Fulani tribe 78(97.5) while only 2(2.5%) are from other unspecified tribes. Also, majority of the women are married 69(86.2%) while only 11(13.8%) of them are divorced.

Hypothesis One

There is no significant relationship between social support and the general wellbeing of the VVF patients at VVF Centre Sokoto. The hypothesis is analysed with zero order correlation statistics and the result is presented below.

Table 2: Zero order correlation showing the relationship between social support and general wellbeing

	1	2
1 General wellbeing	-	50.70 4.83
2 Social support	.260*	- 22.23 2.13

**, Correlation is significant at the 0.05 level (2-tailed)

Table 2 results shows that there is a statistically significant relationship between social support and general wellbeing at ($P < .05$); social support significantly correlates with general wellbeing ($r = .260$; $P < .05$); and the relationship is weak and in positive direction among VVF patients. This result implies that the general wellbeing among VVF is affected by social support. Therefore, the null hypothesis is rejected and we conclude that there is relationship between social support and general wellbeing of VVF patients.

Hypothesis Two

There is no statistically significant relationship between marital status and social and the general wellbeing of VVF patients at Maryam Abacha Women and Children Hospital, VVF Centre Hospital in Sokoto independently and jointly. This hypothesis is analysed using multiple regressions and the result is presented below.

Table 3: Summary of Multiple Regressions showing the independent and joint prediction marital status and social support on general health

Variable	Beta	t-value	Sig	R	R ²	F	P
Marital status	-.341	-3.303					<.05
			<.01	.428	.183	8.641	
Social support	.287	2.778					<.05

Dependent variable: general wellbeing

From the Table 3, The analysis of the independent prediction shows that marital status, ($\beta = -.341$; $t = -3.303$; $P < .01$); and social support ($\beta = .287$; $t = 2.778$; $P < .05$) have significant independent prediction on the general wellbeing of VVF patients. This result implies that marital status and social support predict significant joint and independent influence on the general wellbeing of VVF patients. Therefore, the null hypothesis is rejected and we conclude that marital status and social support predict the general wellbeing of VVF patients.

Discussion of findings

Effects of social support on the wellbeing of VVF patients in the Northern part of Nigeria have been investigated. Studies have revealed that majority of VVF cases are recorded in the northern region of Nigeria (Fehintola, Badejoko, Ijarotimi, Bakare, Fehintola, & Adeyemi., 2017; Maiwada, Rahman, Azlina, AbdulRahman & Mamat, 2017. Our study shows that social support significantly correlates with the wellbeing of VVF patients; VVF patients that receive social support from loved ones are more likely to feel well. This finding is in line with the study

of Dennis, Wilson, Mosha, Masenga, Sikkema, Terroso, and Watt(2016)who states that the VVF patients that receive significant social support from their family have higher general wellbeing. However, some past studies have shown that obstetric fistula patients received poor support from their spouses (Fehintola, Fehintola, Adetoye, Ayegbusi, Alaba., Ajiboye, Adeyemi 2019; Dennis et al, 2016), or no social support (Nweke & Igwe, 2017). In essence, the more social support VVF patients receive from their social network, the better is their general wellbeing, a good catalyst for healing process.

The study also examines if marital status and social support predict significant, joint, and independent, influence on the general wellbeing of VVF patients. The result of the second hypothesis shows that marital status and social support significantly influence the general wellbeing of VVF patients. That is, those who are married and received social support from their social networks are more likely to have improved wellbeing than those not married and have no social support. This is because the family members of the couples may recognize the fact that the patients need to be supported morally, emotionally, and financially. This finding is consistent with the studies of (Dennis et.al., 2016; Olusegun, Akinfolarin &Olabisi, 2009) that women who become pregnant out of wedlock, whose husbands run away because of the disease, and as a result of divorce receive less social support. It is important to state that women who receive less support may develop psychological problems such as depression (Kader, Rahman, Tulsan, Podder, Pial, & Saha.,2020), hence the need for vesicovaginal fistula patients to be supported.

Conclusion

In conclusion, social support has a positive effect on the wellbeing of VVF patients. Therefore, families of VVF patients should ensure that VVF patients are well catered for in every regard including physical, psychological, emotional, and financial support. Also, girl-child marriage and marriage age less than 18 years should be discouraged as both are sources of causes of VVF in the developing world. Many of the VVF patients in Northern Nigeria are Muslims (Shephard, Mamven, Lee & Lengmang, 2019) and this may explain the reason for girl-child marriage and marriage before 18 years. The problem is the lack of proper interpretation of the holy text, and the supporting hadiths of the prophet of Islam. To eradicate this practice, government should engage with Islamic scholars of high eminence to instruct people on the correct understanding of divine injunctions in the holy book. That child marriage is practiced in the north and seen as Hausa tradition (Maiwada, Rahman, Azlina, AbdulRahman & Mamat, 2017) should not be linked to Islamic exhortation not to delay marriage. There is a huge difference between a girl-child marriage and not delaying marriage. Given this fact, it is important to educate parents on the physical consequences of teen marriage and pregnancy because their reproductive organs are not yet ripe to carry pregnancy. The government should ensure that girl-child education is given preference. When a girl-child is well educated it prolongs time of marriage and thereby minimises the likelihood of getting married before 18 years. Also, parents should be enlightened about sex education and campaign against girl-child marriage should be carried out at the community level where child marriage is common. Finally, improvement in the general wellbeing of VVF patients could be achieved by avoiding unnecessary segregation and discrimination.

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