SOCIO-CULTURAL FACTORS INFLUENCING THE PREVALENCE OF VESICO VAGINAL FISTULA AMONG WOMEN OF EBONYI STATE, NIGERIA.

By

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BSU/SS/PhD/08/3807

BEING A THESIS SUBMITTED TO THE POST GRADUATE SCHOOL, BENUE STATE UNIVERSITY, MAKURDI.
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF DOCTOR OF PHILOSOPHY IN SOCIOLOGY

November, 2017.

CERTIFICATION

We here by certify that this study titled: "Socio-Cultural Factors Influencing the Prevalence of Vesico Vaginal-Fistula (VVF) among Women of Ebonyi State" has been undertaken by Joel Ugochukwu Nsofor (Reg. No: BSU/SS/PHD/08/3807) and has been approved as meeting the requirements for the award of PhD in Sociology of Benue State University, Makurdi, Nigeria.

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DECLARATION

I hereby declare that I am the original author of this work and it has not been presented in a similar form for the award of any certificate elsewhere. All authors whose scholarly works are used in the work are duly acknowledged.

Joel Ugochukwu Nsofor _____

DEDICATION

This work is dedicated to Joel Ugochukwu Nsofor (Jnr) who came to this world on 21st of October, 2015 and brought joy to my family.

ACKNOWLEDGEMENTS

To God be the glory for all He has done. The Lord has been so good to me, I am most grateful to God Almighty for the wisdom, health, and guidance, in seeing to the successful completion of this work. I remain grateful to my supervisors, Professors F. Wegh and A. Okau for their understanding, endurance and encouragements; in spite of their crowded programmes found time to read through this work and offered useful suggestions.

My gratitude also goes to my father and mentor in Academia Prof. S.O Alubo who taught me Sociology of Medicine at the undergraduate level in University of Jos. His sound knowledge of the field motivated me to develop interest in health issues.

My special thanks also go to senior colleagues and all those that have been caring, supportive and helpful in relating to me in my career in very significant ways. They include Professor Idu Ode who taught me Statistics at the Post Graduate level, Sam Smar of Department of Sociology Nasarawa State University, Rishante Sule of Kwararafa University, Sa'ad Abdulmumin, Provost Federal College of Education Yola, T. Ojua of University of Calabar and Jonathan Ogwuche of Benue State University Makurdi. Others are Dr. (Mrs) Margaret Bai-Tachia, Head of Department of Sociology, Benue State University, Dr. Igbana Ajir, Dr. Frank Abagen, Prof. P. Ahire, Dr. (Mrs.) Agnes Ikwuba, Dr. Benjamin Ahule, Dr. Ocheja Akoji, Dr. (Mrs.) O. Osagie, Dr. Dauda. Suntai, Dr. Godwin Akphehe, Dr. Godwin Timiun and Prof. F. Onoge whose scholarly achievements helped me to think critically. These sound academicians have positively influenced the quality of my research and publication through their demonstration of the dignity of labour and quality control in academics.

I am grateful to all the lecturers that taught me during my undergraduate and Post Graduate Studies they include Professors E. Alemika, Alaveabee Idyorough, Gray

Ejikeme, Ufot Ibanga (Late), Rotgak Gofwen, E. Olumodeji, O. Adelakun, E. Best, E. Gyong, E. Zasha, and L. Ega. I thank these great minds for exposing me to the knowledge and prospects of sociology. I thank God for granting me the opportunity to learn from these great men and women. My thanks also go to Femi Awalegbe of the Federal Teaching Hospital, Abakaliki who assisted in the analysis of this work and Liambee John for typesetting the work as well as Daniel Sechap. Dr. E. Amuche was also useful to me during the analysis and as such deserves special thanks from me. I am also grateful to all the members of staff of National Obstetrics Fistula centre, Abakiliki, especially staff in the administrative unit for their assistance during the study and to Theophilus Fongong James who also typed the work and Rev. Emmanuel Obadiah.

I also thank all my friends, particularly, Dr. Alemoh Thomas of Department of Mass communication, Taraba State University. I am grateful to my family members- my wife Engr. (Mrs.) Lilian Chizelum and my children, Olaedo, Chiamaka and Ugochukwu Jnr. for their love, understanding, cooperation and support in the course of this work; and my mother Mrs. Juliana Nsofor, Sister Nneka and brothers Chinedu, Chino, Azubike, Ikenna and all their wives and children I say a big thank you for being there for me. To my numerous friends which I have not been able to mention due to time and space constraints, I recognize and appreciate you all.

I also wish to acknowledge, with gratitude, the authors and researchers whose materials have been consulted and cited in this work.

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ACHPR	-	African Charter on Human and Peoples Right
WHO	-	World Health Organization
VVF	-	Vesico Vaginal Fistula
NGO	-	Non Governmental Organization
MCC	-	Mother and Child Center
FMH	-	Federal Ministry of Health
USAID	-	United State Agency for International Development
UNDP	-	United Nations Development Programme
FGM	-	Female Genital Mutilation
RVF	-	Rector Vagina Fistula
FF	-	Ford Foundation
TBA	-	Traditional Birth Attendant
MHC	-	Maternal Health Care
FFWH	-	Ford Foundation for Women's Health
FGD	-	Focus Group Discussion
SPSS	-	Statistical Package for Social Sciences
IDI	-	In-depth Interview

ABSTRACT

This research work was designed to identify socio-cultural factors influencing the prevalence of vesico-vaginal fistula among women of Ebonyi State. The main goal of the study is to examine the socio-cultural factors influencing vesico-vaginal fistula (VVF) among women of Ebonyi State; specific objectives include to assess the prevalence of VVF among women of Ebonyi State, examine the socio-cultural factors influencing the prevalence of vesico-vaginal fistula (VVF), assess the social implication of vesico vaginal fistula, assess the management strategies of vesico-vaginal fistula among women of Ebonyi State and suggest ways of solving the problem of vesico-vaginal fistula. The methodology adopted for the work includes the adoption of descriptive survey design as the study is all about information gathering, key informants were used to gather data for the study. The key informants include ten medical and health workers and six women, youth and community leaders. 381 respondents were used for the analysis and discussion. The study discovered that indeed there are socio-cultural factors that influence the prevalence of VVF among women of Ebonyi State as the responses of the respondents affirmed to this. The study discovered that some of the socio-cultural factors that influence the prevalence of VVF among women of Ebonyi state are; Early marriage, female circumcision and lack of medical care. Among the findings are that, there is a general belief among the people that female are not suppose to see their first menstrual period in their fathers house, this should be observed in their husband's house and as such early marriage which is a contributory factor to VVF is encouraged. The study recommends that government at federal, state and local levels should take the responsibility of the treatment of VVF patients, adopt appropriate laws, discourage all obnoxious cultural practices that limit the chances of survival of women, creation of job opportunities for women, especially those in the rural areas, as some of the solutions to the problem. Others are abolition of early marriage and the need for the government of Ebonyi state to improve on maternal and child health around the state. It is believed that if these recommendations are well implemented, it will go a long way to reduce the prevalence of VVF among women of Ebonyi state and will open a new road map to improve health care for women in the state.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

For centuries, women have not fully utilized their potentials as a result of some socio-cultural factors which hinder their opportunities. Ebonyi women just like women in other parts of Nigeria face some challenges as a result of intrinsic gender discrimination which exist among the people.

In Ebonyi State, men gain enormously from the intrinsic gender discrimination of the colonial system of government. They do not have to co-rule with women as in pre-colonial period. With the new system, they are empowered to make decisions for women. Women on the other hand were encouraged to defer to their husbands, while the domestication of women was encouraged as a sign of affluence and self-sufficiency. As men succeeded economically, educationally, and politically, they conceitedly held on to power and inadequately dispensed resources.

In fact, the acceptance of western gender stereotypes did immeasurable harm to Ebonyi women liberated from the checks and balances the co-governance provided; gender discrimination was heavily constructed into policies, programmes and structures of the system to preserve it for men. The outcome was the development of a politically inactive women population and prejudicial self-serving men.

Female oppression through the system of patriarchy is universal. Nevertheless, the study of Ebonyi women in particular continues to be interesting because of the common nature of their struggles and the correlation in the method they apply in solving their difficulties.

When examining the social position of women in Ebonyi state, Agbo (2001:19), posits that women in the state groan under dehumanizing traditions and human rights abuse which serves as impediments to their growth and development. Across the whole of Ebonyi State,

there is thriving tradition of women abuse, and denial of their fundamental human rights exist. Widows bear the greatest burden of womanhood. Once a woman's husband dies, her journey to Golgotha begins; relatives of her dead husband intimidate, harass, and deprive her of her late husband's property. Some are ejected from their matrimonial homes after being made to undergo dehumanizing rituals. That is not all, some men just decide they have had enough and abandon their wives and children to marry new wives. Some others institute court cases against helpless widows to deny them of what should be their rightful property. Many are denied their husband's death benefits and gratuities. It was because of these dehumanizing tradition in Ebonyi state that motivated the wife of the former governor Dr Sam Egwu to lobby the state house of Assembly in 2001, to pass a law protecting the rights of women in the state and it is with this legal instrument that she used to combat human rights violations against women through their non-governmental organization, family law centre.

When examining the social position of women in Ebonyi State, the most persistent aspect that comes to light is the strong influence of patriarchal culture, deep rooted stereotype of women and their roles and responsibilities which persist in same communities in the state.

Obi, (2013:95), asserted that according to their traditional patriarchal stereotype, women in Ebonyi State are believed to be subordinate to men who dominate the public spectrum of the society. Women are expected to take on the role of mother, faithful wives and housekeepers, whereas, men are seen principally as bread winners. The way women are seen determines the way they are treated and this has effects on their general well-being including their health.

All over the world, health issues are usually sensitive issues that concern all, irrespective of sex, religion and nationality. Health according to Ezekwesili; (2004:12), is derived from an old Anglo-Saxon word 'heath' which means a condition of being safe and sound. The idea and meaning of health seem to change with time and circumstance. The growing child may consider health as his conscious efforts at keeping his body clean. The busy administrator

may also think of health as his ability to survive strenuous hours in his office. To the man on the street, health may be seen as the ability to carry ones functions even when there is pain or discomfort. To Hanloz and Picket, (1979:69), health is a state of total effective physiological and psychological functioning. It has both a relative and absolute meaning varying through time and space, both in the individual and group. It is the result of the combination of many forces, intrinsic and extrinsic, inherited and contrived, individual and collective, private and public, medical, environmental and social, and it is conditioned by culture, economy and government. World Health Organization (WHO, 1998) defined health as "a complete state of physical, social and mental well-being and not necessarily the absence of disease.

Looking at the above definitions of health, it shows that health is a desired state that individuals cherish. However, in most cases the state is usually difficult to attain due to so many factors which Ochu, (1991:52), opines includes constitution of the individual physiological requirements, environmental factors, emotional factors and superstitious beliefs. The inability of individuals to attain a healthy status affects their productivity, thereby by making it difficult for them to contribute to national development. Alubo, (2014:22), posits that one of the crucial sectors in national development is the health sector. "The health sector is a most crucial sector because of the need to protect the human population without which death stalks the land". During colonialism, the attention focused on the Europeans who used a doctrine of Cordonne Sanitaire to protect themselves from infections, thought to be endemic among the natives. Though this jaundiced view, forced medications of the natives, especially immunizations were routine, so long as the health of the natives was only a secondary concern and more for purposes of the sanitary cordon than for the good of the Nigerian people (federal government of Nigeria 1985; Itayavar 1987:18).

Drawing from the colonial legacy, the various independent governments have accorded health priority. Addressing disease and death, as part of the war against poverty, illiteracy and

disease, was therefore a major agenda for post independence government. In addition, Alubo, (2012:5), posits that health was conceived to be related to productivity and entire process of creating wealth as recognised by the popular aphorism, "health is wealth" (Erinosho 1982:14). Nigerians stretch this logic and acknowledge that a healthy nation is a wealthy nation".

Alubo, (2012:13), also asserted that health is also important for political reasons, hence its deterioration has been invoked to justify the over throw of governments in Nigeria. In the military coup of December 31, 1993 and again in August 1985, the coup leaders rationalised intervention by pointing to the degeneration of hospitals to "mere consulting clinics without drugs and equipments" (Abacha 1984). In most recent times, highly placed people especially politicians who are detained or imprisoned for one crime or the other usually demand release to seek medical care abroad.

Due to importance attached to health, health planning in many countries are usually encouraged to take care of the health needs of the people. The main thrust of health planning, policy and implementation is the curative cover tones. Nigeria over the years has made some progress in terms of curative medicine, as may be seen in the count of over 59 tertiary facilities, including teaching hospitals and federal medical centres. (Alubo, 2012:16).

However, the decline in oil revenue has a devastating impact on medical care in Nigeria, creating some health challenges for the people. One of the health challenges is the rising cases of vesico-vaginal fistula. Vesico-Vaginal Fistula according to Tahzid, (1989:9), is an abnormal communication between the vagina and the bladder resulting in constant involuntary dribbling of urine. In developing countries, it is common due to prolonged obstructed labour.

Vesico-vaginal fistula has been a health problem of women worldwide. The profile of vesico-vaginal fistula according to Amiru (2004:78), is that of destitution, illiteracy, unemployment,

divorce and smelling teenager, who has lost control of her bladder functions, and is constantly wearing rag in between her legs during the day and wetting her bed at night.

The effects of vesico-vaginal fistula are life shattering, while women with fistula are perceived as unclean and thus shunned by their husband's, family, the community and they are frequently blamed for their conditions, they are forced to live in isolation (Ejembi and Kees, 2001:49).

Vesico-vaginal fistula is one of the disturbing health challenges of women of child bearing age. This problem is a global problem, as it is found in all the continents in the world. However, the degree or rate of it's occurrence varies from country to country and from society to society. In Nigeria, this health challenge is common in the north (Odebiyi; 2007:22). Nigeria as a result of some cultural practices such as early marriage, female genital mutilation popularly called "wankan gishiri" which is a traditional operation carried out throughout northern Nigeria. In southern Nigeria, the case is not different as there are recorded cases of the health challenges especially in the south east, evidence of the health challenge, leads to the establishment of a centre to cater for the victims from the south eastern part of the country. The centre which started as a project of the former first lady of Ebonyi State Mrs. Josephine Elechi was later (2011) taken over by the federal government and named National Obstetrics Fistula Centre. Since then, the centre has served as a centre for fistula management and prevention serving the South East.

Obstetrics fistula is complications that arise from obstruction or prolonged labour resulting in a hole or opening in the birth canal. This condition develops when the blood supply to the tissues of the vagina, bladder, and or rectum is cut off by prolonged obstructed labour without prompt medical care. As a result of unrelieved obstructed labour, the bladder, the urethra, or rectum and the vaginal wall are compressed between the foetal head and the maternal pubis.

This compression and loss of blood supply produces necrosis of the compressed tissues resulting in uncontrolled leakage of urine from the vagina (NDHS 2008). In case of rectro-vaginal fistula (RVF), the woman is left with chronic incontinence, which results in social problems such as rejection, shame, and stigma as well as economic problems. Fistula can also result from sexual violence or complications from pelvis surgery (FMWA, 2006).

Underdevelopment of the pelvis, arising from chronic malnutrition, is a common cause of obstructed labour that can result in fistula. Obstetrics fistula is almost entirely preventable with timely and effective medical intervention. Fistula affects the most powerless members of the society, occurring disproportionately among impoverished girls and women, especially those living far from medical services and emergency obstetrics care (Andrew, 1999:14). According to (UNFPA, 2008) report, many women do not know that it can be treated and some have lived with the condition for prolonged periods. An estimated 2 million women in sub-sahara Africa, South Asia, and the Arab world are living with the condition and some 50,000-100,000 new cases occur each year (UNFPA, 2008). According to Ogunlela (2010:45), insufficient care for pregnant women in labour has made Nigerians' the country with one of the highest rate of obstetrics fistula in the world. The causes range from medical to cultural and economic factors.

The menace of vesico-vaginal fistula is fast becoming one of the most debilitating factors hindering the development of the women folk. The condition incapacitates victims for months and sometimes for years, causing untold hardship to the clients, their family and the community at large. The situation can be arrested or tackled if care is taken to study the socio-cultural factors influencing the prevalence of the problem in South east Nigeria. It is the challenge posed by these socio-cultural factors that this research work will address.

1.2 Statement of the Problem

Ebonyi state is among the five states that make up south east Nigeria. Despite its endowments, the state has had a disproportionate state of socio-economic neglect and mismanagement by leaders in the past and this has adverse effects on socio-economic development and livelihood of the people, particularly women and children. UNICEF, (2015), report shows that the state is among those battling with poverty as the report shows an increase of poverty level from 3.2% in 2011 to 53.5% in 2015. Reasons for the problem according to report is due mainly to near total collapse of health and public water facilities in major towns like Abakiliki, Ezzar North and South. The neglect has increased maternal mortality rate in the area thereby placing women especially pregnant women at risk during delivery.

In the past decade, there has been a growing upsurge of interest in the prevention of maternal mortality. Available data highlights the multi-factorial and multidisciplinary approach required in the analysis of the problem; the dramatic consequences of it's neglect and the urgent need for intervention. Since the safe motherhood conference in Nairobi in 1987, countries including Nigeria have made efforts to evolve strategies to address the problem of maternal mortality.

Worldwide, it is estimated that more and more women die annually from pregnancy related problems for each maternal death, 10-20 other women are left with permanent disabilities, including Vesico-Vaginal Fistula (VVF). VVF is one of the maternal mortality problems faced by women in Nigeria and considered a major public health problem. The prevalence rate is on the increase because of rising poverty, cultural practices and declining quality of maternal care.

Some of the major constraints to articulation of national response have been the dearth of information on the magnitude and destitution of the problem, resource availability for intervention, the actors in the field and their areas of input and gaps in current interventions.

VVF is a health challenge that is found in the entire regions in Nigeria whether in the South, West or North, the problem exists. However, the magnitude varies. VVF victims abound in many parts of Nigeria. Checks revealed that many of the women who are affected hide their faces in shame and die in silence. To see an adult with nappies or diapers remains one of the most embarrassing to any female, some of them suffer discrimination and neglect from their husbands as a result of the problem. Others feel dejected and rejected.

The menace of Vesico-Vaginal Fistula is fast becoming one of the most debilitating diseases hindering the development of the women folk. The condition incapacitates victims for months and sometimes for years, causing unhold hardship to the victims, their families and community at large.

Over the years, a number of key studies have been carried out on VVF. However, these studies have focused on only the medical factors leaving the socio-cultural factors and reliance on hospital records and information from gynecologist or surgeons who operated on the women. While they give a good indication of the existence of VVF in a particular area, the studies do not furnish adequate information as to the non-medical factors responsible for the prevalence of the health challenge in these areas. This has made it difficult to determine the extent of VVF problem in any region including Ebonyi State. These non-medical factors such as socio-cultural practices influencing the prevalence of VVF are lacking in some of the research works. This has stimulated interest in this study in Ebonyi state. There is a misconception among some people that the problem of VVF is as a result of witchcraft affliction. This has equally stimulated interest in this work as the findings will attempt to demystify the misconception.

1.3 Research Questions

The following research questions will guide this work:

i. What is the prevalence rate of VVF among women of Ebonyi State?

ii. What are the socio-cultural factors influencing the prevalence of Vesico Vaginal Fistula among women of Ebonyi State?

iii. What are the social implications of Vesico-Vaginal Fistula among women of Ebonyi State?

iv. What are the management strategies of Vesico-Vaginal Fistula among women of Ebonyi State?

v. What can be done to solve the problem of Vesico-Vaginal Fistula?

1.4 Objectives of the Study

The main goal of this study is to examine the socio-cultural factors influencing Vesico-Vaginal Fistula (VVF) among women in Ebonyi State. However, the specific objectives of this study are to:

i. Assess the prevalence of VVF among the women of Ebonyi State

ii. Examine the socio-cultural factors influencing the prevalence of Vesico-Vaginal Fistula among women of Ebonyi State

iii. Assess the social implication of Vesico-Vaginal Fistula among women of Ebonyi State

iv. Examine the management strategies of Vesico-Vaginal Fistula among women of Ebonyi State.

v. Suggest ways of solving the problem of Vesico-Vaginal Fistula in Ebonyi State.

1.5 Assumptions of the study

The following basic assumptions have been formulated to guide the study.

i The prevalence of Vesico-Vaginal Fistula is more in rural areas than in urban areas in Ebonyi State

ii There are socio-cultural factors that influence the occurrence of Vesico-Vaginal Fistula among women of Ebonyi State

iii There are social implications associated with Vesico-Vaginal Fistula

1.6 Scope of the Study

This study has given attention to socio-cultural factors influencing the prevalence of Vesico-Vaginal Fistula among women of Ebonyi State. Ebonyi State is one of the states in south eastern Nigeria and shares boundary with Cross River, Benue, Abia and Enugu State. The study target population is Ebonyi women, those residing in rural and urban areas in the state. The study carefully sampled six local governments areas from the existing three senatorial zones in the state. The senatorial zones are Ebonyi North, Ebonyi South and Ebonyi Central. The six local governments were categorized into urban and rural local government areas respectively. Two local governments from each of the senatorial zones were studied and were in Ebonyi North, Abakiliki and Ohaukon, Ebonyi South, Alikpo and Ivo and Ebonyi Central Ezza South and Ezza North. This was done due to the vastness of the area. Although other ethnic groups exist in the area, attention was on Ebonyi women alone.

The study investigated cultural practices of the people, like early marriage, female genital mutilation, deliveries of traditional birth attendants and how they contribute to the occurrence of Vesico-Vaginal Fistula. The study focused it's analysis on those cultural aspects usually neglected by medical practitioners in the management of Vesico-Vaginal Fistula which are also causative factors in every care of Vesico Vaginal Fistula. The time frame for this research exercise was between November and December 2017.

1.7 Significance of the Study

As an additional work in medical sociology, the outcome of this work will be an addition to existing literature in the field of medical sociology, by this, medical doctors, nurses and other Para-medical personnel will find the report useful. It is now recognized that there is a link between sociology and medicine. For some time now, matters pertaining to health, healing, and illness were viewed as primarily within the domain of medical practitioners and scholars in the chemical, biological and medical sciences. The primary focus of disease causation was the micro-organisms that invade the body. More powerful diagnostic tools, more sophisticated surgical techniques and more effective drugs were developed. Neither sociology nor medicine paid attention to each other. This has now changed dramatically, as the path of sociology and medicines have converged.

The complexity of today's issue in health and medicine often demands an interdisciplinary approach for complete understanding. So, one of the significance of this work is that, it seeks to make clear, sociology's contribution to the understanding of health and illness without sacrificing the important, complementary contribution of other social scientists, medical and biological scientists, health care practitioners and scholars in humanities.

The final outcome of this work will contribute significantly to gender scholarship by correlating socio-cultural and ritual subordination of women in Ebonyi State which gave rise to the emergency of VVF. It came at a time when efforts are being made to look at issues from the sociological angel. Findings from this work will also help in the transformation of the wider society by exposing cultural practices that seems as an impediment to the development of women.

This study is of significance for so many reasons, which include providing policy makers and readers with insights into some factors influencing the occurrence of VVF among women in

Ebonyi State. Some of the cultural practices that women, especially teenage girls are subjected to, which have many effects on their health were examined and reported.

Development experts such as United States Agency for International Development (UNAID) and other agencies will find the final report useful, as the report will provide information which are important in the management of Vesico Vaginal Festula. Information' which may not have been provided by other research findings, such as health challenges of women in Ebonyi State and cultural practices of the people of Ebonyi State that tend to promote VVF.

Available reports especially on research findings on Vesico Vaginal Fistula over the years have concentrated on the medical factor; only few reported the socio-cultural factors, so this work will throw more light on socio-cultural determinants of Vesico Vaginal Fistula in Ebonyi State.

The outcome will stimulate further work on the subject matter and will also serve as a contribution to the scanty literature on the issue.

Suggestions that will be advanced will also go a long way to help policy makers towards formulating policies that will protect women from some of the cultural practices that are detrimental to their health.

Ebonyi State Government, particularly ministry of health will benefit immensely from this work as the report findings will help health officials know the health needs of women in the state and proffer solution to the prevalence of VVF in the State.

1.8 Organization of the work

This work is organized into five chapters. Chapter one introduce the study with discussion on the background to the study, which is on the socio-cultural factors influencing the prevalence of vesico vaginal fistula among women. This is followed by statement of the research problem, research questions, aims and objectives of the study, hypotheses, scope of the study, significance of the study, organization of the work and conceptual clarification.

Chapter two of this study deals with reviews of the literature and theoretical framework of the study. The theoretical framework dwells on radical feminism.

In chapter three, the study deals with description of the methodology that explains the process and procedures under which the study is carried out. The chapter discuss the research design, research setting, and population of the study, sample size determination, sample technique, method of data collection, and method of data analysis, decision rule and problems encountered during the study.

Chapter four of the study contains data presentation and analyses. Here, data collected on variables are categorized, so as to enable the researcher answer his research questions, test the hypotheses and draw conclusions from the findings. As well as the contributions of the study to the field of knowledge.

Chapter five, which also the last chapter of the study, dwells on the summary of the work. The summary of the findings. The chapter also discussed conclusion and recommendations made by the study.

1.9 Conceptual Clarification

i. **Culture:** The total way of life of a people. It is used with relevance to a society or group of societies and transmitted from generation to generation.

ii. **Consequences:** This means something that happens as a result of change. It could be a change of status or state.

iii. **Early Marriage:** Marriage contracted before age eighteen, usually between teenagers or an adult male.

iv. **Ebonyi State:** This is one of the 36 states in Nigeria, carved out from Enugu State by the military Government of Ibrahim Babangida. The capital of the state is Abakiliki and the state shares boundary with Enugu, Cross-River, Benue and Abia state.

v. **Ebonyi State Women:** In this study, it refers to women who reside in Ebonyi State. They may not necessarily be indigenes, they may be single, married, divorced or separated.

vi. **Fistula**: A pathological communication between two epithelial surfaces or cavities. Fistula can be divided into three: Vesico Vaginal Fistula, recto vaginal and urethra vaginal fistula in which there is connection between vagina and the bladder, rectum and uterus respectively. Among these three fistulas, vesico vaginal fistula ranks as the commonest type found in gynaecological practices in developing countries of the world.

vii. **Food Taboo**: This means a culture bound that excludes women from eating a particular type of food or meat.

viii. **Health:** A complete state of physical, social, and mental well-being of an individual.

ix. **Harmful Traditional Practices:** Obnoxious practices causing harm to people such as female genital mutilation.

x. **Investigation**: For this study, it means an official attempt to find out about something, especially on social issues.

xi. **Impact**: This means the effect or influence that something or someone has, it could be social, natural or environmental.

xii. **Influences:** This means power to produce an effect; action of natural forces.

xiii. **Impediment**: This refers to a situation or event that makes it difficult or impossible for the growth and development of the female gender.

xiv. **Medical Experts**: These refer to those with medical knowledge such as doctors, pharmacists, nurses, and others like laboratory scientists.

xv. **Motherhood**: In this study, it refers to a term encompassing the practical realities and social significance of being a mother.

xvi. **Marxism**: In this study, Marxism means the body of theory and diverse political practices and policies associated with the writings of Karl Max.

xvii. **Patriarchy**: This means rule of the fathers. The term was originally used to describe social system based on the authority of male heads of household in general terms, it means male domination.

xviii. **Poverty:** A state in which resources, usually materials are lacking. It is a situation where an individual lacks the resources necessary for his/her sustenance.

xix. **Socio-Cultural:** Concept with social and cultural connotation used to explain the way of life of the people. In this work, examples of socio-cultural concepts includes: early child marriage which could be as a result of poverty or cultural belief that a girl must have her first menstrual experience in her husband's house, female circumcision which is popular in Africa but medically incorrect as it affects the physical and mental well being of most women and girls who have had this surgical procedure performed on them.

xx. **Socio-Cultural Factors:** Socio-cultural factors in this study refer to socio-cultural practices such as early marriage, female circumcision, poverty, illiteracy, poor nutrition and traditional birth attendance.

xxi. **Stigma:** For the purpose of this work, stigma can be seen as social disability, it can become a matter status, overriding all other features of a persons identity.

xxii. **Traditional:** For this study, traditional means ancient, ethno cultural, religious beliefs and practices that have been handed down through the generations.

xxiii. **Vesico- Vaginal Fistula:** A condition whereby there is a pathological communication between the epithelial lining of the urinary bladder and vagina, leading to continuous leakage of urine.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAME WORK

The review of related literature in any research work provides an opportunity for the researcher to look at the works of other people, make comparisons and come out with findings. In this work, literature shall be reviewed under the following headings:

2.1 Prevalence of Vesico Vaginal Fistula

Ekene, (2014:16), stated that women constitute about 50% populations of any country and because of their crucial roles in the family and society; it has become imperative that their rights are protected at all times. Just as men, women have rights which must be protected. Their rights which are contained in the United Nations (2012)Article II of the Convention on the Elimination of all forms of Discrimination Against women states that "parties condemn discrimination against women in all its forms, agree to purse by all appropriate means and without delay of policy of eliminating discrimination against women , and to this end undertakes:

a. To embody the principle of the equality of men and women in their national constitution or other appropriate legislation if not yet incorporated there and to ensure through law and other appropriate means, the practical realization of this principle.
b. To adopt appropriate legislation and other measures, including sanctions where appropriate, prohibiting all discrimination against women.
c. To establish legal protection of the rights of women on equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discriminations.

d. To reframe from engaging in any form of discrimination against women and to ensure that public institutions and authorities shall act in conformity to its obligations.

e. To take all appropriate measures to eliminate discrimination against women by any person, organization or enterprises

f. To take all appropriate measures including legislation to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women.

g. To repeal all national penal provisions which constitute discrimination against women.

Unlike other human rights treaties, Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) does not solely address actions by the state or its agencies, it encourages states to take all appropriate measures to eliminate discrimination against women by any person or organization or enterprise. States are also encouraged to modify the social and cultural patterns of conducts of men and women, with a view of achieving the elimination of the prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or stereotyped roles for men and women. In addition, they are to ensure that family education includes a proper understanding of maternity as a social function and the recognition of the common responsibility of men and women in the upbringing and development of their children, it is being understood that the interest of the children are the primordial consideration in all cases.

CEDAW recognizes the rights of women especially the right to work and earn a living as a human being. By this CEDAW maintains that:

a. Women are to be ensured equal rights with men in employment.
b. The right to work is declared to be in aliable right to all human beings.
c. Women have the same right as men to free choice of profession and employment, job security, benefits and vocational training and retraining.
d. States must ensure that the right to equal pay and equal treatment for work of equal value as well as equal social security benefits and paid leave.
e. Women shall have the right to protection of health and safety at work, which must include safeguarding reproduction.
f. Special protection shall be provided for women during pregnancy but any protective legislation with regards to employment shall be reviewed periodically and revised, repeated or extended as necessary.
g. States must prohibit discrimination on the grounds of pregnancy, maternity leave or marital status, they must introduce paid maternity leave without loss of employment, seniority, or social allowances.
h. States must encourage the provision of social allowances and support services such as child care facilities that enables women to combine family life, employment and participation in public life, combine family obligations with work responsibilities and participation in public life, in particular through promoting the establishment and development of a network of child-care facilities.

Looking at the above rights and positions of CEDAW, women in the third world countries cannot be said to be benefiting from these rights. In the view of Breje, (2013), there is a gross violation of women right in developing countries, the violation of these rights has lead to many problems such as trafficking and health challenges like VVF.

Women are seen as inseparable from the family and most functions assigned to the family are allocated to them. However, some health challenges makes it difficult for women to perform

their expected role in the family and one of such health challenges is Vesico vaginal fistula, which is an abandoned communication between the vaginal and the bladder of a woman. It is a health challenge common in developing countries, most especially in sub-Saharan countries like Nigeria. According to Adamu (2016), in the northern part of Nigeria, VVF has posed a serious challenge due to cultural practices like early marriage and female circumcision. In the view of Adebanjo, (1992), the majority, if not all of the dangerous practices which are harmful to maternal health in Nigeria are performed\ under the auspices of traditional or cultural belief and inclinations. Traditional practices are those cultural practices that have been handled down from generation to generation. They have a bearing on a set of actions and behavioural patterns of specific ethnic or tribal groups.

It is acknowledged that a good number of African traditional practices have these merits while some have no known positive effect on society. However, it is an established fact that the more severe the effect of any of the harmful practices the more likely it is that the victims will be either women or children, men generally have been involved in the less severe forms of traditional practices Adebanjo, (1992).

The prevalence of VVF among women over the years has become an issue of great concern to experts in medical and social sciences. Shehu (1992), posits that in the northern part of Nigeria, there are some socio-cultural factors responsible for the causation of maternal mortality and morbidity. The socio-cultural factors which include early marriage and purdah, which means keeping women at home and not allowing them to mingle with other people tend to to put women at risk in the region. Shehu (1992), stated that in northern Nigeria, major political, social and even economic structures are patriarchal and centre based. The low status of women finds expression in a number of practices which have a direct influence on women reproductive health. There is the practice of marriage of girls at early age often before the age of fourteen and before they attain adequate physical and emotional maturity. Another

manifestation of this low status is the tendency of sex segregation. For married women, this is expressed through the practice of "purdah or kulle" proscribes a woman's ambit of movement and her behaviour towards men who are not her relations.

In Hausa culture, the instructions- the family, Islam and Koranic education which is compulsory for all children. Provide the instructional backing for all these practices from one generation to another. These instructions remain stable and hence the values transmitted remain entrenched.

Concerning the practices of early marriage, Shehu (1992), stated that the rationale is that a woman's main role is that of reproduction and this should properly take place within the context of marriage. Girls must consequently be socialized early to look forward to marriage. Mothers are charged with the responsibility of preparing their daughters mentally and maternally for that eventuality. Indeed, parents become anxious if a daughter begins to mature without a possible suitor to express an interest. A girl who remains unmarried by age eighteen or nineteen if not in school, is invariably regarded as a problem. Parents prefer to send their daughter as virgins to their prospective husbands. All major decisions are taken for her by her parents and later by her husband. The prolonged period of life spent in pursuing modern education is not only considered as a waste of time but also as a culprit for moral decadence. Instead early marriage of girls is valued and encouraged. It was difficult for mothers to see the connections between their daughter underdeveloped pelvis, the early marriage, and subsequently pregnancy which contribute to health problems such as VVF and foot drop condition, especially trace they were also married when they were young. The only problem that most women in this situation are prepared to recognize is the impatience of the men who would not exercise restraints and allow the girls to mature before cohabitation.

The two practices-early marriage and restriction of movement of the married women- serve to expose women to undue crises during these reproductive years. In addition to the risk of

cephalo-pelvic disproportion during labour, a girl having a difficult labour cannot be taken out without the express permission of the husband. Shehu, (1992). Furthermore, the operations of Kunya, a culturally instituted behaviour which is a show of modesty and shyness especially with regard to the first pregnancy and everything related to it also increases the risk of a young girl faces during pregnancy and labour. The period may be prolonged unduly.

In southeast Nigeria, some years back, cases of VVF were not common as they were in north especially north west and this is because some of the socio-cultural practices such as early marriage, activities of traditional birth attendants were not common. However, beginning from 1999, some communities in the southeastern part of Nigeria started encouraging some harmful cultural practices which influences the prevalence of VVF in the region. Some of these practices which were silent in the past, began to manifest. The practices include early marriage, female genital mutilation and actions of traditional birth attendants. Apart from genital mutilation, the two practices (Early Marriage and the activities of Traditional Birth Attendants) could be attributed to the high rate of poverty in the region which may have paved way for the emergence of the tradition as people prefer to have their daughter get in married when they find it difficult to train them in school, while pregnant women whose husbands are poor prefer to visit traditional birth attendants if they cannot

afford to go to the hospital for delivery. In the view of Odinaka, (2011), cases of VVF in the southeast Nigeria has been on the increase which led the federal government of Nigeria to set up a centre to cater for the victims from the region.

In Ebonyi state, one of the states in the region, the prevalence of VVF according to USAID 2015. is on the increase, in fact the report stated that the state tops in cases of VVF in southeast Nigeria and government of Ebonyi state has shown concern by including it on the state strategic health development plan. As a result of the prevalence of VVF, many agencies

such as the federal government, state government, private health care providers, civil society organization and development partners have been providing assistance in the management of the problem.

In the view of Adeoye, *et al* (2012), VVF has always been thought to be a scourge of the northern region of Nigeria, surprisingly, it is also a burden in the southern parts of Nigeria. However, the precise incidence is difficult to estimate largely due to the paucity of community based estimates and the stigmatization associated with the problem prevent women facing the challenge to seek for help.

Just like in the northern part of Nigeria, early marriage, activities of traditional birth attendants, poverty and female genital mutilation are all factors responsible for the prevalence of VVF among women in Ebonyi state. As there are evidence of harmful traditions that have refused to die among the people. Okeke (2010) posits that cases of VVF are common in rural areas in southern Nigeria as there are usually problems of shortage of health workers in rural areas and this makes it difficult for women to have access to health care. Moreover, some women in the rural areas do not have knowledge about the problem. In Ebonyi state for example, the VVF hospital is located in the state capital and accessing their services is usually a difficult task for women in the rural areas due to bad roads from the rural areas to the city.

Vesico Vaginal Fistula (VVF) is considered as a serious reproductive health problem in women in developing countries of the world. According to United Nations Funds for Population Agency (UNFPA - 2010), in Nigeria, one out of eighteen women die from complications of birth. According to Njoku (2011:49), fistula usually occurs when a labour lasts several days and cannot access a caesarian section on time. The baby usually dies as the woman is left with extensive tissue damage to her birth carnal that renders her incontinent and according to Muhammed (2011:42), the result is life- shattering as the woman

experiences pain which has adverse effects on her health. VVF is common among young, poor and uneducated rural women in the developing world. However, Ejembe (1994:18) and Kabiru (2004:24), stressed that surgical repair can have success rank as high as 89 to 90 percent, restoring a full reproductive life.

In a research conducted by the Federal Ministry of Health (FMH) and published in the National Demographic Health Survey (2008), alarm was raised over the increasing number of women with VVF. In the view of Efen (2012:43), about 200,000 women are living with VVF in Nigeria. Efen who is the Country Director of the fistula care project of the United State Agency for International Development (USAID), made the statement during a workshop organized by the partnership opportunity for women empowerment rehabilitation (POWER), a Non-governmental Organization and supported by USAID Fistula Project.

Following the above information, it shows that VVF is a serious problem in Nigeria and in Africa. It is a problem because of the growing number of women suffering from the repulsive ailment in some parts of Nigeria. Current discussion on health recognize that, it is no longer adequate to define health simply in terms of absence of disease or illness, but that, it encompasses the state of complete physical, mental and social well-being of the individual, the family and the community. These discussions also indicate that personal health is not simply a matter of individual decisions and action, but that it is dependent on several factors, many of which may be beyond the control of the individual. This emphasis has led to discussions about the social influences on health and the analyses of the social conditions that determine the health of an individual as member of the family, the community and the larger society.

The earliest and oldest evidence of obstructed labour was discovered in the remains of Queen Henhenit, who was a wife of King Mentuhotep II of Egypt sometime in 2050 BC. This observation was made when the Queen's mummy, on discovery by Edouard Naville, was sent

to the Metropolitan Museum of Art, New York in 1907. A thorough observation of the Queens mummy indicated that the vaginal was normal while there was a mass of tissue 10 cm long, possibly intestine sticking out through the anus. In 1923, the mummy was returned to Cairo for detailed clinical examination by Professor D. E Derry, which showed that there was a tear in the bladder connecting to the vagina. A closer examination also indicated that the pelvic bone was abnormal in shape, approximating that of apes. Considering the width of the pelvis, the examiner believed it was too small or narrow to allow a passage of fetal head, and that the severe pain and damage done to the bladder and vagina could have been responsible for the death of Queen Henhenit (Zacharin, 2005:10).

Prior to the above discovery, an Arabo-Persian physician named Avicenna, who died in 1037 AD, was the first individual to observe that urinary incontinence in women may be as a result of Fistula consequent upon obstructed labour (Zacharin, 2005:10), While linking difficult labour to fistula, advised on pregnancy prevention, especially among young girls, he thus said, "in cases in which women are married young, and in patients who have weak bladders, the physician should instruct the patient in the ways of prevention of pregnancy. In these patients, bulk of foetus may cause a tear in the bladder which results in incontinence of urine. The condition is incurable and remains so till death." (p.2) the end of 1600 BC however, became a remarkable period because that was when several clearer descriptions of fistula started coming up. In 1597, Felix Platter, gave the following description of fistula: " as a consequence of a first labour, the young country girl had the opening of the bladder rent to such a degree that there was a long gapping furrow in its place, and the open bladder could be seen. On account of this injury, there is a constant involuntary discharge of urine, and the surrounding parts become excoriated and inflamed" (Zacharin, 1988:88).

At the beginning of the 19th century, major progress was made in the repair and treatment of Vesico-Vaginal Fistula. Notable among the physicians at the time were de Lmballe, Wutser,

Simon, Sims, Emmet and Bozeman (Zacharin, 1988:85) between 1845 and 1859, Doctor Marion Sims has become famous for his aggressive discoveries of instruments and materials used in closing enormous fistula. Till date, Sim has been praised for recognizing that health problem faced by women required urgent medical and surgical attention (Medscape, 2003:17).

2.1.1 Global View of Vesico Vaginal Fistula

Historical understanding of VVF has shown that the condition is not a new phenomenon, as a matter of fact; it is a common scourge throughout the world. However, improved and advanced obstetric care in areas such as Europe and North America has made the scourge relatively unknown in these geographical regions of the world. Metro (2006:14), observed that fistula is almost oblivion in countries where there are universal health care, which takes women's health more seriously. Metro (2006:14), further commented that VVF resulting in urinary incontinence in third world countries centres around obstetric difficulties, while 90% of such cases are caused by in advent bladder trauma during surgery with hysterectomy. A report by Wall (2003:118), observed that there are cases of VVF in industrialized countries, however, these are due to radiation therapy or surgery, thus distinguishing the etiology from that of developing countries, which results mainly from neglect of obstetric complications which occur under very different circumstances (Wall, 2003). According to Valley (2006:202), the incidence of \/VF in the United States is debated, "while most authors quote an incidence rate of VVF after total abdominal hysterectomy (TAH) of 0.5-2%, others suggest only a 0.05% incidence rate of injury to either the bladder or urethra, thus in approximately 10% of cases of VVF obstetrical trauma was the associated etiology. Radiotherapy and surgery for malignant gynaecologic disease each accounted for 5% of cases".

Most discussions about VVF centre on Africa, this is however misleading because several other parts of the world also face this problem. To this end, a report by Wall et al (2003),

brings out the fact that there has not been an up to date study around the world to actually determine the extent and the places where the scourge occur. According to them, “questions regarding the incidence and prevalence of obstetric fistulas have never been included on the standardized Demographic and Health Surveys (DHS) that are carried out to evaluate population characteristics and overall health status in developing countries" (Wall et al (2003).

Existing and accurate data on the problem of VVF are practically not available, although the incidence has been widely reported throughout Africa and the lndian subcontinents. However, a WHO (2006) report indicated that a cautious estimate of 2million young women live with untreated VVF, and new cases of between 50,000 and 100,000 are reported every year. These figures above can be argued to be highly unrepresented because of the stigma which is associated with the problem; hence, several other unknown and unreported victims of VVF live with the condition in fear and isolation. In spite of the stigma associated with VVF, it still records one of the commonest distressing conditions which bring women to hospital in many African countries (Kabir et al, 2003). An isolated study of VVF in some selected parts of Africa undermines the true situation of the scourge in the third world specifically, and around the world in general. In order to come closer to the true incidence and prevalence of VVF around the world, Wall et al (2003), suggest that the mapping of the entire world for a survey on VVF should include virtually all of Africa, South Asia, less developed parts of Oceania, Latin America, Middle East, some remote areas in Central Asia, selected isolated area of former Soviet Union and Soviet- dominated Eastern Europe. However, high maternal mortality rate has been directly linked to the incidence of VVF. Poor countries with high maternal mortality have therefore been observed to have high prevalence of Vesico Vaginal Fistula (WHO 2006). These countries are undoubtedly located in the third world.

2.1.2 Vesico Vaginal Fistula in Africa

There have been different diseases that have serious concerns to different societies with different socio-cultural backgrounds at different periods that were regarded as plagues, yet were responsive to treatment since the creation of mankind. However, the emergence of VVF in Africa has thrown challenges to its peoples and governments, Apart from damage of internal body tissue as consequences of prolonged obstructed labour, VVF can also be caused by burns from chemicals that are meant to induce labour or initiate abortion. In the view of Lawson (2009:14), most cases of VVF can be found in Western Africa and Local Authorities consider it as a major health issue as well as both cultural and social issues. The majority of women who developed fistula run the risk of permanent incontinence and related consequences. They become isolated because they are used and abandoned by their husbands and get ostracized by their communities because, they are unable to have children. According to Makumbi (2010:32), annually, 80% of the 50,000 to 100,000 women who develop an obstetric fistula during child birth are in Africa. Vesico-Vaginal Fistula most commonly appears as a complication of delivery in 97% of the cases. Munabi and Sebwulu (2011:15), posit that it is expected that in East Africa, for each maternal death, there are fifteen mothers who suffer some form of obstetric morbidity, the most common and devastating being the VVF.

Cases of VVF in Africa are usually handled by Consultant Obstetrics and Gynaecologists. In the view of Makumbi (2010:32), in Uganda, and probably in most developing countries, the teaching is that the repair of VVF should be left to Consultants. However, the consultants are few and usually resident in busy National Referral Centres. In addition, the VVF repair operation is very long as such those operations are avoided as they seem to take valuable theatre space and nursing shift time. Makumbi (2010:44), stated that, the successes recorded

by Medical Officers show that it is possible to repair VVF in Africa and in other remote settings of the world.

Mohammed (2010:80), stated that, VVF is common in Africa because of the high rate of poverty in the continent and low level of education of the girl- child. Other reasons are some harmful traditional practices such as Female Genital Mutilation (FGM), early and forced child marriage and male preference. Some of these practices have serious consequences for the girl-child's physical, emotional, and psychological development.

Kachi (2011:81) posits that, some girls and women in Africa are unaware of their basic rights, and others are raised to believe that their tradition is more important than their basic human rights of freedom from torture, cruel, inhuman and degrading treatment, among others. This ensures the acceptance and the perpetuation of some harmful traditional practices which affect their well-being and that of their children.

Prevalence of VVF in Africa varies from country to country. However, from position and views of some scholars on the diseases, it is more prevalent among rural than urban woman due to the shortage of medical facilities in the rural areas and the existence of some harmful traditional practice such as early and forced child marriage. Forced marriage is common in Sub-Sahara Africa, According to UNICEF (2007), when a girl marries early it usually means the end of her education if she is in school and the end of her autonomy to make important decision about work, her health and her well-being. Children sometimes run away from rural areas because of arranged or forced early marriages. The United Nation, (2010) fact-sheet stated that approximately 14 million adolescent girls give birth in Africa each year and girls under age 15 are five times more likely to develop VVF or may even die during pregnancy and childbirth than women over age 20.

2.1.3 The Nigeria Situation

Recent assessment of the health of the Nigerian population indicated that health situation in Nigeria and of Nigerians is dismal and efforts to change the situation over the years have been insignificant. Indeed, Nigeria lags behind many other African countries on various health indicators. World Health Organization (2013) evaluation of the health situation in different parts of the world, placed Nigeria 187 out of 191 countries that were surveyed. The UNDP's (2014) human development report ranked Nigeria 154 out of 177 countries in the world in terms of overall human development. The above statistic shows that Nigeria is lacking in health issues than other countries and health is not simply a matter of individual decision and action but that it is dependent on several factors, many of which may be beyond the control of the individual. This emphasis has led to the discussion about the social determinants of health and the analyses of social conditions that determine the health analyses of the individual especially women. The health of women in some societies is largely dependent on customs and traditions that exist in such society. So there is a link between culture, tradition and development of VVF.

In Nigeria, according to WHO (2013), an estimated number of 400,000 to 800,000 women and girls are said to be living with VVF, while an additional 12,000-20,000 new cases develop yearly; This was contained in Health Report in 2012. Following these numbers, Nigeria is said to be contributing over one third to the global burden of VVF. Experts have lamented on the increasing cases of VVF and the need to respond to the health needs of women in Nigeria. By responding to the health needs of women in Nigeria, their rights are protected and guaranteed. It is a common knowledge that the unequal power relations between men and women often limit women's control over sexual activity and their ability to protect themselves against sexually transmitted infections (STI) including VVF. Current data have shown that one woman per minute dies of pregnancy-related causes. Also, sexually transmitted infections affect five times more women than men; Olabisi, (2009:61). Thus,

there is a link between gender inequality and sexual health conditions in a society. It is also a bias that the general neglect of women's health is a general hindrance to women participation in the development process. Any serious attempt at transforming the quality of life including health at the house hold level must necessary have a better understanding of sexual dynamics at this level, and much more important, an appraisal of the marriage contracts as these exists in our society today.

Women's subordinate position has been linked intimately with the institution of marriage. The traditional form of marriage across cultures (whether patriarchal or matriarchal society) place women at a disadvantaged position. This has over the years continued to serve as a base for the discrimination of women in all spheres of life and in all societies through history.

Victims of VVF are mostly women whose sexual rights have been violated as some of them got married at a very tender age when they were not even ready for marriage. Thus, their sexual rights have been violated, their sexual health will severally be affected. According to WHO (2002), sexual health is a state of physical, emotion, mental and social being in relation to sexuality. It is not merely the absence of disease, dysfunction or infirmity. The 14th world congress of sexology (1999) approved the amendment to the declaration on sexual rights in establishing that "sexual rights are universal human rights based on inherent freedom, dignity, and equality of all human beings. Since health is a fundamental human right, so is the result of an environment which recognizes, promotes and defends sexual rights. Sexual health, therefore, is the enabling environment wherein the sexual right of an individual is protected.

The issue of sexual health has become very important, especially with the emergency of pandemic of Human Immunodeficiency Virus (HIV) infections, increasing rate of sexually transmitted infections (STIs) and growing recognition of public health concerns such as gender related violence and sexual dysfunction. Hence, the World Health Organization has started looking at sexual health rights on it's own. Sexual health has been linked with

reproductive health since the continence on population in 2013 which defined sexual health as an integral part of reproductive health. In order to achieve sexual health, people must be empowered to exercise their sexual rights. A denial of such power is what usually leads to sexual violence and emergency of VVF.

VVF is common especially in the Northern part of Nigeria, where early marriage is encouraged. According to Fasakin (2007:41), there is a Vesico-Vaginal Fistula rate of 350 cases per 100,000 deliveries. This condition is so enormous and thus ravage Nigerian women that the Federal Ministry for Women Affairs and Youth Development has estimated that the number of untreated VVF cases in Nigeria stands between 800,000 and 1,000, 000 (Valley, 2006:12). Going by this report, Nigeria women are under serious siege of VVF.

Corroborating the above report, the Nigeria Federal Ministry of Health estimated that 800,000 women are plagued by the scourge of VVF and majority of them live in the rural areas where there are shortage of health workers and lack of primary health care. The minister, thus, recalled that the country accounted for 40% of the global burden of VVF (The Guardian, 2007).

The Nigerian Demographic and Health Survey (2008) stated that VVF cases in Nigeria resulted in social problems as rejection, shame, and stigma as well as economic problems. Cases of VVF in Nigeria, is an indication that there is need for intervention from government as the situation is worrisome. Nigeria Demographic and Health Survey (2008), maintained that in addition to place of birth, assistance during childbirth is an important variable influencing the birth outcome and the health of the mother and infant. The skills and performance of the person providing assistance during delivery determines whether the complications that may arise will be well managed and hygienic practices observed.

Complication during child birth can be a determining factor for VVF. Nigeria Demographic and Health Survey (2008) also stated that one of the most striking differentials in assistance

during child birth is by urban- rural residence. About seven (7) in ten (10) births to urban women are attended by a skilled provider, compared with three (3) in ten (10) births to women in rural areas. Women in urban areas are most likely to be assisted by nurses or midwives (40%), while women in rural areas are most likely to be assisted by a traditional birth attendants (25%).

VVF is a serious problem in Nigeria, Illiyasu & Umar (2004:62), reported that the problem is common among females between the ages of 10-15 years, accounting for over 70% of patients suffering from the problem in the North. Thus, the age of acquisition of the diseases could generally be said to be in the early teenage period. Most of the patients had their first marriage at a very young age of 10-15 years. However, judging from the Nigeria Demographic and Health Survey (2008), early marriage may not be seen as the only factor contributing to VVF. In the view of Illiya and Umar (2004:62), despite the occurrence of teenage pregnancies in the developed countries, obstetric fistula is a rare occurrence, therefore, it can be argued that early marriage or pregnancy perse are not the major cause of VVF, but the unsupervised deliveries. If essential obstetric services are provided and utilized by all women; harmful traditional practice like female genital activity and mutilation are eliminated in addition to girl-child education, VVF could be prevented in the developing country like Nigeria.

It is a common knowledge that the Nigeria health system is in a poor state when compared to other systems in the developed countries. This is traceable to several factors especially the gross under funding of the Health Sector and shortage of skilled medical personnel to take care of the health needs of the people. The implications or consequences of the poor state of the health system is the high mortality rate in the country. The mortality rate and cases of child birth injuries show that a lot is required from policy makers to arrest the situation. Among the child injury that requires urgent attention is obstetric fistula. Obstetric fistula

according Sukuji (2013:12), is a serious maternal health concern in Nigeria. The 2008 report of the Nigerian Demographic and Health Survey (NDHS), found that an estimated 2 million women in Sub- Sahara African and Arab world are living with the condition and some 50, 000 to 100,000 cases occur each year. Because of the fear of rejection, shame and stigmatization, affected women are often reluctant to reveal their condition.

In Nigeria, Vesico Vaginal Fistula (VVF) poses many challenges to the government. According to Kees (2006:62), approximately 80 percent fistula cases reported in Nigeria are due to unresolved obstructed labour during child birth. In the view of Muhammed (2011:10), obstructed labour is directly related to the custom of early marriage, frequently between the ages of 13 years and sometimes before the onset of menstruation as early as 11 years. Early marriage invariably leads to early sexual contact and subsequently pregnancy at a time when a young girl is not adequately developed physically to permit the passage of the baby with relative ease.

In some communities in Nigeria, it is common to see young girls getting married as early as 13 years. According to Omenka (2011:21), incidence of VVF has contributed to many cases of divorce and rejection in Nigeria. Okeke (2009:12), posits that women who suffer from the problem are usually divorced and rejected by family members, especially by men who are responsible for their predicaments. To Okeke (2009:12), once the problem arises, victims move long distances in search of treatment, which often eludes them. In some cases, they have to take to begging or prostitution for survival.

VVF is considered as a major public health problem in Nigeria, with the prevalence rate on the increase because of rising poverty and declining quality of maternal health. According to Ezenweka (1999:30), maternal injury in child-birth may be the single largest unaddressed issues in women health care worldwide. Child birth injury, especially VVF in the view of Offoma (2012:17), is still a persisting scourge in some communities with medical and social

devastating consequences. The condition has spread sorrow in the lives of victims in the community. According to a victim's confession which was published in daily sun of Thursday April 28, 2011 page 16 "when my husband discovered the problem, he divorced me. I was forced to go to my parent's house and they accepted me but life has not been easy for me. I have been suffering with this disease since then because I have been out of home doing nothing."

In an interview with This Day newspaper of March 28th 2005, the wife of the former Ebonyi State Governor, Mrs. Eunice Egwu reports that "VVF which hitherto was uncommon in the state and other areas of the South East has become a major disease among women in the State. According to the former First Lady, Ebonyi State recorded the highest incidence of VVF in the South Eastern states with about 26.7%. 'This is an indication of the seriousness of the problem'. Mrs. Josephine Elechi the wife of the current Governor, in an interview published in This day of January 9, 2009, states that existing records in the state show a high neonatal/infant and under five mortality rate, while the internal mortality ratio is unacceptably high. In the state, maternal morbidities caused by VVF have remained silent in the state. Prevailing factors that further caused the scourge according to Elechi (2007:18) include: early marriage, teenage pregnancy, female genital mutilation, ignorance and poverty. Other factors include: the poor state of health facilities with no provision for emergency, obstetric care, the activities of quacks and unskilled birth attendants.

In 2008, the United Nations Development Programmes (UNDP) asserted that VVF was prevalent in some Nigerian communities .As a result of the problem, VVF units have been established in many government hospitals, especially Teaching Hospitals and some of the surgical equipments and consumables for the units are provided by UNDP and USAID for the repairs of some patients. Many government hospitals have carried out treatment of VVF patients with the help of Non-governmental Organizations.

2.2 Socio-Cultural Influences on Vesico Vaginal Fistula

Culture plays important role in our lives. In the view of Wegh (2013:14), cultural rules regulate what we eat and even how we eat. So culture plays important role in our lives as individuals. Uzoegbunam (2005:22), stated that, some cultural norms and practices affect the health of women and children and influences fertility as well as child-bearing practices in Nigeria. Examples include female circumcision, child marriage etc.

To a larger extent, culture determines how members of the society think, and feel, it direct their action and defines their outlook about life. In the view of Gbefwi (2010:28), culture refers to established patterns of behaviour and way of life of many group of people or society which have been handed down from generation to generation, either verbally or by practice. Some practices are linked to religion or attitude. According to Gbefwi, (2010), the way people live which includes ways and methods of obtaining food from the environment, adapting to the environment, their rules and regulation that govern people's behaviour in a particular society make them who they are. These include beliefs, religion, morality, and ways of medication. Culture can also be seen as distinctive practices and beliefs of a society, Peoples way of life that determines their conducts at all times.

In the view of Iorvaa (2013:16), culture may be viewed as a blue print for living, which guides the thought, actions, sentiments and even health behaviour of individual families and communities. In the views of Hitchcock and Schubert, (1999) cited in Iorvaa (2013) culture issues are important because the life styles, health, and healing practices are determined by belief originated from cultural and lives of the people. In Medicine, the Health Belief Model (H.B.M) assumed that beliefs and attitudes of people are important determinants of their health-related actions.

Medical Anthropologists and Sociologists have written a lot on the socio-cultural influences of most sicknesses and diseases. They have equally gone further to state the effects of some

of these social-cultural influences on the health of women. However, most of the studies done on the problem of Vesico Vaginal Fistula were from the medical perspective, often neglecting the socio-cultural perspective. VVF is a serious gynaecological condition which results from child birth difficulties and has socio-cultural influence. The socio-cultural circumstances in which Nigerian women find themselves, according to Fasakin (2007:40), function as predisposing factors to their poor maternal conditions, resulting in the high incidence of VVF. These socio-cultural factors are mostly responsible for underlying behaviours and conditions that initiate and sustain the affliction of VVF on its victims.

In many communities, the case is not different as many victims of VVF are those that are socially disadvantaged. In the view of Olikaeze (2009:92), socio-cultural conditions or factors which contribute to the high incidence of VVF are: early marriage, harmful traditional birth practice, poverty and ignorance.

2.2.1 Early Marriage and VVF

The term "early marriage" is used for both formal and informal marriages in which a girl lives with a partner as if married below age 18. According to Owo (1994:38), early marriage also known as child marriage and can be described as "any marriage carried out below the age of 18 years, before the girl is physically, physiological, and psychological ready to shoulder the responsibilities of marriage and child-bearing". Okolo (2010:9), asserted that child marriage, on the other hand, involves either one or both spouses being a child and may take place with or without formal registration, under civil, religious or customary laws.

In the view of Owo (1994:46), there tends to be a relationship between age at marriage, level of education, poverty and health. Early marriage is a contributory factor to VVF, as in most cases, the girl is too young to give birth as her pelvic is usually too small to allow the passage of the baby's head. Since the birth canal is too narrow for the head to come out, a prolonged

and obstructed labour occurs. This threatens the lives of both the mother and the child at the same time, paving way for VVF.

Ekene (2009:52), stated that customs surrounding marriage, including the desirable age and the way in which a spouse is selected, depend on a society's view of the family, its role, structure, pattern of life, the individual and collective responsibilities of it's members. The ideas and function of family varies across the world and is in a state of constant evolution. Ekene (2009:52), posits that early marriage deprives a girl of her adolescence and causes social damage. Kamala (2010), summed up by stating that in early marriage, girl spouses suffer more than boys and distress is generally endured in silence.

From the points raised so far on early marriage, it is clear that the impact of early marriage on the girl-child is wide ranging. Apart from the development of VVF, within a rights perspective, three key concerns are: the denial of childhood and adolescence, the curtailment of personal freedom and the lack of opportunity to develop a full sense of selfhood as well as the denial of psychosocial and emotional well-being, reproductive health and educational opportunity.

To a large extent early marriage apart from being a form of violence against women, because in some cases, the young girls who are victims are forced to comply with the demands of their parents, early marriage is a form violation of the right of the girl child. It is a known fact that the Nigerian society is patterned along gender lines leading to a situation where men control women. As the dominate group, men have access to significant materials resources, while women are cheapened as secondary and inferior. Men of different social classes and races can possibly use violence as a strong mode of subjectivity women. McDonnel (2003), although there are several ways that men as a team reinforce female subjugation in a social circumstances, violence slangs as the most conspicuous and functional means of control, even if individual men abstain from applying violence on their partners men as a group gain from

how women lives are inhabited and contained and all these serve as violation of their rights. Rights are fundamental in the lives of all individual whether race of female, children or adult, it should be enjoyed by all irrespective of religious affiliation or cultural background, violation of this right is usually frown at, it is in recognition of this fact that a group of women in Calabar, Cross River State Nigeria staged a protest in 2013. The protest was staged by 3,000 women of the Christians faiths who where members of different Churches in the south and south eastern regions of the country. The women said it has become necessary for them to condemn the practice of early marriage openly and to discourage the state house of assembly whom they were told was about to endorse child marriage by collaborating with some women folk. They said, they reject child marriage as it is dangerous to the health of the girl-child.

Child marriage is child abuse it is for this reason that efforts are being made by all to end the practice. The addition of SUN December 3rd 2016 focused on ending child marriage in Nigeria, the editorial stated that it is cheering news that Nigerian has signed up to the campaign to end child marriage by becoming the 16th country on the continent to join the campaign by the African governments. On Tuesday November 29, 2016 the federal government, in collaboration with the United Nations office in the country, the Canadian government, religious leaders traditional rulers and other stakeholders called for an end to the harmful practices that affect women. This level of collaboration among local and international entities shows the seriousness of the problems and the concerned efforts required to solve it. The vice presidents Yemi Osibanjo observed at an occasion, marking the day of the African child that Nigeria has made notable achievements in ending the phenomenon of child marriage through the enactment of the child right act. The fact that only 24 states out at 36 have passed the law, indicates that there is still room for improvement, if

the country is to achieved appreciable progress in ending the obnoxious tradition of early marriage.

To put the matter in proper perspective, not even all the 24 states that have domesticated the child right act are committed to its enforcement. The problem goes far beyond the northern region of this country where the practices is more prevalent, in those parts because of the dominance of the Islamic religion and the provision of the sharia marriages, there is an unwarranted resistance to the enforcement of the child right which put the age of maturity for the girl child at 18. It will be misleading to think that the problem is only in the north. It is nationwide, especially in the rural and remote areas of the country, where civilization and government are far removed. No wonder then, that there is correlation between the problems of child marriage and poverty, recent studies (Okanume, 2014, Muhammed, 2015 and Haruna 2015) showed that the problems is highest in west and central Africa

This connection should interest us all, why is the problems of child marriage not as high in north Africa which ordinarily should have a higher number of Muslims adherence than the two-sub-regions that have been singled out as having high prevalence, what this suggest is that it is beyond the Islamic practice, what promote child marriage more is poverty and the failure of political actors to put end to it. Parents buffered by extreme want and hunger gives out their young female child in early marriage, not minding what the law and religion they adhere to says. The girl child too could be attracted to early marriage, regarding it as a bulwark against hunger and neglect.

It is an irony that child brides are subject to all kinds of physical and psychological abuse, leading to severe torture. The incident of vesico vaginal fistula is directly traceable to child marriage. Apart from this health challenges, one wander how a child bride can properly raise and support her babies, this problems must be seen, therefore, as one that is fundamental to the failure of the family structure in the country. This is why government and indeed all

relevant stakeholders must approach the problem with the two key tools of persuasion and enforcement.

Onuzulike (2006) posits that limited economic opportunities and lack of higher educational expectations can lead to early parenthood. Other scholars (Blood and Uwife, 1978, Fursbenberge (1976) stated that some females marry early in order to escape from unhappy home situations.

Constant conflicts with siblings, crowded living conditions and authoritarian parents also induce young people to choose early marriage as an escape. In the view of Onuzulike, (2006), pre-marital pregnancy has it's own contribution to early marriage.

The trend towards more unprotected sexual behaviour prior to marriage has given rise to increased risks of unwanted pregnancy. Some teenagers who find themselves untainted in such problem may have no option than to be forced on a man for marriage.

The desire for independence from parental control is another possible motive for young people's involvement in early marriage. Strong social traditions and family pressure in which the teenage girl will have a relatively limited voice in making the decision of whom and when to marry can equally be a predisposing factor to early marriage. Other reasons are the social and economic pressures of urban life make it difficult for some parents to effectively supervise their young daughters adequately. Added to this is the harmful influence of electronic and print media that negatively stimulate opportunities for sexual encounter and experimentation among young people. The end result of most of these experiences is unwanted pregnancy and unprepared marriage with the resultant negative consequences.

The traditional Nigerian culture also encouraged early marriage. Marriages are usually arranged quite early in life especially where families are friendly, in order to cement the family relationship, marriages are arranged early to avoid the children mixing up with the other people which could make them change their minds when they get older. Parents are

anxious to have successors especially when they have an only son. The parents marry for him quite early so that they will have a grandchild, someone who will carry on with the family name and this is common among the Igbos of south east Nigeria and some other ethnic groups in the country.

Poverty also leads to early marriage. Sometimes, young girls are forced to marry adult men as a means of paying debts which their parents owed. Parents borrow money from these men and promise to pay back or give their daughter to them in marriage. This was common in the traditional African society but surprisingly, the practice is still on. In most cases this is done without the consent of the girl-child. Some parents are so poor that they cannot afford to pay for the education of their children. In such cases where the finance is limited, the boys are given preference since they will inherit their parents and keep the family name. The girls are married out early to provide money for the education of the male children. Moreover, when parents are unable to meet the demands of their teenagers as a result of poor financial background, the teenagers find alternative means of providing for themselves by moving with and receiving gifts from older men who in turn have sexual relations with them which may result in pregnancy, sometimes they are forced to marry these old men and become either second, third or fourth wife.

Unfavorable home environment can also lead to early marriage. Psychologist believe that a comfortable home environment in which the adolescent feels secure is necessary for good moral development, where this is lacking and the home is devoid of parental love and affection the adolescent feels insecure and may look for a permanent image for affection.

School dropout is one of the causes of early marriage, where a girl continuously fails in school work, she may find that the only alternative available to her is to marry and raise a family. School dropout can also be as a result of teenage pregnancy. When the girl can no

longer continue with her education career, she drop out of school and what comes to her mind may be marriage.

We can also look at early maturity. This can lead to early marriage, where a girl matures earlier than her mates she may attract attention earlier and may be married off. Peer group influence, a girl may want to marry because her friend got married. Promiscuity on the part of a girl can make parents marry her out in time to avoid disgrace which may be caused by their daughter getting pregnant out of wedlock (Iroegbu, 1996), where there is extreme permissiveness, where adolescent are allowed to do what they like without control, there is more likelihood of deviant sexual behaviour which may force parents to marry the girl out. Above all, large family size and the depressed economy contribute to early marriage. Some parents give birth to many children, and they find it extremely difficult to cope with their educational, social, economic and other demands as the children grow up. Hence, such parents give out the daughter for marriage at a very tender age; thereby, shifting the responsibilities to the husbands.

Early marriage apart from leading to the development of VVF has other consequences. In the view of Onuzulike, (2006), marrying before physical and mental capability has a lot of debilitating effects on the part of the spouses and the women in particular. Fletcher, (1969), pointed out that the effects of early marriage stems from lack of understanding and attack of self esteem by the masses. Fursbernberge, (1976), opined that early marriage can result in couples lacking acquisition of complex knowledge and skills. Lack of substantial involvement of material resources, and lack of overall knowledge and managing a home are also effects of early marriage.

Besides, early marriage and the resultant pregnancy may expose the woman to medical, educational and socio-economic consequences among the medical consequences, apart from VVF, the girl child may experience Anaemia and malnutrition, others are high blood pressure,

eclampsia and infection. Among the educational implication are that, it may place limitation on the educational pursuit of the teenager due to the culture orientation of some ethnic groups, parents do not show much interest in the education of their girl-child especially when they are married. Among the socio-economic implication, Nzeako, (1994), stated that early marriage disrupts the normal life course of the mother, unscheduled parenthood propels the young mother into a role for which she is only casually prepared and often feels unready to assume. This situation often leads to divorce, separation and child abandonment. High divorce rate is usually experienced later in life due to change of values and wanting to catch up with what they missed as teenagers. Also teenagers do not appreciate the demands and sacrifices needed in marriage because of immaturity. There may be wife battering and family problems following such premature relationship.

In addition, precipitate entry into parenthood prompts the social and vocational experiences that adolescent would otherwise acquire to prepare her for the adults roles including motherhood. Apart from biomedical factors, inadequate parenting (because of the immaturity of the young mother and father) will affect the offspring.

There is also the likelihood of an adolescent pregnancy occurring in the next generation as well, this perpetual poverty and contribution to uncontrolled population growth as well as negative stigma on the family tree. The risk of having too many children cannot be overemphasized. This is because the fertile years are long between 15-45 years. Besides, the teenagers lack education and cannot appreciate the need for family planning.

Furthermore, there could be inferiority complex, teenage pregnancy and early child marriage can predispose such teenagers towards looking older than their ages, therefore, they may feel ashamed on seeing their fellow ex-school mates who still look radiant, economically dependent and developed economically, Nzeako (1994), rightly pointed out that when a girl breaks her education due to marriage, she starts a cycle of poverty for herself and her family.

The tendency is that she may not be able to go back to school, she may end up being an unskilled person and this limits her resourcefulness as well as the type of job she can get. It will therefore become difficult for the family to cope with the financial demands of their nuclear as well as extended family structure. The cycle in turn may affect the children who may not attend good schools because of lack of money to meet up with the financial demands of good schools, amidst such poverty, the children may end up engaging in secret hawking, prostitution and child labour, such cycle of poverty may continue from generation to generation.

Teenage marriages are less stable than adult marriages. Teenagers have higher divorce rates than couples who are older at marriage studies (Ekene, 2011, Farok, 2011) also revealed that infant mortality was higher among children born of young mothers.

Apart from the development of Vesico vaginal fistula, early marriage according Ajie, (2006) has many other consequences. They include that it leads to marriage of sexual incompatibles and dissatisfaction in marriage in some cases, the female victims of early marriage indulge in social vices such as drug addiction, alcoholism and extra marital relationship or affairs and gynaecological complications.

The United Nations Population Fund (UNPF) (2017) maintained that 39.000 child marriages holds every day in Nigeria and that more than 140 million girls will marry between 2011 and 2020. The report was published in New Telegraph. According to the report of the 140 million girls who will marry before the age 18, 50 million will be under the age of 15. Despite the physical damage and the persistent discrimination to young growing girls, little progress has been made towards ending the practice of child marriage. In fact the problem threatens to increase with the expending youth population in the developing world UNPF. (2017), maintained that child marriage is an appealing violation of human rights and robs girls of their education, health and long term prospects. A girl who is married as a child is one whose

potentials will not be fulfilled. It has been observed (Okoye 2009, Babajinde, 2017) that girls married young are more vulnerable to intimate partner violence and sexual abuse than those who marry later.

Complication of pregnancy and childbirth are the leading cause of death in young women aged 15-19. UNPF, (2017). Young girls who marry later and delay pregnancy beyond their adolescence have more chances to stay healthier, to better their education and build a better life for themselves and their families. Child marriage – defined as marriage before the age of 18 applies to both boys and girls, but the practice is far more common among young girls. Child marriage is a global issues but rates vary dramatically, both within and between countries. In both proportion and members, most child marriage takes place in rural Sub-Saharan Africa more than one third of young women are married by their 18th birthday.

According to UNPF, (2017), the 10 countries with the highest rates of child marriage are Niger, 15%, Chad and central Africa Republic 68%, Bangladesh, 66%, Guinea 63%, Mozambique, 56%, Mali, %%%, Burkina-Faso, and South Sudan, 52% and Malawi, 50% in terms of absolute numbers, because of the size of its population, India has the most child marriages. The progress that has been made to stop the practice has been in Urban areas where families see greater work and education opportunities for young girls.

UNPF (2017) maintained that early marriage is a violation of the rights of girls and no girl should be robbed of her childhood, her education and health and her aspirations. Yet today millions of girls are denied their rights each year when they are married as child brides. Early marriage and child marriage robs the future. Girls lose the opportunity to choose their future and must live with that pain for the rest of their lives. It is for this reason that so many world organizations such as United Nations, Young Women Christian Association, United Nations Population Funds and a host of others are making effort to end child marriage.

UNPF, also maintained that despite the fact that countries have set the legal age for marriage at 18 years, laws are rarely enforced since the practice of marrying young children is upheld by traditional and social norms.

UNPF (2017), also maintained that the detrimental effects of early marriage is much, child marriage is not only wrong, it is dangerous. It exposes them to profound health risks and exposes her baby to complications of premature birth. According to United Nations. (2016) complication from pregnancy and childbirth are the leading causes of death for girls aged 15 to 19 years in developing countries. According to the report, of the 16 million adolescent girls who give birth every year; about 90 percent are already married. UNICEF (2017) estimates some 50,000 die almost all in low and middle-income countries. Stillbirth and newborn deaths are 50 percent higher among mothers under the age of 20 than in women who get pregnant in their 20s. In many poor countries, most young girls, regardless of age are forced to demonstrate their fertility once they are married.

These children, because they are discouraged from using contraceptives or might have to ask their husband permission, or they have no knowledge or access to what they need get pregnant willingly.

According to UNFPA, (2017) violence is also common in child marriages even though some parents believe early marriage will protect their daughters from sexual violence, the reverse is often true. According to United Nations, (2016) studies young girls who marry before the age of 18 have a greater risk of becoming victims of intimate partner violence than those who marry at an older age between the child bride and spouse is large. Child marriage marks an abrupt and often violent introduction to sexual relations. The young girls are powerless to refuse sex and lack the resources or legal and social support to leave an abusive marriage. Child marriage is a complex issue with deep roots. This practice which has existed for centuries is rooted deeply in gender inequality, tradition and poverty. The practice is most

common in rural and impoverished areas, where prospect for girls can be limited. In many cases, parents arrange these marriages and young girls have no choice. Poor families marry off young daughter to reduce the number of children they need to feed, clothe and educate. In some cultures, a major incentive is the price prospective husband will pay for young brides.

Social pressures within a community can lead families to wed young children. For example, some cultures believe marrying girls before they reach puberty will bring blessing on families. Some societies believe that early marriage will protect young girls from sexual attacks and violence and see it as a way to insure that their daughter will not become pregnant out of wedlock and bring dishonour to the family too, many families marry their daughters simply because early marriage is the only option they know.

2.2.1 Some Harmful Traditional Birth Practices

Most countries of the world have cultures and traditions which dictate the pattern of behaviour of the people. Some cultures according to Utulu, (2009), have remained and become a symbol of identity of it's group. However, since society is dynamic, attempts are usually made to modify, change or eradicate certain societal practices and traditions which are considered harmful to the society while promoting beneficial ones. Traditions according to oxford dictionary of sociology is a set of social practices which seeks to celebrate and inculcate certain behavioural norms and values implying continuity with a real or imagined past and usually associated with widely accepted rituals or other forms of symbolic behaviour. Tradition, just like cultures stipulate how people behave and how they respond to situations. It include their actions, languages which according to Alubo, (2012), codifies symbols into words for communication.

Tradition differentiates people as different ethnic groups have different ways of reacting or responding to issues. For example among the Igbos, method of establishing marital

relationship are usually not the same. Although they may be seen as one ethnic group but the tradition are usually not the same when it comes to social issues. So norms which are general codes of behaviour which often guides particular activities and institution varies from society to society.

Nigeria is a multi-ethnic society with diverse and rich cultures and tradition. However, some of there cultures and traditions have negative effects on the people particularly women and children. Some of them, affecting the health and social status of women and children. The harmful traditional practices includes child betrothed and female genital mutilation.

Child betrothal according to Utulu, (2009), is a form of engagement between a male adult and a female child or an engagement between two young children usually sealed by their parents. Fadipe, (1970), cited in Utulu, (2009) noted that child betrothal in Yoruba land is the responsibility of the man's immediate female relatives especially on the paternal side to look around for a suitable wife. To the Yoruba's of Delta state, the practices of betrothal called "Esavwioto" literally translated to mean you have been "trapped or reserved" is widely accepted.

Newsline of 14th November 1999, cited in Utulu , (2006), reported a search in Agbor, Delta state Nigeria for a wife for the young Obi (king) who was studying in Britain (UK). The search was for a virgin who would be betrothed to the obi by wearing beads on her hands as a symbol of engagement. The girls interviewed by Newsline claim that any girl the obi points at automatically becomes his wife. Also refusal is regarded as a taboo to their number one citizen and the entire Agbor people of Delta state, which could lead to excommunication of the girl and her entire family from Agbor.

According to Utulu, (2009), child betrothal sometimes in our society is motivated by a desire to marry up (Hypogyny). Parents want to be associated with a wealthy family. The problem of child betrothal is the binding nature of the contract even when it proves distasteful or

unsuitable. Perhaps the major reasons for trying to sustain the relationship even when the bride finds it unsuitable is that some form of communication "dowry" or bridal price has been paid by the bridegroom or his family to the bride's family. The payment in Africa includes monies and services rendered by the bridegroom and his family to the bride's parents and her relatives, for example, payment consists of livestock, objects of daily use, that is hoes, fishing nets, spears, gifts of food clothing and other valuables and objects for ceremonial use. Betrothal especially among the middle classes involves responsibilities and duties of the bridegroom to the bride's family which includes paying school fees for the bride or members of her family. This may act as a guarantee of the stability of marriage; it may also be regarded as compensation to the family of the bride for relinquishing authority over their daughter. Betrothal in most societies where it is practiced lead to forced marriages. This is because freedom in the selection of spouse is not stressed or considered important. When the girl-child later finds the union unacceptable the parents who have committed themselves in the agreement or have benefited have no option than the use of force. While it is recognized that marriage must be legitimized. It's emotional aspect cannot be ignored as it forms part of the union and to a large extent determines whether there is a union or not.

Some harmful traditional practices such as female genital mutilation or what is also known as female circumcision is a factor to consider in the problem of VVF. In some communities in Nigeria, the operation is done on healthy female children for traditional reasons. Reasons are that, it prevents premarital pregnancy. It is also believed that once it is done, it guarantees marriage with subsequent economic and social security for the girl's future.

Female circumcision among communities in Nigeria revealed a terrible condition of the practice. According to Nnachi (2012:18), the instrument used for circumcision inspires much with its crudity and savage look. To Nnachi (2012:18), "a hard metal carving knife known as" "aguba" is usually used in cutting the clitoris, where upon herbal concoctions are used to

stop blood flow and reduce the excruciating pains". As the baby cries, the mother takes pleasure in the feeling that at least, she has a "normal" woman made ready for her husband's ecstasy. Nnachi (2012:18), stated that to speed up the healing process, palm oil is applied to the wound intermittently using a feather to spread the oil around the cut edges of the former position occupied by the clitoris. This traditional practice is common in some communities in Nigeria because of it's alleged benefit that uncircumcised women would have an obstructed labour. According to Fasakin (2007:41), recent investigation on this practice indicated a connection between FGM and VVF; hence infant and maternal mortality. Female circumcision and insertion of the birth canal ultimately predisposes young girls to prolonged labour and development of fistula.

According to Ihejiamaizu (2012:19), apart from the development of fistula, other effects of female genital mutilation are; severe pains, hemorrhage, injury to adjacent tissues and organs, shock, infection, urinary retention and tetanus. Others which Brady (1999:82), stated as long time effects are psychological and sexual problems, urinary and incontinence and difficulty with child birth.

Thomas (1987:82), stated that obstructed labour may occur if a woman has been infibulated. Infibulations involve cutting of the external genatalia and sewing together the two side of the vulva, leaving a small hole for urination and menstruation. According to Thomas (1987:82), if the woman genitalia is not cut open, during delivery, labour may be obstructed causing life-threatening complications for both the mother and the child including perennial lacerations, bleeding and infection, possible brain damage to infants.

Ihejiamaizu (2012:19), posits that the beliefs sustaining practices of Female Genital Mutilation (FGM) include; continuing long standing customs and tradition despite it's health hazards, maintaining cleanliness in terms of purifying a woman, maintaining chastity and virginity even though there is no evidence to show that circumcised women are virgins

at marriage and more chaste than others; of holding family honour and some time perceived religious dictates and controlling women sexuality in order to protect the entire community if women sexuality urge is given free reign.

Both in Nigeria and other countries surveyed by the Demography and Health (2008), good customs and traditions are most frequently cited as reasons for approving female genital mutilation or circumcision. Bad custom and tradition is one of the primary reasons for discontinuing the practice.

Perhaps, one of the most repulsive restrictions on women sexuality is the issue of female genital mutation (FGM), a process of female circumcision performed on young girls in child hood. Female circumcision is considered a significant custom in dozens of countries across African, Asia, and the Middle East where girls may be seen as impure and unworthy of marriage if they have not undergone it.

Circumcision is preached to a lesser extent in some countries like Indonesia, Malaysia, Pakistan and India which has sizeable Muslim populations. The practice is believed to have started 4,000 years ago, before the advent of organized religion. This practice, which is prevalent in most parts of Nigeria, the exception of some parts of the northern states is essentially clitoral laceration. The intention of this procedure is to curtail the sexual drive of girls and to keep them less promiscuous until they get married. Customary dictates justify this process as an indigenous measure improvised to prevent teenage pregnancy and to curtail sexually transmitted infections which young girls must be subjected to before they are wise enough to make rational decisions about sexual relations. Although the argument might sound persuasive in terms of restricting a child's sexual adventures. One cannot discount the fact that girls do grow up to be women. The long term effect of the process is awful to the victim. It is a careful orchestrated scheme to curtail female sexuality. According to Morolake (2003:43), most people are unaware of the terrible repercussion of female circumcision.

Apart from the pain and suffering that young girls and women go through from the primitive and unsterilized blades of the perpetrators, they are forever afflicted with frustrated sexual lives. Indeed FGM is irreversible thus, women's sexual drive could be seriously eroded and it could also impair their ability for sexual satisfaction. Many Nigerian women are not very comfortable discussing issues of sexuality, as a result, it was difficult for some people to express their true feelings about FGM except for some outspoken ones.

Mwamalubia (2010:82), asserted that other reasons which are sociological and encourages the practice are; first, some communities in Southeastern part of Nigeria have a range of enforcement mechanism to ensure that majority of women comply with the practice. Second, in some communities women who are not circumcised may face immediate divorce, forced excision. Girls who undergo circumcisions sometimes receive rewards including public recognition and celebration, gifts, potential-for- marriage respect and the opportunities to engage in adults social functions. Thirdly, the desire to conform to peer group norms and pressure also encourage circumcision. The desire leads many girls to undergo circumcision voluntarily. In a report by United Nations population fund (2014), 86 million girls will undergo genital mutilation by 2030 if urgent steps are not taken to address the issue. According to the report, already, in 29 countries studied in African and Middle East where the practice is common, more than 125 million girls and women have been circumcised. The report stated that it is unacceptable that these human right violations continue to threaten the lives and future of so many women and girls. It is an affront to their human dignity, an assault on their health and impediment to well-being of their families, communities and countries. Human development cannot fully be achieved as long as women and girls continue to suffer from this human rights violation or live in fear of it. The challenges of eliminating female genital mutilation remains enormous, female circumcision posses devastating short and long

term consequences for the health of women and girls. It is imperative that women are protected, and support provided to those who have been subjected to the practice.

2.2.2 Influence of Poverty and Illiteracy on Prevalence of VVF

Poverty and illiteracy play important roles in predisposing women to the problem of VVF. Poverty not only means unequal access to health facilities but also the greater propensity of those at the bottom of the income ladder to experience more ill-health than those at the top of the ladder. These facts according to the Nigeria health review (2008), eloquently demonstrated when we compare inequalities between the richest and the poorest segments of the Nigerian population along the dimension of the number of births attended by skilled health personnel, the number of children who are fully immunized, the number of children at age 5 years who are under height, under 5 mortality rates and infant mortality rates per 1000 live births. Poverty is not only a cause of ill health; ill health can also lead to poverty, thus, creating and sustaining a vicious circle. Poor people not only run the risk of more frequent ill health, they face the possibility of premature death more than those at the top of the social ladder. The risk of illness and premature death is indeed twice as high among the poor as among the rich. Since poverty is often a convergence of the absence of several factors and conditions needed to maintain life at an appropriate level, poor people also suffer from diseases that do not or hardly affect those at the top of the social ladder. Thus, ill health arising from VVF is more likely to be more prevalent among the poor than among the rich.

Poverty also has implications for access to health facilities and treatment. Poor people are less likely to be able to afford the cost of treatment for most VVF cases and where an illness becomes protracted and treatment becomes costly, the poor are likely to resign themselves to faith and death. Poor people are also less likely to be able to access health facilities, which are located far away from them as the cost of transportation may be above the means available to them.

World Bank (1995), defined poverty as the inability to attain a minimal living standard. World Bank Report (2011) on poverty and welfare in Nigeria revealed that, though Nigeria has abundant land oil and natural resource, many of her citizens are still very poor. In the view of Onwuchekwa (2008:75), people in poverty are victims of depravation in spheres which include education, nutrition and prevalence of disease, and the alarming rate of poverty in most developing countries like Nigeria and has attracted the attention of the United Nations. Poverty destroys the body and mind, it dehumanizes and predominantly affects women and children. It is a state of marginalization and deprivation in the condition needed to make life meaningful for individual as members of distinct social groups. While the condition will include economic and social dimensions, the economic and political dimension will have primacy. In general, the evidence provided by UNDP (2010), the Nigeria Government and several other sources indicate that the incidence of poverty have been growing in the country over the years. Nigeria Health Review (2006)

This confirms the report of WHO (2011), that women suffering from fistula are usually from poor families with poor subsistence family background. Poverty has posed challenges to many people especially women and this has become a determining factor to health. Some communities in Nigeria have had their own share of the problem of poverty and illiteracy and the incidence of VVF in those areas is a notable example. In some communities, the rate of poverty and illiteracy is very high.

Nigeria is classified by the World Bank (2010) as one of the poorest nations in the world, third world countries which Nigeria happens to be one, shares common characteristic, which according to Todaro (1982:111) include: low level of living, high rate of population growth and dependency burdens, high and rising level of unemployment, significant dependence on agricultural production and primary product export, low average income per person and literacy level. The extent of poverty is measure by the level of national income and the degree

of inequality in it's distribution. In Nigeria, as is the case with other developing countries living standard is low for majority of rural dwellers and the urban poor. Life is beset with malnutrition, poor housing conditions, poor health, inadequate public and private provision for waste disposal and medical care, insufficient communication, transport, educational facilities. A population of over 140,000,000 (Census 2006), Nigeria is highly populated and this calls for effective health planning. In the view of Ihejiamaizu (2012:66), the maternal/mortality, that is, number of women who die during pregnancy and pregnancy related cases is high. Ihejiamaizu (2012:66), stated that, 64% of Nigeria population live in rural areas. Most of the rural areas suffer from economic stagnation, cultural pattern that are unfavourable to development, and lack of alternative employment opportunities.

They are also characterized by poor quality of life because of the scarcity of essential goods, facilities and money, isolation caused by distance and poor communication and unfavourable environment, predisposed by malnutrition, inadequate health facilities and lack of sanitation, poor educational opportunities, social injustice including inequitable land tenure systems, inadequate representation and influence in national decision making and corruption of traditional elite all work to weaken the health of the rural populace, as they find it difficult to afford basic health care.

Women in some communities in Nigeria dwell in terror and torture from resulting disorders, from child-bearing in a generation that must procreate. Out of these include an unacceptable high incidence of Vesico Vaginal Fistula (VVF), high maternal and child mortality rate, and high level of illiteracy among women in the country. This has posed serious challenge to the Federal Government. As a result of poverty, many parents withdraw their female children from schools, so as to be given out in marriage to attract high bride prices. When the child becomes pregnant, she is sometimes sent to her parents for delivery and if in the process, VVF arises, some parents may not even afford the cost of treatment.

As social problem, Poverty and illiteracy influence the prevalence of other problems including crime. Poverty according to Nsofor (2013), is the instability of an individual to meet his or her basic needs. Ikwuba (2017), asserted that poverty is deprivation, poverty as deprivations has several dimension. Personal and physical deprivation can be experienced in health, nutrition, literacy, educational disability and lack of self-confidence. Economic dimension of this deprivation include lack of access to property, income, assets, factors of production and finance. People who may be deprived of their social rights because of personal and economic deprivation encounter barriers to full participation in social, political and economic life. People can culturally be deprived of values, beliefs, activities, knowledge, information and orientation which can hinder them from taking advantage of economic and political opportunities. People who are politically deprived occupy lowly positions and are subjected to economic threat.

In the view of Dike (2002), poverty is a detestable condition that has no racial, geographical, religious, political, ethnic and any other barrier. It affects every aspects of human existence. It affects its victims, socially, physically, mentally and psychologically. For instance, it limits the possibility of the poor from realizing their mental and physical potentials. It destroys aspiration hope, happiness, self-esteem, personal competence, tolerance of others, self-satisfaction and one's disposition to participate in community affairs.

Poverty in the view of Ikwuba, (2017), is also associated with social vices such as prostitution, human trafficking, spread of disease such as HIV/AIDS, child labour and abuse, corruption, disruption of family relations and increase in crime wave. Generally, poverty shortens life span, human progress and development. Poverty existed from time immemorial. Relative poverty is as old as history of man and it is a divine arrangement meant to last as long as mankind exist Ikwuba (2017).

Poverty is a global social phenomenon as no continent of the world exists without it. The global economy is therefore characterized as an increasing disparity between the rich and the poor. At the global level by 2008, the following facts were reported. Nearly half of the world population live on less than two US dollar a day. One billion people live in abject poverty of less than one US Dollar a day. About fifty thousand (50,000) people die from poverty related causes every day. Eight hundred (800) billion people go to bed hungry every night. Eight hundred and eighty (880) million people lack access to basic health care and in every three seconds, a child die from poverty related cause. Half of the population of humanity is affected by problem of safe water. One million people are in poverty of shelter and health. One point four (1.4) million children died every year from lack of access to safe drinking water and sanitation. One point six (1.6) billion people i.e. a quarter accounted for three in every four poor people living on less than one Dollar a day (ANUP, Shar, 2008)

Every region, nation and community of the world experience poverty. This means that the first, second and third world experience poverty. The difference in poverty between nations lies in the cause, rates, type and dimension. There are factual and statistical evidence to show that poverty exist in the first world (i.e. developed world). There are traces of poverty in developed nations (e.g United states, Canada, Britain, Germany, France, Italy, Japan) that dominate the world economy.

Although there are traces of poverty in every nation, the situation is more pronounced in developing countries especially sub-Saharan African countries, of which Nigeria is one. For instance, in 2008, 1.1 billion people in developing countries have inadequate access to safe water and 2.6 million lacked basic sanitation. Out of 1.9 billion children in developing countries, 640 million lack adequate shelter (1 in 3), 400 million have no access to safe water (1 in 5) and 270 million (1 in 7) of them lacked access to health care facilities, about 7.2 million children of primary schools age were out of school in 2005 and 57% of them were

girls. In the same vein, some 2.5 billion people were forced to rely on bio-mass fuel wood, charcoal and animal dung to meet their energy needs for cooking (Estrado, 2008).

Sub-Saharan African countries remain the poorest in the world. The world bank in it's 1995 poverty report pointed out that poverty in sub-Saharan Africa is typically higher than everywhere in the world. They are rated for prevalence of absolute poverty in all its characteristics features. Poverty here is massive, pervasive and chronic. For instance, sub-saharan African rural poverty accounted for 65-90% of overall poverty, about 77% of the farmers are poor out of which more than 48% are extremely poor. Also in the region, over 80% of the population depends on traditional bromates for cooking, while 547 million people have no access to electricity (ANUP Shar, 2008). The causes of poverty in Africa are myriad and complex by their leaders. The effects of bad governance and attitudes to the progress of the nations. The socio-economic formation mentioned in corruption and mismanagement of national resources are fundamental obstacles to progress which help to explain the intractability of the problem of poverty in Nigeria like any other developing country, it has been a long-standing issue. The Nigerian poverty situation is a paradox one, as Nigeria is rich in both human and mineral resources but yet inhabited by many poor people, Ikwuba (2017). The world Bank and UNDP (2001) ranked Nigeria as the 6th and 7th in petroleum export and crude oil production. Despite this, Nigeria poverty situation ranked her as the 20th poorest country in the world. That is poverty in the midst of plenty. Nigerian poverty situation has worsen over the years and human conditions have greatly deteriorated. An analysis of series of national consumer surveys over sixteen years period put together by Olaniewaju and Abiodun in (2005) showed that the incidence of poverty rose drastically between 1980 and 1996 but decreased between 1985 and 1992. Poverty rate increased from 28.1% in 1980 to 46.3% in 1992 which increased to 65.6% in 1996. This further increased to 69.7% in 2004 and112.47% in 2010. The percentage rate for the north- west was 77.7%, north east 76.3%

and southwest 59.1% respectively. The world bank president Mr. Jim Yong Kim in the world bank meeting of 10/4/2014 reported that Nigeria is one of the top five countries that has the largest number of poor. Nigeria rank third in the world. India ranked first with 33% of the world poor, china ranked second with 13% and Nigeria 7%. The current poverty situation has obviously grown worse with 70% of the Nigerian population living in poverty and (7) out of every ten (10) Nigeria living below the poverty line of less than one US dollar a day.

Poverty in Nigeria is more severe in the rural areas where social services and infrastructures are limited or non-existence. The great majority of those who live in the rural areas are poor and depended on agriculture for food and income. In 1985, 1992 and 1996, the share of the poor in the rural areas were 49.9%, 46.1% and 67.8% respectively. It will not be wrong to state that poverty is also responsible for the high rate of illiteracy recorded in Nigeria. Illiteracy in Nigeria is a development challenge that various governments over the years have had to grapple with, Ugbem (2017). Various programmes such as universal primary education, universal basic education UBE were all programmes established to tackle problem of illiteracy in Nigeria. In the view of Ugbem, (2017), a national literacy survey carried out in 2010 by the Bureau of statistics, showed that 1.5 million children of primary school age were out of school. Also over 1 million children dropped out of school in 2010. In a related development, according to a survey conducted by the national mass education commission in 2011, seventeen out of thirty six states in Nigeria are at risk of not achieving education for all by 2015. Also Nigeria is saddled with the largest number of out of school children established at over 7 million (19% of the global total) Olajede *et al,* (2013). The former minister of education, Nelson Wike during a ministerial briefing to commemorate the world literacy day in 2013, said that Nigeria's adult illiteracy have increased from 25 million in 1997 to 35 million. This shows an increase of 10 million between 1997 to 2015. The implication is that the illiterate adult cannot participate fully in what concern them. It will be difficult for them

to make rational decisions that will transform their lives for the better. Apart from not being able to contribute to the younger one on life issues. According to Ugbem (2017), illiteracy has health implication. An illiterate will have difficulty in understanding and putting into practice messages that are aimed at encouraging health behaviour and risk prevention.

Illiterate persons are not likely to adopt adequate nutritional and hygienic practices in their homes. Issues of vaccination and medical checkups may not be taken seriously by illiterates because of their lack of understanding of the importance of same. Illiterates are also unlikely to take precautionary measures against diseases. Measures such as personal and household hygiene, good nutrition may not be taken seriously by illiterates. Illiterates may also lack understanding of first aid measures that are needed in times of emergency. This places them and members of their families or household at risk. Abuse of medication may also be prevalent among illiterates since their limited or lack of knowledge may not allow them to understand the impact of such an action. Illiterate at the workplace have the challenge of not understanding written instructions for the operation of machinery. This puts their health and that of their co-workers at risk. Illiterates may not be able to communicate effectively with others in the phase of danger at the workplace, thus placing the life of other workers at risk. Illiterates also increases the likelihood of high risk sexual behaviour. This is likely because of the lack of awareness of sexual and reproductive health as well as inadequate use of contraceptives. Awareness of the right sexual behaviour is important for the wellbeing of individual. Illiterates may not be aware of these practices and may end up being victims of the lack of these. It is not common to see illiterates with so many children, much more than they can carter for. This may be due to lack of understanding of contraceptives and attachment to cultural beliefs of having so many children as possible.

2.3 Social Implications of Vesico Vaginal Fistula

A lot have been said about health. Wilson (2007:14), asserted that physicians have traditionally held rough common sensical view of health as the absence of symptoms; health, therefore becomes residual category, uninteresting opposite of disease. Hadley (2010:12), stateed that health is a status which an individual of a given sex and of a given stage of growth and development is capable of meeting the minimum physical, physiological and social requirement for appropriate functioning in the sex category and at the given growth and developmental level. The above definitions are acceptable under different circumstances. However, in a more simplified way, health can be view as a state of being well and free from disease.

Health issues usually bring to mind illness and every society has it's own definition of illness. The definition of illness varies. In the view of Mbah (2006:81), definition of illness fall along cultural patterns. In order to admit being ill, there have to be some standard against which to measure current or past physical or mental changes. An individual measures these changes against his own criteria or against his society's concept of health or illness. For example, a headache or high blood pressure is often not enough reasons for one to label oneself ill. Also in our society in Nigeria, a person with malaria is not regarded as being really ill, Mbah (1996:81). One hears such comments from a father whose child is suffering from malaria "My child has just malaria fever" this statement implies that malaria is not considered a serious matter by same people. On the contrary, an European with malaria is not just regarded by his people as being seriously sick, he is equally viewed as infectious and so isolated.

Sociologists view illness as deviance, which is departure from the norm. The concept of illness was first formulated by Parsons in 1951. Parsons saw sickness as a physical and social deviation from normal life. He criticized the sole dependence on medical reference of illness without looking at the sociological angle. Parsons argued that a person is sick when he acts

sick. Having analyzed the concept of health and illness, it is pertinent to view the two concepts as a continuum, which means that human beings swing from one end to the other and this involves social influence. Coping with health problems occupies a large part of most people's lives. The social consequences of illness are so devastating that in some cases attention is paid to them as is paid to the medical consequences. For example, the social consequence of HIV/AIDs is as important as the medical consequences.

The social consequence of illness includes stress and in some cases chronic stress, which the patient passes through, and social exclusion. According to Nigeria Health Review (2006), the cultural definition of what it means to be sick often leads to the social exclusion of those diagnosed with illness. Social exclusion which is being treated as less than being equal to others and being excluded from participating in the life of society, has implication for premature death, cardiovascular disease, isolation, addiction, and suicide. Nigeria Health Review (2006). Cultural beliefs in fatalism and the supernatural, which abound in Nigeria, also have implications for the health of the population: they affect beliefs about cause and effect relationships in any illness, mode of treatment and patient choices and behaviour. Beliefs about the role of women in the economic, political and social life of the community also has major implication for health related decisions of women. When those beliefs lead to lack of empowerment for women, social exclusion, great susceptibility to particular forms of disease and higher risks, physical injury are likely to occur for more women than men. These and associated factors explain why some victims of VVF are women who are also poor.

In some cases, cultural definition of certain forms of disease may lead to silence and denial, thus, creating variable grounds for the continuation of behaviours and actions that promote the disease. According to Beluonwu (2009:100), studies on the social meaning of VVF in Nigeria have shown that beliefs on VVF play a determinant role in the interpretation and

treatment of the illness and more importantly, in the social relationship formed with women who are victims.

The health of a woman is as important as the health of a man and it is as a result of this notion that the African Charter on Human and Peoples' Rights (2010), states that every individual, irrespective of sex shall have the right to enjoy the best of physical and mental health. The above position shows the importance attached to health. The point; however is, to what extent does the female gender enjoy these rights? In the view of Angya (2005:14), women in many societies are usually care givers and as such, the task of taking care of the sick falls on them. But with a problem like VVF, most, if not all the roles performed by women, will remain dormant and this will create another problem. VVF makes it difficult for most women to attain their potentials in life.

The effects of VVF on women's health are closely related to each other as one leads to another. Family members of a VVF patient also suffer as they are made laughing stocks in the community. Apart from shame, the problem is usually seen as hereditary and this sometimes prevents the unmarried sisters of the victim from getting married. Awolusi (2009:61), summed it up that the shame and psychological effects of VVF makes some families to be outcasts and avoided by the community. In some communities, the situation makes the unmarried sisters of the victim not to get married to any member of the community except one from neighbouring towns where they are not known. So as the victim suffers, members of the family also suffer and under such condition, the victim may not be able to carry out some of the domestic chores around the house. More so, as a result of the constant leakage of urine, the patient cannot actually take part in any economic activities in the family or support the family financially since she cannot maintain a good hygiene standard.

2.4 Management Strategies of VVF

From research findings Muhammed, (1999:75), Ogedo, (2012:12), women with VVF come from poor subsistence farming background and are part of the disadvantage members of the society. Management strategy varies from society to society, culture to culture. At the individual level, Kees, (2006:56), posit that the woman adopts strategies that best suits her. The strategies include commercial support from public sponsored individual which includes non-governmental organizations like society for family health, Engender health, a USAID funded programme in Nigeria, which is dedicated to Fistula conditions. There is also support in form of information from other stake holders which include those who have been repaired from the condition. These individuals compare notes on how to assist more and more women and improve maternal care generally.

Managing VVF is not an easy task due to the nature of health challenge. Some women suffering from the health challenge are seen as out-cast and sometimes treated as one. It is for this reason that Olaedo, (2014:44), posit that the condition is common where ignorance and poverty are prevalent, even as it occurs to young teenage girls of poor social economic background and women who are delivering babies for the first time, Okeke, (2009:31), posit the condition is also common among older and even elderly women as well as uneducated women living in the villages with the latter mostly labeled.

Other management strategies in the view of Oghito, (2007:52), are support from family members and taking the victim to health centres. Some members of the family assist the victims and this help a lot in assisting the victim to recover. In this regard, some families employ the services of a care giver, may be a nurse, to visit the victim once in a while and see to the quick recovery of the victims. Some religious bodies also assist in this regard during hospital visitations to victims on admission. The training centres established by these religious bodies go a long way in managing the health challenge.

Notable management strategies also include the free medical advice given by the national Obstetric Fistula Centres across the country. Virtually all the centres according to Olaedo, (2014:44), carry out campaigns and treatments on VVF victims and usually the treatment is free. The treatment which is surgical in nature is done by competent medical personnel. The love shown to the victims also go a long way in helping them psychologically. Although, according to Unachukwu, (2002:33), there are few sources of empirical data, studies show that some common psychological consequences that Fistula patients face are the despairs from losing their child, the humiliation from their husband and inability to perform their family roles and the fears of developing another fistula in future pregnancies. Showing victims love helps them a lot in overcoming all these challenges.

At the individual level, some strategies are adopted which serves as management strategies. Although they are coping strategies but they serve as management strategies since they help the individual manage the health challenge.

They adopt many coping strategies so as to live a normal life. Accepting the fact that the problem exists is a coping strategy which is common among the victims. Other strategies include counseling from time to time which is done by trained social workers. However, this starts from the time the patient seeks for help, through to when she returns to the community. Apart from serving as coping strategy, the counseling also forms part of a whole package of rehabilitation which according to Hassan (2009:12), should start with the treatment but not end with it. The victim has various stresses including physical, psychological and socio-economic which only this approach can bring complete healing.

In the view of Fasakin (2007:42), in as much as women live with the VVF condition, they face the problem of stigma in the society. According to Olaedo (2012:33), stigma is an attribute an individual possesses which makes him or her different from others in the category of persons with a desired kind. Goffman's (1963:18), phenomenological theory gives an

insight into how individuals present their everyday life. More importantly, is the way individual self-presentation is aided by socially categorized group. Their demands might be called demands in effect, i.e. a virtual social identity on the other hand, the individual herself could posses some attributes which are indeed a relation to her real self, such is termed an actual social identity. Fasakin (2007), summed it up by stating that VVF patients due to their conditions have failed to meet the normal expectations of their family and society and as such, they are isolated into their own world.

Some girls living with fistula are very strong; they resort to fighting the disease rather than losing hope. Some of them in communities go into the forest to gather woods and fetch water to sell in order to survive. They may spend months or years saving money in order to pay for medical care and treatment. It is rather unfortunate that, while being alone, some might go into deep physical and emotional decline and may resort to suicide (UNFPA 2005).

Some people especially in some societies may attribute their problems to some spiritual forces and this is also applicable to VVF patients and as such, it means they have turned their problems into spiritual one and may have turned to some spiritual divinity as a source of coping with their unfortunate condition (Balogun 1997:82).

However, with the above management strategies listed, there is need to state that the involvement of the victims in the management strategies is very important. This is lacking from the works of the experts discussed. The involvement of the victims means the victim knowing that she has a problem and must cooperate with the doctors or care givers to recover. This can be done by the victims taking to doctor's advice. Complication sometimes arises from the treatment of VVF because victims- disregard professional's advice given by the health care providers.

Managing a health challenge like VVF is not always an easy task especially in a country like Nigeria. Health challenge like VVF required management strategies to overcome. The

treatment alone cannot help the victim to overcome all the challenges that goes with the health challenge. Nigeria as we all know is a multi-ethnic country and by this, it means that the country is made up of many ethnic groups. These groups have different culture which determines how they behave and relate to one another, especially when they do not share the same language or culture. In dealing with a patient, culture comes in to place. Developing countries like Nigeria are faced with many health problems like VVF which can also be seen as complications from child birth among women. Most of the women who develop this health challenge are usually young and from a low socio-economic status. Some of them are from rural areas. The problem can be managed through a well coordinated efforts. From report (Onuzulike, (2015) Ekene, (2016) and Haliru,(2016)). VVF is a life threatening challenge and as such require assistance from relations of the victims to manage the problem. apart from assistance from relations, the government and members of the public have different roles to play for effective management of the problem.

The cost of treatment is usually very high that not all the victims can afford the treatment. Generally, the rising cost of medical care is responsible for self medication which victims of VVF sometimes indulge in and indulging in self medication has negative consequences on the patient. The shortage of specialist to handle cases of VVF is another challenge. The alarming shortage of VVF specialist in Nigeria at a time of rising incidence of the problem motivated some team of medical personnel from United States to visit some VVF centres in Nigeria in 2015. According to Onuoha, (2015), the manifestation of VVF places the victims in the hospital. While in the hospital, they are first admitted as pre-operation patient and then later operation patient. In each of this stage, the victim faces some challenges which need the support of family members and health care providers. Women who are living with VVF needs support from family, friends and health care providers to cope with their situation.

Management of VVF can take the form of avoidance of stress taking of birth regularly and the use of perfume among others (Ishola, (2016)). In the view of Ekene (2012), factors that hindered the effective management of VVF include, the high cost of medical care, poor attitude of people towards sick persons and that poor helping behaviour and ignorance on the part of victims who may not know that opportunities are available for VVF victims.

Among all the factors listed, the high cost of medical services and the attitude of people towards VVF patient are more prevalence than others. The cost of medical care over the years in Nigeria has been on the increase and this has affected virtually all aspect of health care ranging from price of drugs and services. Factors responsible for high cost of medical care could be the inflationary spiral that has been a common feature of Nigeria economy in the recent years. Other factors could be high dependency on foreign inputs in health care delivery, the battered economy, health technology, either in health care delivery or manufacturing of remedies, is still to a greater extent dependant on foreign technology. Even some alternative health care practitioners still import remedies including herbs which are paid for in hard currency (Ishola, (2016)).

The helping behaviour of Nigerians is very poor and as such they do not see any need to assist people in need. Helping behavior goes with attitude. That is people developing attitude of help. The effect of attitude on behaviors shows that one's attitude in one way or the other influences ones behaviour it content conditions that are present. These conditions according to Ugwu (2012) are possible if attitude are extreme or are frequently expressed. Those who develop the attitude of helping those in need will always manifest it in their behaviour and by so doing will always offer assistance to those in need which may include VVF victims. Haliru (2012), also stated that victims of VVF can manage the health challenge by joining a group forming which may be religious or social. A religious group is a group in which all the member shares the same faith. By this, it means that membership is drawn from people who

are members of a church. The second group is the social group and in this case, membership is drawn from people who share the same language or culture, it also includes those who may not share the same group or language but are of the same age mates or status.

All these associations assist VVF victims to manage the health challenge. They do this through several means. Apart from providing succor for their members; they sometimes give them money to take care of their needs. By so doing, they make the victims to have a sense of belonging.

2.6 Theoretical Framework

Maternal Mortality Framework

The use of theory for any sociological work gives a direction for the work. Some of the theories used by sociologists in health and illness include health belief models, sick role theory, Fabregas model, feminist theory and maternal mortality framework.

Health belief model centred on individual's health behaviour and seeks to explain factors that affect or influence reaching a decision to utilise health care facilities. This theory identified individual predisposition towards a given preventive health behaviour which is governed by belief and attitudes. Basic features of this theory by Rumum, (2014), are individual's perception of his own vulnerability to illness, his belief about the severity of the illness, which may be declined by terms of physical harm or interference with social humanity, the person's perception of the benefits associated with actions to reduce the level of severity or vulnerability and a person's evaluation of potential obstacles associated with the proposed actions. These actions may be physical, psychological or finance. To assess, there must be a belief of interference of disease before the benefits of preventing the disease will be considered. They also have to consider the benefits, cost and inconvenience involved in seeking a particular health care services.

Sick role theory is a functionalist's theory and developed by Tallcott Parsons. Parsons offers one of the earliest formulations of the socio-psychology of illness behaviour as part of his explanation of social systems (Parsons, 1951). Illness according to Parsons disrupts normal life function and relationships and is therefore behaviourally deviant. Illness is not a biological or psychological condition, or an unstructured. Cockerham (2000), stated that sick role is characterized by the sick person being exempted from normal social roles that the person takes for the direction of the illness, the sick person is not responsible for his or her illness, the sick person has the duty to try to get well and the sick person must seek competent technical help and co-operate with the help of the doctor.

Fabregas model emanated from the ideas of Fabregas in 1974. As a theory of disease, the proponents of the theory believed that theory of disease is based at the fact that man perceives ill health or disease condition as emanating from three factors and they are natural, prefer – natural and mystical. Natural in terms of diseases that arise from natural objects or happenings such as earthquakes, accident, rain storms, thunder storms, fair disaster, and many more, while that of pre-natural, emanates from natural causes that are manipulated by the supernatural to cause disease conditions affecting their victims such as snake bites, bees sting, or accident. The mystical factors arise from punishment by supernatural beings or humans who have offended them. These supernatural objects such as deities, divinities, spirits including God are capable of inflicting all kinds of diseases on people that contravene divine injunctions or break taboos, incest prohibition and so on.

Feminism is the general belief in women's rights. It is a belief that women are presently suffering from deprivation, exploitation, oppression, domination and subjugation in various spheres of life incomparable to men, and consequently a movement to secure and deled equal rights and opportunities for women equal to those of men.

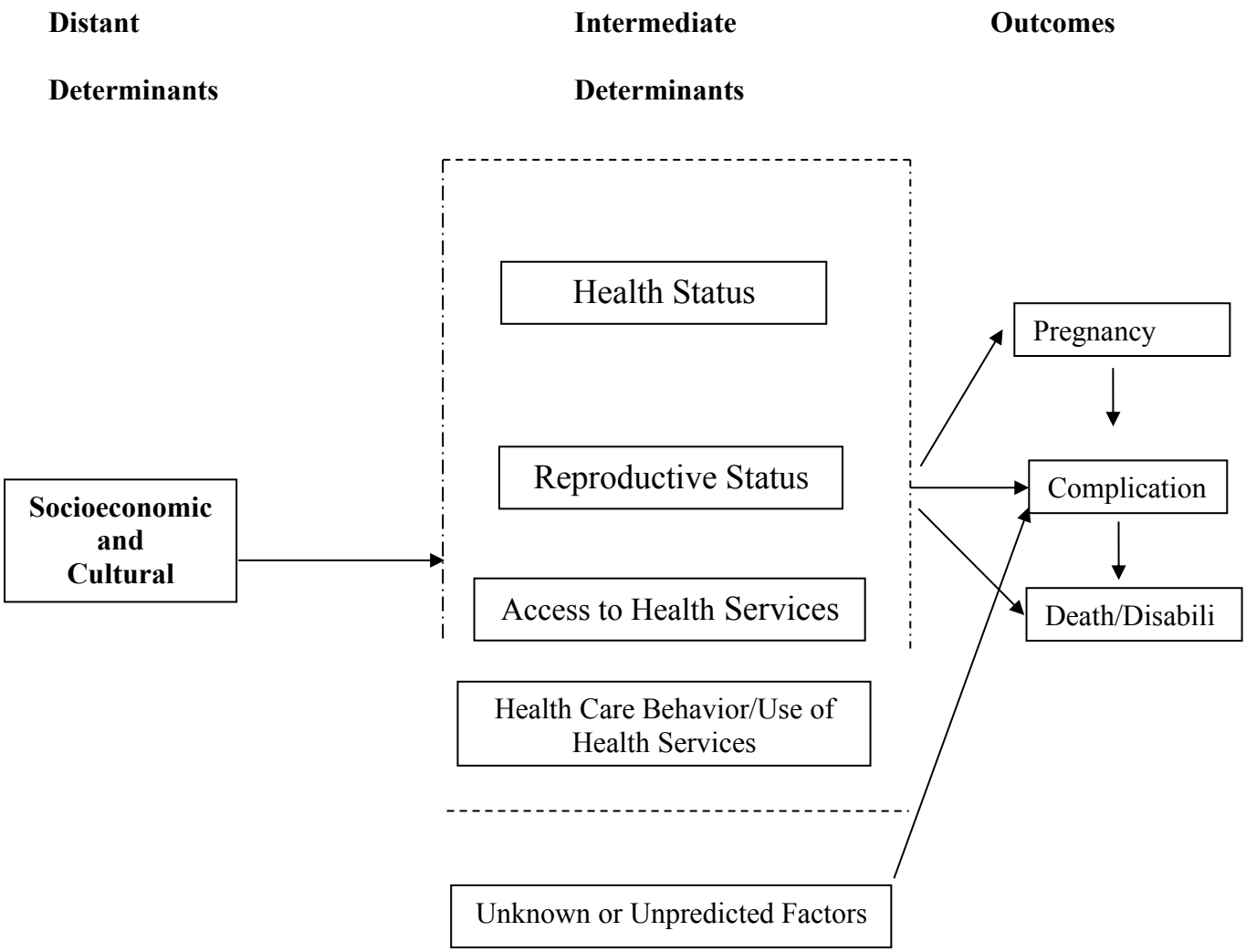
Maternal mortality framework is the theory adopted for this study. A framework for maternal mortality emanated from the ideas of James McCarthy and Deborah Maine in 1992, they are the proponents of the theory. The main provisions of the theory is that the women especially in developing countries die each year from complications of pregnancy, attempted abortion and child birth. The theory presents a comprehensive and integrated framework for analyzing the cultural, social, economic, behavioural and biological factors that influence maternal mortality. This framework which come into existence in 1992 took a more systematic approach to understanding the determinant of maternal mortality. In the view of McCarthy and Maine (1992), the framework is useful for research in developing countries where cases of maternal mortality is prevalent. Reviewing the concepts behind the framework, the framework includes the basic stages in the process that result in material disability or death and a brief description of each of the stages. The framework is organized around three general stages or components of the process of maternal mortality. Closest to the event of a maternal death are a sequence of situation or out comes that culminates in either disability or death; those outcomes are pregnancy and pregnancy – related complications such as VVF. The framework maintains that a woman must be pregnant and experience some complication of pregnancy or childbirth, or have a pre-existing health problem that is aggravated by pregnancy before her death can be defined as a maternal death. This sequence of outcomes are most determinants: the health study of the women; her reproductive status, her access to health services, her health care behaviour which will include her use of health services and a set of unknown factors also included are cultural background of the woman.

The framework also maintains that considering pregnancy and pregnancy complications as part of the sequence of events or outcomes that culminant in material disability or death leads to a obvious but important set of propositions. Any factor that is thought to influence maternal mortality, and therefore any efforts to reduce maternal mortality, must operate these

events. These efforts must reduce the likelihood that a woman will become pregnant; reduce the likelihood that a pregnant woman will experience a serious complication of pregnancy or childbirth or improve the outcomes from women with complications.

The diagram further gives a clear picture of the sets of intermediate determinants

A Framework for Analyzing the Determinant of Maternal Mortality and Morbidity



The implication of this theory for any research exercise is that it improves any study and clarifies the mechanism through which social, behavioural, and biological factors interact to produce an outcome. The countries that are still experiencing high rates of maternal mortality, the framework maintains that programmes must be developed to improve both prevention and treatment. The most effective preventive measures will be the widespread acceptance of planning. By effective planning of when to marry, get pregnant, cases or prevalence of VVF will be drastically reduced among women especially in the rural areas.

Apart from VVF, it will also reduce the chances that a woman will die from pregnancy – related causes in societies characterized by both high fertility and high maternal mortality. The contribution of effective planning to increase maternal survival could be considered. Increase in the age of marriage, especially in those population in which marriage age is very low, could also influence maternal mortality, not only by reducing fertility but also by reducing the chance that a women's pelvis will be immature at the time of her first birth, a condition that is associated with VVF.

The justification for the use of this theory is that since VVF is a problem associated with the reproductive health of a woman, it is a maternal mortality issue and such, this frame work (maternal mortality) best explains the issue.

Application of Maternal Mortality Framework to the Study

Linking the theory to the work, it will not be out of point to state that women especially women from developing countries bear an unacceptable huge burden of disease and death. The state of maternal health in Africa is dismal, with the region accounting for more than half of all maternal deaths worldwide. Each year, and sadly, the situation is not improving significantly. Cases have become worrisome.

The framework critically analyse health issues that affects women, paying attention to developing countries like Nigeria. The link between socio-economic variables and health was extensively examined by the framework. Some other variables that can serve as socio-economic status was also highlighted. VVF as a health challenge has a link with socio-economic status of parents, apart from that, there are services, reproductive status and others that have a link to the problem of VVF which the framework addressed.

VVF as a health challenge is common in developing countries and factors responsible for it include poverty, early child marriage and others were all captured by the framework. It is a common knowledge that no discussion on VVF can be done without considering the cultural,

social economic, behaviour and biological factors that influence it's occurrence. The framework is integrating and comprehensive, hence, it's adoption. Complication affected with some cultural practices such as female genital mutilation and activities of traditional birth attendants ere highlighted by the framework.

Although the framework has a more systematic approach to understanding the determinants of maternal mortality. The understanding of other demographic events, has not been advanced by the development of the framework.

Reviewing the lives of the people of Ebonyi state, it is clear that due to the patriarcial nature of the people, some of these determinants discussed above are directly or indirectly promoted thereby leading to the development of VVF factors, such as denying women the freedom to choose health care services thereby promoting VVF. Although the framework is on the development of maternal mortality, it can be applied to other health challenges like VVF which is also maternal care, as it involves injury sustained during pregnancy.

Reasons for the adoption of the framework are that, it discourages early marriage and the use of untrained medical personnel and equipments to attend to pregnant women. All these factors if discouraged can help to reduce the prevalence of VVF among women anywhere in the world and especially in developing countries. More so, over the years, Nigeria official statistics by Nigeria demographic health survey (2015), reported a high maternal mortality rate, which stood at 545 over 100,000. With this record, Nigeria was rated as one of the countries with the highest maternal and in fact maternal record in the world, hence the need to adopt a framework of this nature that will explain, factors responsible for the problem and offer solutions.

Addressing women's health and the challenges, maternal mortality framework occurs in-depth analysis of the challenges. Women's health as we know has risen high on international development agenda in recent years as the evidence mounted at the key contribution they

made to society. A host of different initiatives have followed all targeting initiatives that will move the agenda forward.

Women according to Connell (1994), are seen as inseparable from the family and most functions assigned to the family are allocated to women within it. Women are usually the careers, the nurturers, the educators, the source of stability and increasingly they are the major cash contributors. For the most part, women meet their responsibilities to their children, their men and other relatives with generosity, self-sacrifice and unstinting labour. Many men similarly are devoted to the creation and maintenance of the family and demonstrate respect for its individual members. However, the health status of the woman sometimes poses serious challenges to the realization of these dreams and aspirations. Many of the health challenges suffered by women especially in developing countries like Nigeria usually lead to or are responsible for the high rate of maternal mortality experienced in developing countries like Nigeria. As a defense to this, some Non-Governmental organisations are making input in the bid to improve the health of women and ensure that developing countries like Nigeria raise maternal and child health. According to Afolabi (2013), Nigeria ranks second to India in Maternal mortality, Motherhood in developed countries is a positive and fulfilling experience, hence, it should not be associated with ill-health and death that are easily preventable. Afolabi (2013), said that the death of women during pregnancy or delivery is a major public health problem. Equally the deaths of infants or children under five is closely related to maternal health and double when the mother died in child birth due to lack of care and provisions which could weaken the child's chances of reaching better life standards.

Okoye (2015), posits that women had featured in maternal health issues as victims and objects rather than subjects in the campaign against death. In the view of Ishola (2016), this has reinforced stereotypical notions of females being positive in such a matter, that is, of un-paralleled intimacy to them, thus deepening their social disempowerment.

Afolabi (2013), asserted that through the campaign against infant and maternal mortality, we promote the discourse that maternal health issue is a human right concern and that government has an obligation to ensure that women's rights were respected and protected. It is in recognition of this that scholars in public health experts (Alubo, 2010, Akinwumi, 2011) tasked government at federal, states and local level on the need to provide quality maternal health services which would contribute significantly in reducing maternal mortality and morbidity in Nigeria. There is need for a blue print to reverse poverty, hunger, maternal health and disease affecting billions of people around the world. There is need for initiatives to build a consensus on maternal mortality reduction.

The adoption of the maternal mortality framework shows that maternal mortality is a social issue that requires a social solution. Dwelling on the global perspective to the issue of maternal mortality, Akinde (2014), showed that as a result of high mortality rate in Nigeria and other developing countries, a woman dies every 90 seconds from complications during pregnancy or child birth. According to Akindele (2014), the safe motherhood initiative launched in 1987 by the United Nations for population Activities (UNFPA) is a step in the right direction. The safe motherhood initiative, world health organisation and world bank should raise awareness, setup efficient ante-natal care and working referral systems and emergency management of obstetric cases as well as increase of family planning awareness.

Reducing maternal mortality in Nigeria will require expanded use of skilled birth attendants, qualitative ante-natal care, improved health systems as well as accessible and affordable contraceptives.

The adoption of maternal mortality framework for this work is because VVF is a maternal mortality issue that requires collective solution from both the government and the people, it is a common knowledge that factors contributing to maternal mortality are the same factors contributing to the developing of VVF. These factors according to Akindele (2014), are lack

of ante-natal care, absence of skilled birth attendants, primary, secondary and tertiary delays, socio-economic status, otherwise known as poverty, maternal educational level and cultural practices of the people.

The issue of lack of ante-natal care is a very serious threat to health care services of women. Some women due to ignorance hardly require for ante-natal care at the early part of their pregnancy. Some do not even go for ante-natal care. Some justify their actions with one excuse or the other which places them at risk during child birth. According to Kisekka (1992), women die most by from pregnancy and child related problems than from any other causes. Lack of ante-natal care is one of the factors responsible for the problem. Issues of the absence of skilled birth attendants such as nurses, doctors and midwives is also a factor to be considered. In the view of Orebuch (2014), people in Nigeria over the years have continued to experience avoidable death; they continue to die of treatable illness. Most times, people especially women seek medical assistance when the illness is at advanced stage. In some of the health facilities, shortage of medical personnel discourage women from visiting such facilities. The only option left in some cases is the private hospital which is usually beyond the reach of the poor. In some cases, even the private hospitals do not even have the skilled health needed. Equipments and manpower challenges in the health sector is responsible for some of the cases of maternal mortality recorded in some states in Nigeria. The emigration of health workers have not helped matters as on daily bases, the health sector loses her professional out of the shores of the country which is today regarded as brain drain. This act which is seen by many Nigerians as a form of neo-colonialism by the west has complicated issues. Nigeria spends much to train her professionals especially medical doctors only to lose them as soon as they complete their training programmes to the United Kingdom, US and other European countries. All these have contributed to the problem of lack of skilled personnel in our health care centres. The un-seriousness of the government at the federal and

state levels have also not helped matters as there are still evidences of low budgets for the health sectors which makes it difficult for health professional to operate.

Delay in taking pregnant women to health hospitals is yet another factor to consider. Some husbands or relations of pregnant women find it difficult to take the women to the hospital when the need arises. Some midwives or birth attendants report cases of late arrival of patients to the hospital and that it is not a good development in some cases, when the woman is undergoing labour, the consent of the husband is usually sought before she is taken to the hospital. In this case, it is the husband who determines the hospital his wife should be taken to and when the husband is not around the wife has to wait for him to come back before she is taken to the hospital. This sometimes is responsible for delivery at home which when there is an emergency, it becomes very difficult for the woman to access health care service. So, delay in going to the hospital is very dangerous and can lead to complications, which is not in the interest of the women. Okeke reported that some of the complications recorded during some deliveries which have negative consequences on the lives of pregnant women would have been overcome if the women were brought to the hospital. However, it would not be out of point to say that apart from negligence from the patients and her relation, the problem of bad roads is another issue to consider when discussing delays in taking pregnant women to the hospital or health centres. Some roads in Nigeria, especially rural roads are so bad that it takes hours to move from one place to the other and in the case of emergency it becomes very difficult to meet up to time.

Socio-economic status of some women also determines whether they get health care services or not. Some women especially those from rural areas who in most cases are poor sometimes deliver their babies at home and this is an ugly development. Delivery at home due to poverty can be dangerous. According to Awom (2011), the joy of every pregnant woman is to deliver safely and see her baby. However, this is sometimes not the case with some women who are

from low economic status, even though it is true women have been giving birth at home before, The emergence of professionals in the hospital, this type of home birth always record a high rate of danger for both mother and child.

The case of health care services is another factor to consider in this case. Even with the low charges from government hospitals, some patients still find it very difficult to pay because of their socio-economic status. Osagie (2015), said that Nigeria like many developing countries place emphasis on the establishment of government owned health institutions. This government hospitals are miniature society that is made up of people of different socio-economic backgrounds. Most times people patronise those government hospitals for health care services, but what determines the quality of health care they get is their socio-economic status. Socio-economic status here refers to the level of poverty among the patients, which in this case is the women.

The cultural practices also contribute to maternal mortality. Culture is the way of the people. Culture according to the 1988 cultural policy of Nigeria and cited Asagba (2011), is the "totality of the way of life evolved by a people in their attempt to meet the challenges of living in their environment, which gives order and meaning to their social, political, economic, aesthetic and religious norms and mode of organisation thus distinguishing a people from their neighbours." It goes on or further to calculate that culture comprises material, institutional, philosophical and creative aspects. However, for this work our attention shall be on culture as a way of life of the people and how, what they do affects them positively or negatively. Metiboba (2008), posits that there is a link between culture and health. Culture plays a very important role in health and illnesses. To Metiboba (2008), the health status of a society is a function of the norms and values of the society. Culture and health cannot be separated because each represents to some extent different aspects of the same coin. So, the culture of a person can contribute to maternal mortality.

Reasons for the adoption of the theory are that the issue of maternal mortality have existed for many years. Royshon and Armstrong (1989), pointed out that due to the fact that child bearing is essentially a healthy and welcomed process, traditional societies have somehow accepted the risks as being unavoidable. Maternal mortality over the years has generated great concern among United Nations (UN) and many countries in the world including Nigeria. The risk factors or causes of maternal mortality can pre-dispose women to maternal deaths. Muokwigwo (1992), revealed a pattern that is but qualified under medical factors, health service factors, reproductive factors and socio-economic factors.

Health service factors which includes lack of pre- natal care, lack of access to maternity service, lack of essential supplies and trained personnel. Similarly, W.H.O 1991 identified low socio-economic and political status, lack of local suppliers, facilities, equipment and human resources, as well as harmful traditional customs and practices as factors that adversely affects Women's lives and many leads them to death. Maternal health problem exposes women to stress, tension, depression and financial strain. According to Onuzubike (1988), she may be a woman who has had several previous pregnancies; or a teenager without any answers to family planning information or services. She may not have received any pre-care by trained assistant during deliver. She may be illiterate, working very hard all day to provide her family with food, shelter and clothing.

Chiwuzie etal; (1995) cited in Onuzubike in (1998), explained that the high level of maternal mortality in developing countries stems from a complex array of factors in addition to the inadequacy to health services, such factors include socio-cultural, economic and logistics problems coupled with very high fertility. Using other criteria, Fathalin (1986), opined that the factors of maternal death are complex arising from conditions such as early marriage and haemorrhage from placenta preview, anaemia due to parasitic infection and mal-nutrition. Others are late arrival at the hospital with already existing complications, lack of basic pre-

natal care, inadequate health facilities and supplies, non-seeking of medical help, multi-parity, and lack of family planning, poverty, poor socio-economic status, illiteracy, poor nutrition, poor residential location and pride in having many children. Fathalin (1986), further grouped these causes of maternal death into four and they are; Medical factors.

Chiwuzie (1995), pointed out that the common medical causes of maternal deaths are haemorrhage, severe complication of hypertension in pregnancy, infections, obstructed labour and unsafe abortion. Fathalin (1986), sub divided the medical cause of maternal death into direct and indirect causes. Direct causes include those that their management, such as haemorrhage, toxaemia, illegally induced abortion, embolism, ruptured uterus and obstructed labor. Indirect causes include those factors that result from the aggravation of some existing conditions such as hepatitis, anaemia and heart diseases.

Health Factors

These include deficient medical treatment of complications; mistaken or inadequate action by medical personnel is also a contributory factor. Others include lack of human and material resources like trained personnel, blood transfusion, drugs and other equipment. Lack of access of maternity is another crucial step that can cause maternal mortality. In areas where access of hospital or health care is difficult, maternal mortality rates are increased, equally listed as a health factor is lack of pre-natal care, in Nigeria and other developing countries of the world, considering all the ages and parity groups. Maternal mortality is lower among urban women who have pre-natal care than rural dwellers

Reproductive Factors:

The risk of maternal death is highest in certain types of pregnancies. Fred (1992), classified four specific types of pregnancies that are at risk of maternal death, these include;

i. Pregnancy before the age of 20.
ii. Pregnancy after the age of 30.

iii. Pregnancy after fourth birth.

iv. Pregnancy spaced less than 2 years.

The risks are both biological and social. Welto (1987), highlighted that the ages of women at risk of maternal death is based on three factors and they are;

i. Reproductive inefficiency as in the case of incompetent cervix and inadequate pelvic.

ii. Parity: women are safest at their 2-3 times delivery. While risk increase as they reach grand multi pafae and are subject to complications.

iii. Social class: women who are poor and unskilled are six times more at risk than those of management group due to poor nutritional status and lack of ante-natal care.

There is increased risk associated with having many children. Fathalia (1986), pointed out that women having 6-9 births have greater risk followed by those that with 5th births (greater risk) and those with 4th births have relatively low greater risks.

Another reproductive factor of maternal mortality is unwanted pregnancy. Fathalia (1986) and Kli (1990), were of the view that illegal abortion is a major killer of women and accounts for 25 to 50% of maternal deaths due to reluctance to seek formal medical help.

Socio-Economic Factors:

Poverty is a major socio-economic factor, poor women are less likely to have formal education than wealthy ones are and are less likely to be in good health or to seek and receive medical care when pregnant.

Also involved is the status of women. The status of women affects their nutrition, reproductive behaviour, utilisation of health care services and vulnerability to harmful traditional practices (Starrs, 1987). These in turn pre-dispose women to maternal morbidity and mortality as the case may be.

Another factor that can lead to maternal mortality is lack of modern obstetric service. According to Chiwuzie, etal (1995) the modern obstetric services available in Ekroma were inadequate for anything beyond routine ante-natal care. The story is likely to be similar in some urban and most rural communities in developing countries. In addition, shortage of skills and essential tools and lack of commitment on the part of the health workers tends to reinforce traditional socio-cultural beliefs and practices. In these circumstances, pregnant women may prefer visiting traditional birth attendants and healers who are comparatively accessible and affordable.

In areas where modern obstetric services are available, some cultural practices could prevent or delay the decision to use them and from modern obstetric care.

Specially believed is that certain foods were potentially disadvantageous for pregnant women and that some cases of haemorrhage in pregnancies and deliveries could be caused by supernatural forces, may hamper seeking care in modern obstetric health institutions by pregnant mothers.

Transportation difficulties equally occur, following such difficulty, there is the tendency to continue relying on the care provided by traditional birth attendants which sometimes may not be in the interest of the women and may result in the development of VVF or other health challenges.

Negative perception of the quality of care provided in modern obstetric institutions also affects pregnant mother's decision to patronise such institutions. Maine (1996), pointed out that such perceptions could be related to bureaucracy, lack of drugs and supplies, absence of doctors (especially at night), unfriendly attitude of health workers towards patients and unorganized referral from one level of care to another.

Maternal mortality best explains cases of VVF as VVF is one of the maternal mortality problems women face. The framework explains factors responsible for the problem.

CHAPTER THREE

THE STUDY METHODOLOGY

This chapter presents the procedures the researcher employed in carrying out the study. The chapter is therefore subdivided into the following sub-headings: Research design, research setting, area of the study, population of the study, sources of data, sample and sampling techniques, instrument for data collection, administration of the study instrument, validation of the instrument, reliability of the instrument and method of data analysis.

3.1 Research Design

The research design adopted for this work is the descriptive survey design. Survey design are well suited for descriptive studies which this work fall into. According to Alubo (2016), survey is a method of obtaining information about a population by interacting with only some people drawn from the population. The logic here is to circumvent the problem of cost. Scientifically, it is not even necessary to include everyone in the population. Often, some rather than all in the population are included in the study. Ademola (1985), posits that a descriptive research often limits itself to its immediate subjects and usually does not go beyond it. It does not make judgement or evaluation. The reason behind the adoption of descriptive survey method for this work is because of the nature of the issue being investigated. VVF is a medical and as well a social issue and as such a descriptive survey method is the only method that suits the work as data for the work are collected from the population for intensive study and analysis.

Moreover, this type of research is based on information gathered through questionnaires, interview and rating scales which shall be employed for this work as a method for data collection.

3.2 Study Setting

The study was conducted in six local government areas in Ebonyi State and National Obstetric Fistula Centre Abakeliki, Ebonyi State. The local governments are Abakiliki, Ohaukwu, Ezza South, Ezza North, Afikpo North and Ivo. Ebonyi State is in the South-East geo-political zone of Nigeria. It was created out of Abia and Enugu States on 1st October, 1991. It derived it's name from the Ebonyi River. The State capital is Abakiliki known for it salt deposits. The State also has other mineral deposit such as lime stone, granite, clay and gypsum. The tourist attraction found in the state includes the eleven official gazette forest reserves and the 40 hectares Akanto game reserve. The state is referred to as the salt of the nation. In the 2006 population and housing census, Ebonyi State is made up of 1, 064,156 male and 1,112, 791 female giving a total figure of 2,176,947.

There are 13 Local Governments Area in Ebonyi State, they are: Abakili, Afikikpo North, Afikpo South, Eboyi, Ezza North, Eza South, Ikwo, Ishielu, Ivo, Izzi, Ohaozara, Ohaukwa and Onicha.

The people of Ebonyi State are Igbo stock, however, they are also non-Igbo speaking indigenes. The non-Igbo speaking people of the State include the Okpotos and the Natezi in Ishielu Local Government Area. English is widely spoken as the second language and well understood anywhere in the state; people speak English language or its local Variant, the pidgin.

Ebonyi State is richly endowed culturally. The traditional mode of dressing for the man is a cover flowing jumper or long sleeve shirt worn over a George wrapper tied around the waist and flowing down to the ankle. This is complemented with a cap and a walking stick for support and defense.

For the women, the traditional dress is usually a blouse cover an Abada or George wrapper around the waist. This outfit goes with a headgear, earring and necklaces.

Two important traditional festivals are observed every year, the masquerade and the yam festivals. The masquerade is a very important and colourful institution, and features the "Omaba Ekpe and Ogbodu" masquerades. The New Yam Festival is known by various names such as "Joku, Ihejoku or Njokuji". The festival marks the end of the farming season and ushers in the harvest and consumption of the new yam.

There are a variety of colourful dances in the state. The notable are the "Nkwa umogboaho" of Ehogbo "Nkwa Nwite" of Ehugbo "Ojianyahere" of Amasiri "Uri" and Akpoha Iqurube" and the Dibugwu" cultural dance of ofogbu Edda.

Traditional industries and works of arts including black-smiting at Ezza and pottery works at Ishaugu in Ivo local Government Area. Other works of Art produced in the state included carved door and stools, walking stick, traditional flutes, wooden mortars and pestles.

Ebonyi State has three (3) important centres; Abakiliki, Afikpo and Onueke. Abakiliki, the state capital, has a vibrant economy based essentially on it's traditional role as a market for the produce of the rich ago cultural hinterland, beyond with rice and yam. The town has an impressive infrastructural network, particularly in terms of road network and water supply, anchored on the greater Abakiliki water scheme.

A General and Federal Teaching Hospitals are located in Abakiliki, in addition to Ebonyi State University, and recreational facilities such as parks and ultramodern golf course. Afikpo, the second major town is noted for the educational institution located in the area, particularly, the Akanu Ibainu Federal Polytechnic Uwana.

The third main urban centre is Onueke which is the headquarters of Ezza south Local Government Area. The area is noted as an important centre for food production.

Besides the above urban areas, the headquarters of the other Local Government Areas are functional and effective 'central places' most of these fall within the country side, each with

its own requisite infrastructure, indicative of wide scope of incipient urbanization which is generally taking root in the state.

In Rural Development Programmes of the Ebonyi State, government emphasizes road construction and rehabilitation, aimed at improving access to the hinterland to marginally exploit farm lands for the evacuation of agricultural produce to urban markets. Rural electrification schemes are also pursued as an essential infrastructure for successful small scale and cottage industries schemes.

In addition, various agricultural innovations are being put in place and farmers are encouraged to go into large scale farming through the adoption of these innovations, which include tractor hiring scheme, fostering, irrigation, land consolidation for extensive and intensive farming, seed livestock breeding, multiplication and fish farming.

Water resources improvement programmes have been instituted to provide clean and safe water in the villages and in guinea worm prone areas. The provision of Primary Health Care (PHC) facilities and the development of effective rural information delivery system, are important facets of the state's rural development programme.

Effective communal involvement through community development association (or Town Union), age grade are also encouraged to promote rural development in Ebonyi State.

Settlement patterns in the urban areas often take the form of distinct neighbourhood or quarters, some of these neighbourhoods are of high density, while others are of medium and low density in varying degrees, of admixture of rural settlements are dispersed, covers much of farmlands.

In almost every community, however, there are vast unoccupied area set aside as farm land and somewhat removed from the settlement. The village is the traditional unit of settlement in most Igbo speaking communities. The dispersed pattern of village settlement is traditional among the people of Southern Nigeria.

Each homestead is made up of houses in an oblong form around the hit of the head of the household, is separated from those of his wives and adult members of the household. Compounds are often walled, thus separating one compound from the other traditional houses that are built of local materials, such as clay for walls and mat or thatch for the roofs.

Increased influence in some communities have led to the introduction of cement bricks, western architectural design concepts and use of corrugated sheets, into the construction of village homes.

Women constitute more than half of the population. The women are mostly found in rural areas and are mostly illiterate but they are the ones that put food on the table through agriculture. According to a report by Dovenet (2012) a non-government organization (NGO) women and girls in Ebonyi State over the years have suffered various forms of violence raging from wife battering, rape, acid bath, harsh widowhood practices, disinheritance spouse, murder, threats, psychological violence, verbal abuse, sexual denial and abandonment of home and children. These have led to gradual family disintegration. The family institution is seriously being threatened by violence, thus, the need for the intervention, of engaging men to eliminate the social vices

The National Obstetric Fistula Centre, Abakaliki formerly known as the South East Fistula Centre, Abakiliki, was established by the Mother and Child Care Initiative (MCCI) of the wife of the Governor of Ebonyi State in December 2008. Due to the success recorded by the centre with the free treatment programme accessible to all Nigerians, and the series of advocacy by the wife of the Governor, the Centre was taken over by the Federal Government as the First National Obstetric Fistula Centre of Excellence for the provision of free treatment, training, rehabilitation, research and prevention.

3.3 Population of the Study

The population of the study consists of women in selected Local Government Areas in the state. The selected Local Government are: Abakiliki, Oha-Ukwu, Ezza South, Ezza North Affikpo North and Ivo. In order to save cost and to make sure that all the women of Ebonyi state are represented, the researcher used the already three senatorial zones in the state for the study. the zones are: Ebonyi North, Ebonyi South and Ebonyi Central. It was from these zones that the above mentioned six local governments were selected to be used; two Local governments from each senatorial zones. The populations of these Local governments were used for the study. The population was the 2006 population census, however, the national growth rate of 3.2 provided by National Population Commission was used to determine the actual population of the six Local Governments. Below is the 2006 population figure of women in the selected local government areas.

Table 3.1: Population figures of Ebonyi women in selected LGAs

Local Government Area	**Population**
Abakaliki	69,280
Ohaukwu	67,127
Ezza South	69,595
Ezza North	77,084
Afikpo North	79,243
Ivo	60,933
Total	**423,262**

Source: Federal Republic of Nigeria Official Gazette (2007)

Population Determination

Population at 2006 = 423262

At 2017 = 11years after

Growth Rate (NPC) = 3.2%

$$\text{Growth rate} = \frac{423262}{1} \text{ x } \frac{3.2}{100} \text{ x } 11$$

$$= \mathbf{149{,}988}$$

Therefore, population at 2017 = 423262 + 149988

$$= \mathbf{573250}$$

3.4 Sample Size Determination

Taro Yamen (1967) formula was used to determine the ample size for the study. The formula was chosen because it concern with the application of normal approximation with 95 percent confidence level and 5 percent error tolerance.

The formula is stated below

$$\text{n} = \frac{N}{1+N(\in^2)}$$

Where n = The Sample size required

N = The Population size

E = Level of Significance

$$\text{N} = \frac{573250}{1+573250(0.05)^2} = \frac{423262}{1+573250(0.0025)}$$

$$\text{N} = \frac{573250}{1+(573250X0.0025)} = \frac{573250}{1434.125}$$

N = 399.72

Based on the formula above, the sample size will be 400. With this, 400 respondents will be proportionately selected from the six Local Governments and national obstetric centre, Abakaliki where the key informats are located.

3.5 Sampling Technique

Sampling techniques adopted for this study are cluster, systematic and purposive sampling techniques. These sampling techniques were adopted because of the strengths on research topics of this nature. Cluster sampling according to Ibanga (1992), assumes heterogeneity of the population as in the case of stratified sampling. But the stratification carried out at design stage is not on the basis variables that describes the elements, but on the basis of residential areas. One basic assumption of the cluster sampling, therefore, it is in the adage that 'birds of the same feather flock together'. In other words, the assumptions is that people of similar characteristics like women tend to share similar challenges. In cluster sampling, it does not require that the exact population size be known in advance. In fact, one advantage of this method is that the exact population size does not have to be known in advance.

Systematic and probability sampling tend to display some characteristics and operates on certain assumptions of known major probability sampling plans, although it also manifest some attributes of non probability sampling. In the view of Adefila (2008), a systematic sampling, individual are chosen at regular intervals and this can be done randomly.

3.6 Methods of Data Collection

Data for this study was got from women of Ebonyi state residing in the local government selected for this study through the used of structured questionnaire design to extract vital information on VVF. In addition, sixteen key informants comprising ten medical and health workers who are staff in national Obstetric Fistula centre, Abakilike and who managed VVF cases in the centres and six women, youth and community leaders residing in the six local government areas selected for the study. Their responses were cross checked with what the

women claimed are responsible for the prevalence of VVF in the state. All the views of the key informants were integrated in the work through the principle of triangulation. In social sciences, triangulation is often use to indicate that two (or more) method are used in a study in other or check the result of one and the same subject. Triangulation is a powerful techniques that facilities validation of data through cross verification from two or more sources.

The structure questionnaire has 23 questions which all centred on VVF. The questions were drafted from the five research questions which guided the researcher. This research questions are: What is the prevalence rate of VVF among women of Ebinyi state?, what are the socio-cultural factors influencing the prevalence of VVF among women of Ebonyi state?, what are the social implication of VVF among women of Ebonyi state?, what are the management strategies of VVF among women of Ebonyi state? and what can be done to solve the problem of VVF in Ebonyi state?.

Questions 1-7 in the questionnaire address research question one which is on the prevalence of VVF in Ebonyi state. questions 8-13 address the second research question which is on socio cultural factors influencing the prevalence of VVF in Ebonyi state, question 14-17 address research question three which is one social implications of VVF, in Ebonyi state. question 18-20 address the fourth research question which is on management strategies of VVF while question 21-23 address the last research question which is on solution to VVF in the state.

Apart from question three and four in section B where the respondent is expected to write the name of the local government in which victims of VVF they know comes from and what VVF is called in their locality, all other questions have options from which the respondent is expected to choose options that best represent their views

3.7 Techniques of Data Analysis

To ensure proper analysis of data collected, frequencies and percentages were used for interpretation of tables. Basic assumptions were discussed thereafter.

3.8 Problems Encountered During The Study

Carrying out research of this nature is not without challenges. Ebonyi state, just like any other state, has its own problems. In the cause of carrying out this research, the researcher observed that a large proportion of Ebonyi state population live in the rural areas and this constituted a challenge to the researcher, as transportation was a big problem to the researcher. Visits to the three geo-political Zone mapped out for the research was not an easy task.

There was also the challenge of non-cooperative attitude from some of the residents where the researcher visited. Some of the women were not willing to respond to some questions. Some even demanded that time should be given to them to seek permission from their husbands before they can respond to some of the questions asked. Some who could not speak English or Igbo language also made it difficult for the researcher to obtain information. Some of them could only speak their native dialect, which the researcher and members of his group could not speak.

Finance was also a big challenge as this research work was self sponsored, so the researcher did not find it easy to carry it out. The distance between Jalingo where the researcher is based and Ebonyi state is much, as such, it was very difficult for the researcher to embark on the long distance journey especially, during the field work and distribution of questionnaire.

Collection of filled questionnaires was also a problem as some of the respondents insisted on filling it at their own time or after consulting their husbands and when the researcher assistant comes back for them, they are usually asked to still come back. This was a problem because the research assistants usually come back and in some case without collecting the questionnaire.

Within the period of field work, the civil servants in the state were on strike and this created problems for the researcher as some government offices were under lock and key. This made it difficult for the researcher to have access to some organizations.

At the VVF centre Abakiliki, it was easy convincing management of the centre to allow the researcher and his team access to the victims even when the centre is a research centre. Various appointments were booked before permission was granted.

However, through the researcher's hard work, dedication and devotion from the entire research assistants, the researcher was able to over-come virtually all the challenges faced. In the area of transportation, the services of a commercial driver were hired by the researcher, who took the researcher and all the research assistants to all the places mapped out for this work.

In the area of cooperation, the research assistant engaged, who are also indigenes of the areas, were useful as they encouraged the respondents to provide answers to the questions with assurance that their responses will be treated with utmost confidentiality.

For those who could not speak English, the assistants interpreted the questions to them in their local dialect and this enables them to participate in the exercise.

For finance, the researcher sought for assistance from family members', friends and relatives including well wishers to overcome the challenge. Personal saving was also invested to make this work a success.

Overcoming all the challenges has made it possible for the researcher to produce result that will stand the test of time and contribute to Knowledge.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS OF FINDINGS AND DISCUSSION

RESULT AND DISCUSSION

This chapter presents results of the data analysis and discussions of the findings of the research. Frequency and percentage were used for the presentation. A total of 400 set of questionnaires were printed and distributed among the women selected for the study. The questionnaires were distributed to them in their local government areas. Some of the local governments represent rural areas while others represents urban areas. However, from the 400 sets of questionnaires distributed only 381 (95.25%) questionnaires were found usable and as such were used for the analysis. 19 (4.75%) sets of questionnaires were found unusable as they were not appropriately filled by the respondents and as such were not included in the analysis. The responses of the women will be compared with that of the key informants who are medical personnel that handles VVF cases.

Socio-demographic characteristics of the respondents captured in this study include age, marital status, educational level, occupation and religion.

Table 4.1. Socio-Demographic or Personal Data of Respondents

Age Distribution of Respondents		
Age	**Number of Respondents**	**Response Rate (%)**
15-19	102	26.77
20-24	77	20.21
25-29	51	13.39
30-34	32	8.40
35-39	47	12.34
40-44	40	10.50
45-49	23	6.04
50 above	9	2.36
Total	**381**	**100**
Marital Status of Respondents		
Single	12	3.15
Married	318	83.46
Divorced/Separated	19	4.99
Widowed	32	8.40
Total	**381**	**100**
Educational Level of Respondents		
Age	**Number of Respondents**	**Response Rate (%)**
No Formal Education	74	19.42
Primary Education	224	58.79
Secondary Education	54	14.17
Tertiary Education	20	5.25
Others	9	2.36
Total	**381**	**100**
Occupation of Respondent		
Farming	140	36.75
Business/Trading	112	29.40
Civil Servant	27	7.09
Housewife	54	14.17
Student	29	7.61
Others	19	4.99
Total	**381**	**100**
Religion of Respondent		
Christian	329	86.35
Muslim	35	9.19
Traditionalist	11	2.89
Others	6	1.57
Total	**381**	**100**

Source: Field Work, 2017

Information on the above table 4.1 indicated that in terms of age, 102 (26.77%) are between the age of 15- 19,77 (20.21%) are between 20-24, 55 (13.21%), are between 25-29, 32 (8.40%), are between 30-34, 47 (12.34%), are between 35-39, 40 (10.50%) were between (40-44%), 23(6.04%) were between 45- 49, while 9 (2.36%) were 50 years and above.

For marital status, 12 (3.15%) were single 318 (83.46%) were married, 19 (4.90%) were divorced or separated, while 32 (8.40%) widow. For educational level 74 (19.42%)had no formal education, 224 (58.79%) had primary education, 54 (14.17%) had secondary education, 20 (5.25%) had tertiary education, while 9 (2.36%) had other forms of education like fellowship. Furthermore, in the area of occupation, 140 (36. 75%) are into farming, 112 (29.40%) are into business or trading, 27 (7.09%) are civil servants, 54 (14.27%) are house workers. 29 (7.61%) are students, while 19 (4.99%)are into other occupations.

For religion, 329 (86.35%) are Christians, 35 (9.19%) are Muslims, 11 (2.89%) are traditionalist, while those in the other forms of religion are 6 (1.57%)

Table 4.2.1 Local Government with VVF cases in Ebonyi State

	Frequency	**Percentage**
Abakaliki	31	8.14
Ohaukwu	29	7.61
Ezza South	22	5.77
Ezza North	47	12.34
Afikpo North	211	55.38
Ivo	41	10.76
Total	**381**	**100**

Source: Field Work, 2017.

Table 4.2.1 showed that 31 (8.14%) responders stated that VVF victims they know are from Abakaliki, 29 (7.61%) are from Ohaukwu, 22 (5.77%) are from Ezza South, 47 (12.34%) are from Ezza north, 211 (55.38%) are from Afikpo North and 41 (10.76%) are from Ivo This showed that more than half of the VVF cases recorded in the state are usually from Afikpo north local Government Area.

However, from the key informant interview, 10 agreed with the respondents that Afikpo North has the highest rate of VVF victims in the state and that according to the informant, the local government has a good number of Igbo Muslims, in the view of the informant Afikpo North is a model Islamic community in Ebonyi State. Many of the Igbo from the local government including the traditional rulers are all Muslims, hence the practice of early marriage.

Table 4.2.2 What VVF is called in some communities in Ebonyi State

	Frequency	**Percentage**
Mkbapia Akpa Mamiri	154	40.42
Oria Akpa Mamiri	198	51.97
I don't Know	29	7.61
Total	**381**	**100**

Source: Field Work, 2017.

Table above (4.2.2) showed what VVF is called in some communities in Ebonyi State 154 (40.42%) stated that VVF is called Mkbapia Akpa Mamiri, 198 (51.97%) stated Oria Akpa Mamiri while 29 (7.61%) stated they don't know

All the key informant affirmed that Oria Akpa Mamiri and Mkbapia Akpa Mamiri are common names used to described cases of VVF.

Table 4.2.3 Number of VVF victims known to the respondent

	Frequency	**Percentage**
One	241	63.25
Two	106	27.82
Three	18	4.72
Four	3	0.79
Five	1	0.26
None	12	3.15
Total	**381**	**100**

Source: Field Work, 2017.

Table 4.2.3 showed the number of VVF victims known to the respondent.

241 (63.25%) stated that they know one person, 106 (27.82) stated they know two persons, 18 (4.72%) stated they know three persons, 3 (0.79%) stated they know four, one respondent (0.26%) stated five and 12 respondents (3.15%) claimed they don't know any person suffering from VVF.

Table 4.2.4 Stage at which victim developed VVF

	Frequency	**Percentage**
First Pregnancy	4	1.05
Second Pregnancy	80	20.99
Third Pregnancy	97	25.46
Fourth Pregnancy	192	50.39
I don't know	8	2.09
Total	**381**	**100**

Source: Field Work, 2017.

The above (4.2.4) table showed the stage at which the victim developed VVF. 192(50.39%) respondents stated that victim develop the health challenge during their first pregnancy 80 respondents (20.99%) stated during the second pregnancy, 97 respondents representing (25.46%) stated that it was during the third pregnancy 4 respondents representing (1.05%) stated that it was during fourth pregnancy, while 8 respondents representing (2.09%) stated that they don't know.

However, there is a variation from the responses of the key informants. From the key informant, victims developed VVF during the first or second pregnancies. This was the views of some of the key informants especially the health workers

Table 4.2.5 How to identify a VVF victim

	Frequency	**Percentage**
Looking dejected	117	30.71
Wet clothes	202	53.02
Sober looking	62	16.27
Total	**381**	**100**

Source: Field Work, 2017.

The table above (4.2.5) showed how to identify VVF victim in a community. 117 respondents representing (30.71%) claim that VVF victim usually look dejected, 202 representing (53.02%) stated that VVF victim usually wear wet clothes, while 62 respondents (16.27%) affirm that they usually look sober.

Table 4.2.6 Socio-cultural factors that influence VVF

	Frequency	**Percentage**
Female circumcision	21	5.51
Early marriage	302	79.27
Activities of traditional birth attendants	18	4.72
Lack of medical care	40	10.50
Total	**381**	**100**

Source: Field Work, 2017.

Table 4.2.6 showed the socio-cultural factors that influence the prevalence of VVF. The table showed that 21 respondents representing (5.51%) stated that female circumcision is a factor that influence the prevalence of VVF. 302 respondents representing (79.27%) stated that early marriage influence the prevalence of VVF. 18 respondents representing (4.72%) stated activities of traditional birth attendance, while 40 respondents representing (10.50%) stated lack of medical care as a social factor. From the responses of the respondents, early marriage is the socio-cultural factors that influence the prevalence of VVF in Ebonyi state.

The key informants also stated that early marriage and female circumcision are the socio-cultural factors that influence the prevalence of VVF. They (informants) also stated that apart from early marriage, VVF is also linked to early sex, so even if the girl is not married, exposing her to early sex can led to early pregnancy which can lead to VVF

Table 4.2.7 Place where women suffering from VVF delivered

	Frequency	**Percentage**
Hospital	28	7.35
At home	217	56.96
Maternity home	68	17.85
Homes of traditional birth attendants	68	17.85
Total	**381**	**100**

Source: Field Work, 2017.

Table 4.2.7 showed where women suffering from VVF deliver their babies. 28 respondents representing (7.35%) stated that VVF victim deliver in the hospital, 217 representing (56.96%) stated that VVF victims deliver at home, 68 respondents representing (17.85%) delivered at maternity home, while another 68 respondents representing (17.85%) stated that VVF victim delivered at the homes of traditional birth attendance.

Table 4.2.8 Family background of VVF victims

	Frequency	**Percentage**
Poor family	238	62.47
Average family	87	22.83
Rich family	20	5.25
I don't know	36	9.45
Total	**381**	**100**

Source: Field Work, 2017.

The above table 4.2.8 described the family background of VVF victim. 238 respondents representing (62.47%) affirm that victims are usually from poor families. 87 respondents representing (22.83%) stated that victims are usually from average family. 20 respondents representing (5.25%) stated that victims are rich family while, 36 representing (9.45%) claimed they don't know were victims delivered.

Table 4.2.9 Age at which VVF victim got married

	Frequency	**Percentage**
Below 15 years	83	21.78
Between 15 and 18	271	71.13
Above 18	21	5.51
I don't know	6	1.57
Total	**381**	**100**

Source; field work, 2017

Table 4.2.9 showed the age at which women with VVF usually get married, 83 respondents representing (21.78%) stated that women with VVF usually married below 15 years, 271 respondents representing (71.13%) stated that victims usually married between 15 and 18

years 21 respondents claims victims usually marry when they are above 18 while 6 respondents representing (1.57%) stated they don't know when victims marry.

Key informants especially women and community leaders stated that victims of VVF married early, mostly before the age of 18 and this is in conformity with the responses of women that filled the questionnaire in the local government.

Table 4.2.10 The educational level of husbands of VVF victims

	Frequency	**Percentage**
No formal education	61	16.01
Primary education	199	52.23
Secondary education	87	22.83
Tertiary	28	7.35
Others	6	1.57
Total	**381**	**100**

Source; field work, 2017

Table 4.2.10 showed the educational level of husband of VVF victims. From the above table, 61 respondents representing (16.01%) stated that husband of VVF victims usually have no formal education, 199 respondents representing (52.23%) stated that victims husband usually have primary education, 87 respondents representing (22.83%) stated that victims husband usually have secondary education, 28 respondents representing (7.35%) stated that victims husband usually have tertiary education, while 6 respondents representing (1.57%) claimed that victims husband have other educational qualification.

Table 4.2.11 Social implications of VVF on women

	Frequency	**Percentage**
Prevent siblings of the victims from getting married	103	27.03
Causes stigmatization	171	44.88
Family members are treated as outcast	48	12.60
Family members feel ashamed	59	15.49
Total	**381**	**100**

Source; field work, 2017

Table 4.2.11 showed the social implication of VVF on women, 103 respondents representing (27.03%) stated that VVF prevent siblings of the victims from getting marry as suitors view the health challenge as hereditary, 171 respondents representing (44.88%) stated that VVF causes stigmatization, 48 respondents representing (12.60%) stated that family members of the victims are treated as outcast, while 59 respondents representing (15.49%) stated that family members feel ashamed as a result of the health challenge.

However, the key informants stated that, apart from stigmatization and preventing the siblings of the victims from getting married to suitors from the communities the health condition is seen as hereditary.

Table 4.2.12 How husbands of VVF victims treat them

	Frequency	**Percentage**
They are treated well	67	17.59
Some are divorced by their husbands	172	45.14
Some are abandoned in the hospital by their husbands	103	27.03
I don't know	39	10.24
Total	**381**	**100**

Source; field work, 2017

Table 4.2.12 showed how husband of VVF victims treat them as a result of their health challenge, 67 respondents representing (17.59%) stated that husband treat the victims well,172 respondents representing (45.14%) stated that some divorce their wife as a result of heath challenge, 103 respondents representing (37.03%) stated that some husband abandon their wives in the hospital as soon as they discover the heath challenge, while 39 respondents representing (10.24%) stated that they don't know how husband of VVF victims treat them.

In the view of the respondents apart of from stigmatization, the victims also suffer rejection. According to the key informants, once VVF occur, to any woman often than not, the man, the husband first reject the woman (victim) and after that she (victim) is force to go back to her family. In the views of the informants, the gesture from the family members is usually short lived as the victims is equally rejected because of the unstoppable leakage and smelling of urine. The next thing that naturally followed these two levels of rejection will be for her to reject herself psychologically. So, rejection is one of the social implications of VVF

Table 4.2.13 Relationship between VVF victims and health workers

	Frequency	**Percentage**
Very cordial	93	24.41
Not always cordial	197	51.71
Hostile	61	16.01
I don't know	30	78.74
Total	**381**	**100**

Source; field work, 2017

Table 4.2.13 is on the rating of relationship between VVF victims and health workers. 93 respondents representing (24.41%) stated that the relationship is cordial 197 respondents representing (51.71%) stated that the relationship is not cordial 61 respondents representing (16.01%) stated that the relationship is hostile while 30 representing (78.74%) stated that they don't know.

Table 4.2.14 VVF Victims management strategy

	Frequency	**Percentage**
Taking regular bath	174	45.67
Use deodorants to avoid appalling odour	115	30.18
Use tissues, pads or napkins	89	23.36
I don't know	3	0.79
Total	**381**	**100**

Source: Field work, 2017

Table 4.2.14 shows the management strategy adopted by VVF victims. 174 respondents representing (45.65%) are of the view that taking bath regularly is one of the ways victims manage the health challenge 115 respondents representing (30.18%) stated that the use of

deodorants to avoid appalling odour is a form of management strategy 89 respondents representing (23.36%) state that use of tissues, pads or napkin is another way victims manage the health challenge 3 respondents representing (0.79%) could not state how victims manage the health challenge.

Table 4.2.15 Who takes decision on where to go for treatment

	Frequency	**Percentage**
Patient	42	11.02
Family members	266	69.82
Husband	61	16.01
I don't Know	12	3.15
Total	**381**	**100**

Source; field work, 2017

Table 4.2.15 the above table showed the respondents view on who takes the decision to go for treatment. From the table, 42 respondents representing (11.02%) stated that victims take the decision, 266 respondents representing (69.82%) stated that family members take the decision, while 61 respondents representing (16.01%) affirm that the husband take the decision while 12 representing (3.15%) could not state who takes the decision.

Key informants stated that family members take the decision on where to go for treatment, as in most cases victims are usually sent home by their husbands who put them in the condition the find themselves.

Table 4.2.16 Solution to the problem of VVF?

	Frequency	**Percentage**
Discouraging early marriage	112	29.40
Promoting girl-child education	121	31.76
Sensitizing the general public on the causes of VVF	107	28.08
Discouraging other obnoxious cultural practices against women	41	10.76
Total	**381**	**100**

Source: Field work, 2017.

Table 4.2.16 is on solution to the problem of VVF. From the responses of the respondents, 102 respondents representing (29.40%) stated that one of the solution to the problem of VVF is discouraging early marriage, 121 respondents representing (31.76%) stated that promoting girl child education can serve as solution, 107 respondent representing (28.08) stated that sensitizing the general public on the causes of VVF can be a solution, while 41 respondents representing (10.78%) stated that discouraging other obnoxious cultural practices against women can also serve as solution.

The key informant stated that, among solutions to the prevalence of VVF are that, they should be comprehensive rehabilitation of victims of VVF as they are usually not educated and they have no skills and this is different from the views of the women in the community.

Table 4.2.17 Expected Role of government in the fight against VVF?

	Frequency	**Percentage**
Encouraging delivery in the hospital rather than visiting untrained birth attendants or delivery at home	128	33.60
Sponsoring the treatment of VVF cases as victims are usually poor and cannot afford the cost of treatment	99	25.98
Encouraging women to go for regular medical check-ups	82	21.52
Sanctioning parents who give their underage daughters out for marriage	72	18.90
Total	**381**	**100**

Source: Field Work, 2017

Table 4.2.17 is on the role that the government can play in the fight against VVF, as 128 respondents representing (33.60%) stated that encouraging delivery in the hospital rather than visiting untrained birth attendants or delivery at home can go a long way to fight against VVF, 99 respondents representing (25.98%) stated that government can contribute towards the fight against VVF by sponsoring treatment of VVF cases as victims are usually poor and cannot afford the cost of treatment, 82 respondents representing (21.52%) stated encouraging them to go for medical cheek up can contributed to the fight against VVF, while 72 respondents representing (18.90%) opined that sanctioning parents who give their underage daughters out for marriage by the government can also serve in the fight against VVF.

Key informant stated that the three tiers of government have critical role in the fight against VVF and these role can be done through information dissemination on the danger of VVF and these can be done through formal and informal channels.

4.3 Evaluation of the Study Assumptions

This section of the study discussed and evaluated the main assumption of the study and drew conclusions based on the findings. The study set out with three main assumptions that aimed at establishing that there are socio-cultural factors that influence the prevalence of VVF among women of Ebonyi State. The assumptions are discussed below.

Assumption I

"The prevalence of VVF is more in rural area than in urban areas in Ebonyi state".

This assumption is aimed at identifying whether VVF cases are more in rural areas than in urban areas in the state. The study, thus, selected six local governments from the state. In the selection, three local governments where selected from the rural areas and three from the urban area.

From the findings, it showed that cases of VVF were recorded more in Afikpo north which is a rural area when compared to Abakiliki. According to majority of the respondents (55.38%), Afikpo north recorded high cases of VVF. Some of the victims are farmers who in most times cannot afford the cost of medical care and in some cases cannot access it due to the rural areas where they reside. So with this, assumption no I which stated that prevalence of VVF is common in rural area is hereby accepted.

Assumption II

"There are social cultural factors that influence the occurrence of VVF among women of Ebonyi state".

This assumption seeks to examine if there are socio cultural factors that influence the occurrence of VVF among women of Ebonyi state. The assumption is to find out if really there are socio-cultural factors that are responsible for the cases of VVF.

From the data obtained from the respondents, there are socio-cultural factors that influence the occurrence of VVF among women of Ebonyi state and prominent among them is early

marriage, (79.27) followed by lack of medical care (10.50) female circumcision (5.51) and deliveries by traditional birth attendants (4.72). Second assumption is hereby accepted as there are socio-cultural factors that influence the occurrence of VVF among women of Ebonyi state.

Assumption III

"There are social implications associated with VVF".

This assumption seeks to examine the social implications associated with VVF among women. From the responses of the respondents, VVF has social implications. They include, preventing the siblings of the victims from getting married as suitors view the health challenge as hereditary and as such the fear that the siblings may likely suffer from the same predicament. Other social implication are that the health challenge causes stigmatization, family members are treated as outcast and some members feel ashamed. With these responses, the third assumption that there are social implications associated with VVF is upheld.

4.4 DISCUSSION

The discussion for this study will be based on the questionnaire administered to the women of Ebonyi state selected from the six local governments for the study. the local government are Abakaliki, Ohaukwu, Ezza-south, Ezza-north, Afikpo-north and Ivo. The administration of the questionnaire was done in such that women in both rural and urban areas were given the opportunity to air their views. This means that, the opinions of the entire women in the study areas were sought and obtained. All the women were given the same sets of questionnaire and were expected to respond to them. Discussion will be done following he research questions. The questionnaire had 23 questions which all centred on the research questions. Questions 1-7 address research question one, which is on rate of prevalence of VVF among women of Ebonyi State. Question 8-13 addressed research question two, which is on socio-cultural factors influencing the prevalence of VVF among women of Ebonyi State. Questions 14-17 addressed research question three, which is on social implication of VVF on victims. Question 18 -21 addressed research question four, which is on management strategies for VVF victims, while question 22 and23 addressed research question five, which is on possible solutions to the problem of VVF.

In addressing research question one, respondents' responses to the question showed that indeed the prevalence of VVF in Ebonyi State is high, as majority of the respondents stated that they are aware of the health challenge called VVF, some also stated that they know one or two persons suffering from the health challenge. It was also discovered from the respondents that the local government with the high rate of prevalence in the state is Afikpo North as majority of respondents stated the point. The question on what VVF is called shows that some respondents stated, that it is called 'Mgba Pia Akpa Maniri', while other respondents said, it is called Oria Akpa Mamiri, and some said they don't know what it is

called in their locality. Some respondents stated that the victims they know got the health challenge during their 1st pregnancy while others said victims got VVF during their second and 3rd pregnancies. Some respondents also stated that some of the VVF victims can be identified as they usually look dejected, others said they can be identified with their wet clothes and sober look.

Respondents also responded to the question on socio-cultural factors influencing the prevalence of VVF. Majority affirm that indeed, there are socio-cultural factors that influence the prevalence of VVF among women of Ebonyi State. Many respondents stated that early marriage is the common socio-cultural factors that influence the prevalence of VVF in Ebonyi State. Others are female circumcision, lack of medical care, and Activities of Traditional Birth Attendants. Some of the respondents also stated that women who had VVF usually delivered at home. Few of the respondents affirmed that victims of VVF are usually from poor family. It was recorded that victims of VVF got married between the ages of 15-18. This shows that early married is indeed one of the factors that contribute to the cares of VVF among women of Ebonyi State and this correlate with the study of Amadu (2016) Shehu, (1992) and Owo, (1994) that there tend to be a relationship between age of marriage and development of VVF. For the educational level of the husbands of VVF victims, majority of the respondents affirmed that primary education is their highest educational level and this shows that ignorance could be a factor that also contribute to development of VVF. Respondents stated that among the social implication of VVF is that it causes stigmatization some respondents stated that it prevents siblings of the victims from getting married. This also corresponds with the research findings of Fasakin (2007) which states that in as much as women live with VVF condition, they face problem of stigmatization in the society. According to Olaedo (2012), stigma is an attribute an individual possess which makes him or her different from others in the category of persons with a desired kind. Other social

implications the study identified that some of the victims are usually divorce by their husbands who put them in the condition some respondents attest to this. Few respondents states that some of the women are abandon in the hospital once their husbands are aware that they have the health challenge. This also shows that ignorance is a factor to considered in VVF cases. Other respondents stated that the relationship between VVF victims and health workers are usually not cordial and this adds to the social implications victim pass through.

In the area of management of the health challenge. Some respondents stated that taking regular birth by victims is one of the management strategies other respondents stated use of deodorants, tissues, and pads or Napkin, as management strategies. Also in the area of management of the health challenge, many of the respondents stated that it is usually family members of the victim that takes decision on where and when to go for treatment. Only few respondents confirm that husband takes such decision. This shows that the level of involvement of husband in the management of the health challenge is very low.

Among the solutions, some respondents stated that promoting Girl-Child Education is one of the solutions of VVF. While other respondents states discouraging early marriage, sensitizing the general public on the causes of VVF can also serve as solution to the problem. very few respondents stated discouraging obnoxious cultural practice against women as solution.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter aim at summarizing the whole work, conclude and make recommendations. The recommendation is based on the research findings and covers both the short term and long term measures that are needed to ameliorate any observed challenges arising from the findings.

The short-term measures shall serve as cosmetic solution meant to bring about immediate changes, while those of long-term shall be guided by the theoretical frame work adopted for the study and meant to bring about fundamental changes that should permanently lead to a resolution of the challenges.

5.1 Summary

This is a community based research which seeks to highlight the socio-cultural factors influencing the prevalence of Vesico Vaginal Fistula among women of Ebonyi state of Nigeria. The questionnaire printed and distributed were 400 but 381 was used for the analysis. The 400 questionnaires were distributed to the key informants selected for the study. The key informants are medical workers, relations of VVF victims and community, religious and women leaders. The medical workers were mainly those who contribute to the management of VVF cases, they are those who play key roles in the treatment of the health challenges and they are medical doctors, nurses, physiotherapists, pharmacists and medical social workers. They were located within the National Obstetric Fistula Centre, Abakiliki, Ebonyi State. They were administered with the same questions given to the relations of VVF patients and community leader.

The relations of VVF were located within the National Obstetric Fistula centre in Ebonyi state. Relatives were parents, husbands, sisters, brothers, cousins, and so on.

Community, religious and women leaders were located within the six local government mapped out for the study. These local governments are Abakiliki, Ohaukwu, Ezza South, Ezza North, Afikpo North and Ivo. The selection of these local government were because they represent the zones in Ebonyi state. The zones are Ebonyi north, Ebonyi south and Ebonyi central. Just like all the states in Nigeria have three senatorial zones, Ebonyi state also has three senatorial zones. Two local governments were selected from the three senatorial zones for the work. In Ebonyi north, Abakiliki and Ohaukwu were chosen, Ebonyi central Ezza south and Ezza North were chosen while in Ebonyi central Afikpo and Ivo were selected. So all the 13 local governments in Ebonyi state were grouped into three and from the group, 6 local government were selected. So the community, women and religious leaders in these local government were administered with the questionnaire.

The finding of the research showed that they are socio-cultural factors influencing the prevalence of VVF among women of Ebonyi state and these factors include early marriage, female circumcision and activities of traditional birth attendance. The study also discovered that cases of VVF were common in Ebonyi state and most of the victims are from rural areas of the state. Most cases of VVF are related to lack of knowledge of the problem.

Under the social implications of VVF, it was observed that some people see VVF as a divine punishment or a curse for disloyal or disrespectful behaviour and as such can cause barrenness which leads to stigmatization and disrespect by in-laws and other members of the society. It was also noted that victims suffer inferiority complex and lack of self esteem among peers. Some of the victims are divorced by their husbands, ridiculed by friends and even isolated. The high stigmatization suffered by these women, sometimes cause intense loneliness and shame which can lead to clinical depression and even suicidal thoughts. Among the management strategies, it was observed that taking bath regularly is one of them,

others are the use of tissue or pads, use of deodorants to avoid offensive odour, support from family members, encouraging the public to accept VVF victims and not discriminate against them and encouraging victims to open up to medical workers, go a long way to manage the problem. Solution to the problem on the causes and effects of VVF, abolition of early marriage and female circumcision, promotion of girl-child education and going for medical examination especially when the young girl is pregnant and early treatment when symptoms are observed.

5.3 Conclusion

This study has focused much attention to socio-cultural factors influencing the prevalence of VVF among women of Ebonyi state. VVF is a childbirth injury, usually occurring when a woman is in labour for too long or when delivery is obstructed, and the woman has no access to a caesarean section. She endures internal injuries that leave her inconvenient, tricking urine and sometimes faeces through her vagina.

The findings showed that indeed VVF exist among the women of Ebonyi state and it is for this reason that the federal government established a VVF centre to cater for those who have the problem in the state and other states within the geo-political zones called the southeast. Apart from the federal government, state government equally show concern for those who face the challenge. Non-governmental organisations also play key roles in managing the problem. Some of the non-governmental organisation include Rotary club, Fistula care project. Though they are mainly international organisations, their impact are felt by victims of VVF. They all carry out fistula care works to prevent fistula from occurring, treats and cares for women with fistula, and assists in their rehabilitation and reintegration.

VVF has socio-cultural factors that contribute to the challenge, from the findings of this work, the socio-cultural factors has a lot to do with the tradition of the people.

Tradition generally are established to protect and guide humanity. Most traditions are created out of necessity mostly to solve a quagmire and prevent such from happening again. However, as times changes, many traditions become obsolete and have no relevance in the modern day. Some of these traditions such as early marriage of the girl child, female circumcision have severe health implication and one of the implication is VVF, which this study has established. The findings showed that victims suffer stigmatization as a result of the health challenge and prominent among them are stigmatization of victims and the treatment of victims as outcast. Furthermore, research showed that some women who develop VVF do not even have knowledge of the problem. The study concluded that solution to the problem should include sensitization of the people on the dangers of VVF, abolition of early marriage and female circumcision, problem of girl-child education, going for medical examination when a young girl is pregnant and early treatment of signs and symptoms of VVF.

Furthermore, the study concluded that socio-cultural factor such as early marriage, activities of traditional birth attendance and female circumcision influence the prevalence of VVF among the women of Ebonyi state and as such there is need to re-visit some of these cultural practices as they do not contribute positively to the lives of women.

Modern cultures and advanced research have proved some age long cultural practices like early marriage of the girl-child, discrimination of women on the basis of gender and female circumcision are no more useful and should be abolished. Traditions and cultures can be beautiful. However, when some of them have no place in the modern day society and causes health problem like VVF or even places one human being over another, such tradition or culture should be taken out completely.

5.3 RECOMMENDATIONS

Government at federal, state and local government levels should take the responsibility of treatment of VVF patients. This should be free to enable those who are poor to get treatment.

If this is done, it will further boast access to reproduce health services which is currently being encouraged by United Nations.

Treatment of VVF patient should be taken seriously as the problem is increasing. More VVF centres should be established at the Local Government level to take care of those residing in the village. This will compliment the efforts of the existing ones.

Experts should be trained to handle VVF cases since not all hospitals and medical personnel have the competence to handle VVF cases.

The above recommendations can serve as short term measures to bring about changes in the situation. However, for long term solution, the following recommendations are made:

1. The prevalence of VVF among women should be checked consistently by the government especially state government to know when the prevalence increases. This can be done through periodical checks and the sponsor of researches that centre on maternal mortality, collaboration can also be made with non-governmental agencies especially those into health care services like Global 2000, Gimmy Cater and Glown. From the findings of this work, the prevalence of VVF among Ebonyi women is high and this shows the need to look into the needs of the victims and help reduce the health challenge in rural communities. People should be encouraged to report cases of VVF to the hospitals and knowledge about the problem should be shared, so that those who are ignorant about the health challenge will have more information and knowledge about the problem. If people are aware of the problem, it will help them take decision that will help curtail the health challenge.
2. All socio-cultural factors influencing the prevalence of VVF and places women at disadvantaged position like female circumcision, early marriage, and pregnancy, lack of antenatal care as a result of poverty and cultural practice of seeking for husbands approval before going for antenatal, poorly performed abortion, sexual and domestic

violence such as rape, activities of traditional birth attendants, poverty, illiteracy and quest for social acceptance should be discouraged.

It is a common knowledge that apart from the development of VVF, female circumcision has other devastating effects on the victims. The effects include haemorrhage, sexual pain, shock which manifest as psychological effects and damage to the Urethra. Female circumcision has gain wide attraction in recent times and it suffices therefore to state categorically that these unfortunate cultural practices especially against women and children should be stopped as it is medically and socially dangerous to the life of the victim.

Early marriage and pregnancy should also be discouraged. Just like circumcision, it also has negative effects on the girl-child. Among the social and health effects of early marriage and pregnancies are that, it prevents a female child from completing her education and getting a good job in future and contribute her quota to the development of the society. Medically, children born by teenage mothers are likely to die than children born to women. So, there is need to end early marriage and teenage pregnancy because of it's health implication which includes the development of VVF.

Activities of traditional birth attendants should also be checked as the untrained ones expose women to danger. One of the dangers is the development of VVF.

3. It is now established that there are social implication of some health challenges of which VVF victims also suffer. Because of the social implication, there is need for public enlightenment. The social implication manifest because some people see VVF as a divine punishment. Other groups see the health challenge as a curse from ancestors. For this, VVF victims are stigmatized and disrespectful by in-laws and other members of the society. As a result of this, victims suffer inferiority complex and lack self esteem among peers. Other social implication are that, it leads to isolation of

victims because of offensive odour, family members feels ashamed and are treated as outcast and it prevents other female siblings of the victim from getting married as it is believed that VVF is heredity.

All these social implications can be overcome by public enlightenment. People should be encouraged to see VVF patients as normal human beings who are facing health challenge as any other patient and should not be discriminated against or isolated. Respect should be accorded to the siblings of the victim.

4. There is need for the government to map out strategies to curtail the problem of VVF in our society. The management strategies should be encouraged. The management strategies can take the form of taking regular bath, use of tissues, pads or napkins, use of deodorants to avoid unappealing odour. There is also need to show love and general support from family members, encouraging the public to accept VVF victims and not discriminate against them.

   Government especially at the local level should encourage victims to open up to medical workers, senior family members, religious leaders and other respected and trained members of society. If the above management strategies are adopted and encouraged, it will go a long way to contribute to the effective management of VVF challenge.

5. The possible solution for the problem of VVF among women lies with both the government and other individual members of the society. With this, it will not be wrong to state that sensitization of the general public on the causes and effects of VVF should be taken seriously. There is need for the abolition of early and female circumcision. The promotion of girl-child education should be taken seriously. The use of girl-child is now a global issue because of the social benefits of it. The social benefits from female education includes, being better informed on issues that affects

them, such as marriage, reproduction, and others. When female are educated, they make meaningful contributions to the development of the society. The promotion of girl-child education will go a long way to impact on their lives, positively. There is also need to encouraged regular medical examination and check up. Early dictation of any health challenge leads to proper management and VVF is not an exception. Early treatment when signs and symptoms are observed go a long way to help victims of VVF live a normal life again.

There is need to discourage home delivery. Whatever be the reason for a woman to deliver at home it must be discouraged by all as the practice puts the live of the womn and child at risk and such woman, especially those in the rural areas should be encouraged to always go to the hospitals anytime they are due for delivery, so that competent hands can make sure they are safe during and after delivery. Creating awareness will go a long way to encourage women on the need to visit any health centre around their locality for medical help rather than home delivery or self medication.

In the long run, there is need for government at the federal, state and local levels to tackle the issue of corruption, as it is a major factor that cannot be neglected when addressing women health or health issues generally. Poverty is at the centre of some of the issues raised in this work. The issue of early marriage can be viewed from that perspective. Who are those likely to encourage or give their daughters hands in marriage, they are likely to be poor parents. The same is possible with those who may not go to the hospitals for check up or delivery. They are likely to be poor rural women who may not be able to afford the cost of medical care.

When poverty is addressed, it will lead to improved living standard which is an antidote to health challenges. Poverty apart from being a social problem, affects the

lives of the people negatively. Even the cultural practices like female genital mutilation is common among the rural poor as children of the rich are usually exempted from such practices. So government need to address poverty, so that the problem of inequality will be addressed.

Finally, the government both at the federal, state, and local levels should be determined to change the orientation of its policies and bring rural women into consideration in policy making and planning process and in current or future development programmes and projects.

Contribution of the Study to Field of Knowledge

This study has made several contributions to the field of knowledge. The study has brought to fore the socio-cultural factors that influence the prevalence of Vesico Vaginal Fistula among women especially in rural areas. It is generally believed that the causes of some health challenges are purely medical and this has made people to always seek for medical solutions, ignoring the socio-cultural factors. A health challenge like VVF has socio-cultural factors that influence it's occurrence. The contribution of this work to knowledge is the identification of those socio-cultural factors that influence the occurrence of a health challenge like VVF. Socio-cultural factors like the belief system of the people which to a large extent determine how they live their lives and what happens to them as a people. Disciplines like medicines are no more seen as an isolated field of study but as globally now that people are discussing issues from multi-disciplinary perspective. So this work is a contribution to the field of medicine and sociology, in the field of medicine, medical doctors can learn more about the culture of their patients and know those socio-cultural factors that can influence the occurrence of health challenge like VVF. This will further enhance their performance as health providers as they will be able to provide holistic health care services which goes beyond the patients health care to his psychological, spiritual and social wellbeing.

To sociologists, it will enable them know the role to play in the health sector. It helps sociologists to use their knowledge of peoples' cultures to know how it affects them positively or negatively,

Secondly, this work is a contribution to knowledge as it is a common knowledge that developing countries of the world are faced with so many health problems such as infant and maternal mortality, sexually transmitted diseases (STDs), high dependency ratio, over population, unwanted pregnancies and complications from child birth among others. All these problems have cultural undertones, there are some cultural practices that contribute to these problems. A work of this nature exposes those cultural areas that contribute to the health problems.

Finally, this study has brought to fore the relationship between health, behaviour and social variables.

References

Abaha, U. (1984*). VVF And its Prevention:* Warri Delta Press

Abu, M. (2017). Behavioral Aspects of Health and Illness. Daily Asset, Monday September 25, page 23.

Adamu, A. (2016). Struggle for equality: Kano: Qidly Press.

Adebanjo, O. (1992). *The Dilemma of VVF:* Ibadan Ambassadors Press

Ademola Z. (1985). Women in Nigeria: Kaduna: Zadan Publication.

Ademola A. (1998). *Introduction to Sociology:* Lagos: University Press.

Adeoye, N., Adelarati, W., Ikotu O. (2012). Violence Against Women in Nigeria: Amana Books.

Afolabi, A. (2013). Studies in feminism: Ilorin Swan press.

Africa Chater on Human and People's Right (ACHPR), (2002).

Agbo, A. (2001). *The Socio-Cultural factors affecting health care delivery in Nigeria.* Journal of tropical medicine.

Ajie, A (2006). The Chenyong Socio-economic Role of Women in Nigeria: Jos: University Press.

Ake, C (1991). *A political Economy of Africa:* New York, Long man press.

Akindele, (2014), *Adolescence and the Crisis Of Hope:* Ibadan Milan Press

Aleng, H. (2006). *"Principles of Control of diseases, Epidemiology and Immunology"*: Takum; Halson Communication

Alubo, S. O. (2010). *"In Sickness and in Health":* Issues in the Sociology of Health in Nigeria Inaugural Lecture series 41 University of Jos, Nigeria

Alubo, S. O. (2012). *Sociology: A concise Introduction:* Jos Ichegum Press.

Alubo, S.O. (2014). *In sickness and in Health:* University of Jos Inaugural Lectures series

Amina, H. (2010) *Vesico Vaginal Fistula in Nigeria:* Extent of the Problem and Strategies for Prevention and Control in B. E. Owumi (ed), Primary Health Care in Nigeria Ibadan: Department of Sociology.

Amiru, U., (2004). *A survey of VVF cases among Hausa women in Sokoto State Nigeria:* a paper presentation at investment conference on women and children in Northern Nigeria. 3rd edition

Andrew, M.H. (1999). *Vesico Vaginal Fistula Associated with Urinary Prolapsed: In British Journal of Obstetric and Gynecology 106:1227-1228.*

Angya, C. A. (2005). *Nigeria Women and the Challenges of HIV/AIDS in Perspective on Violence Against Women Anaya(ED) Makurdi:* Aboki Press.

Ann, (2000). *Bladder-Only Repair of VVF:* Twelve Years Experience In South-Eastern Nigeria: Enugu Eastern Press

Asagba, A (2011). Survey on Harmful Traditional Practices that affects women: Benin: Bright Publication.

Asuwon, H. (1997). *Sociology of Health and Illness:* Calabar Ezton Press

Atemie, J. D. (1999). *Nigerian Socio-Cultural Heritage*: Port Harcourt; Amelthyiest publishers.

Awom, (2011). Cultural Diversities in Health and Illness: New Jersey River Books

Awolusi, J. O. (2009) *Vesico Vaginal Fistula in Nigeria*: in H. O. Ekeh (ed) Jornal of Primary Health: Ibadan.

Aziza, R. O. (2009). "*The role of women as catalysts for development of the Niger Delta"* paper presented at the town hall session with women opinion on leader December, 3.

Babatunde B. (2009). Human Ecology and Population Studies: Ibadan: University Press. Bakere, B. (2015) Child *Marriage and Day of the Africa Child in National Mirrow:* Wedding July 1, Age 17

Balogun, S.K (1996). *The VVF Victims:* Ibadan Stirling Horden.

Balogun, S.K. (1997). *Socio-Demographic Trends Among VVF Victims and Early Marriage in Nigeria:.* A Paper Presented at Reproductive Health Workshop Held in Ibadan

BAOBAB for Women's Health Rights (2007)

Beechey, U. (1977*). Law of nature: shaping sex, preference, and family:* United Kingdom: Oxford press

Being of Women in Nigeria": An M.Sc. Thesis Submitted to Institute of Health and Society Linkopings University

Beluonwu, S. (2009). *Sociology for Nurses*: Enugu Tinsel House

Berger, P. and Incleman, T. (1996). *Studies in Sociology of Knowledge:* Toronto: University of Toronto Press.

Bilkisu, L. (2012). *Aspect of Psychological Problems of Vesico Vaginal Fistula:* in a Journal of Gynecology vol. no. 2

Brady, H. (199) . Preventive Care and Allied Health: Kentucky; Alah Publishers

Breje, B (2013). *Women, Power and policy:* Tarana Font press

Brownmiller, B. (1976). *Women in third world development. Kenya*: werr point press

Chiwuzie, O. (1995). *VVF In South East Nigeria*: Enugu Organ Press

Cockerham, W. (2000). Medical Sociology: New Jersey: Prentice-Hall

Connell, C. (1994). Human Sexuality Inadequacy: Mascow Progress press.

Dike (December, 2002). *Reproductive Health Problem:* A paper Presented at National Conference of women in Medicine University of Abuja

Dorsey, C. (2003). A case study of Tradition Attendance in Tanzania: *An unpublished M.Sc thesis submitted to department of public health University of Tanzania.*

Dovenet, D (2012). Documentary on Ebonyi Women.

Dubes, R. (1978). *Man Adapting New Haven:* Yale University Press.

Education Trust fund (2010). *House Journal of education Trust fund vol. 3 & 6*.

Efen Z.C. (2012). *Women Perspective in Reproductive Health* Enugu: Dikon Press.

Egwu, E. (2001). *Plight of Ebonyi Women:* in Tell October 1 pp14

Ejem, O. (2012). *Medical Sociology: A Selective view.* New York free press.

Ejambe, U. (1994). *"A problem Associated with VVF":* A Paper Presented at the National Workshop on Management and Counseling of VVF Patients, June 12-25 at Lifaya Hotel Katsina

Ejambe, U. and Kees, V. (2001). *State of VVF in Nigeria:* Lokoja Heritage Press

Ekene, N. (2009). "Early Marriage: the Causes and Context" *in Asia Pacific Population Journal. Vol* 8 no. 3

Ekene, N. (2014). *The Undeclared War on Women. Enugu*: Crown publishing

Ekene, O. (2011). Conditions of the Girl-Child in Nigeria: Asaba: Bekuo books.

Ekwempu, C. et al (1992). Development of Maternal Mortality in Zaria Areas in Kisekka (Ed) Women's Health Issues in Nigeria (pp 51-55) Zaria: Famaz Publishing Company Limited

Elechi, C. (2007*). Women in Ebonyi State:* Abakelike Kyurba press

Erinosho, O.A. (1982). *Health Planning in Nigeria:* A critique . Nigeria Journal of Anthropology and socisology. Vol 8 September.

Erinosho, O.A. (2006). *Health Sociology:* Abuja: Bulwark consult.

Estrado, O. (2008). *Women and Medicine*: A Study of Social Control London Sky Books

Ezekwesiri, F. (2004). *A Socio-Cultural Analysis of Female Circumcision Among The Igbos's:* Enugu Phillips Publishing

Ezenweaka, B. (1999). *Socio-cultural Factors Associated with maternal in Nigeria*: Awka Jamco Press.

Fabregas, A. (1974). Disease and Social Behavior: An interdisciplinary perspective. Cambridge MIT Press.

Fasakin, G, (2007). "*Vesico Vaginal Fistula and Psychological effect:* an unpublished M.Sc submitted to department of Sociology University of London.

Farok, U. (2011). Feminism and the future of women Calabar: Cedenial press.

Fathalin, B. (1986). Health Seeking Behaviour: London: Stone Books.

Federal Ministry of Health (2010*). "The National Health Policy and Strategy to Achieve Health for all Nigerians":* Abuja Federal Government Press.

Federal Republic of Nigeria Official Gazzete 2007 *Female Circumcision:* Clinical Medical Bulletin 3:33.

Fadize U. (1970). *Culture and Health:* New York Church Hill Books

Fortney, U., et al (1989). *Health Policy for Developing Countries:* UK Madji Books

Fredrick, N. (1940). Theory Construction: New York: Free Press

Fred, E. (1992). *Curtailing Maternal Mortality in Developing Countries:* Tanzania Lyrics Books

Freud, C. (1977). Totem and Taboo. London penguing

Gall, B and Borg, U. (2007). *Women Roles and status in Eight Countries:* New York Wiley books

Garba H. (2012). "*Obstetric Fistula in Africa"; Women Health Issues*: Vol. 6 No. II

Gbefwi, O. B. (2010). *Omi's Public and Community Health Dictionary*: Nassarawa Health Resources

Girigiri, B.K. (2002). *"Economic Institutions in Nigerian in Nigerian Cultural Heritage.* In Anikpo (Ed). Nigerian Cultural Heritage (1-12) Porthercourt

Goffman, E. (1963). "*Presentation of Self in Everyday Life":* Garden City: Anchor Press.

Hadley, F. (1979). *Medical Sociology*: New York Free Press

Halim, G. (March, 2009). *VVF Cases among Hausa Women:* A paper at Seminar on VVF at Amadu Bello University Zaria

Haliru, I. (2012). The place of women in Development Abuja Dominion Press.

Hanloz, U. & Picket, P.(1979). *Medicine under capitalism.* New York: Psodist press

Harrison, H. (1979). Equality in access to medical case: *A review of Nigeria Approach to health promotion. Ife Social Science Review* Vol. 7 No 2

Hartman, H. (1981). *Capitalism, patriarchy and job segregation:* London: George Aken

Hassan, A. (2009). "*Ambulatory Maternal Health Care":* America Public Health Association.

Health Reform Foundation of Nigeria: Nigeria Health Review (2006)

Higher, I. (1998). *"Nigeria Women Battle with VVF"* National Concord, April 3 Page 4

Hillies, B. (2010). The Afro-American Women: Strugles and Images. Washinton: Kannikat press

Hitchecock, U. & Schibert, C (1999). *What is Social Medicine.* New York Milbank memorial fund.

Ibanga, U. (1992). Statistics for Social Science: Jos: Jos University Press.

Ibie I. (2011). "*Women in Development": Abuja Cebo Press*

Igun, U. A. (1988). *Medical Sociology*: Ibadan, Shaneson Press.

Ihejiamaizu, O. (2012) "*Health Communication and Development"*: Ibadan Spectrum Books

Ijele, M.D. (1991). "*Women in Nigeria Co-operative":* Enugu ACENA Published.

Ikwuba, A. (2017). Poverty In Nigeria: In Ode and Ikwuba (eds) Readings in nigeria Contemporary Social Problems (PP: 25-83): Makurdi Ticky Colours Books

Illiyasu, H. L. and Umar, U (2004*) Obstetric Fistula:* The Challenge to Human Rights. *Journal of Obstetric and Gynaecology*.

Ishola, A. (2016). *Counseling in Gender Dimension of Education:* Lagos Shaks Publications

Iorvaa, T. (2013). Socio-cultural Issues and Health Makurdi: Eagle Dove prints

Itayavar, D. (1987). Background to the development of modern Health care services *Journal of Medical science* Vol. 3 no 1.

Itomer, J. and Lerfreshow (1989). "*Health Behaviour":* London: Swiz Press.

Jagger, U and Rosebergs, S. (1984). Women's Health Issues. London: Oxford University Press.

Jike, V. (2001). "Gender Inequality and Institutionalized legitimatization stereotypes in contemporary Nigeria Epoch". *In journal of social studies 4 (1) march 2001.*

Kabir, M. (2003). "*VVF in Nigeria":* Lagos: Mcmillan Press.

Kabiru, L. (2004). "*Campaign to End Fistula":* A Paper Presented at Fistula Forthnight Launch Babbar Ruga Fistual Centre, Katsina, Nigeria 21st February, 2005.

Kachi, A. (2011). "*Qualitative Health Research":* London SAGE

Kamala, U. (2010). "*Early Marriage: Who's Right to Choose?" In Asia Pacific Population Journal* Vol 8 no 3

Kees K. (2006). *Prevalence of* Obstetric *Fistula in Northern Nigeria.* A Report Presented to Federal Ministry of Health.

Kisekke, M.N. (1992) Women's Health Issues in Nigeria, Zaria: Tamaza press

Kli, O. (1990). Social Inequality: Lagos: A-Z press.

Koul, K. (2006). Health behaviour, Illness behaviour, and Sick role Behaviour: New Delhi: Kama Press

Lawson, A. (2009). "*Nursing Research a Qualitative Perspective*": New York, Nursing Press

Learner, P. (1986). Creation of Patriarchy: Britain: Oxford press

Lerfreshow, O. (1989). "*Statistics for Social Science": London: University Press.*

Lesco Press.

Lorapuu, M.A. (2015). *Patriarchal Ideologies and media Access.* Lagos: Bahili and Dalila putingness

Magashi, A. (2004). "*Female Genital Mutilation and our Society":* Retrieved from the Web 28/11/2012. http/www.nigerianmasterweb.compaperfrmes/html.

Makumbi, M. (2006). "*Introduction to Health Education*": 1st Edition Ibadan University Press

Makumbi, M. (2010), "*A New Health Science for Africa*": London Harry Press

Makumbi, U. (2010). Feminist Theologies: West minister: John Knox press

Mazrui, A. (1991). The black woman and the problem of gender: trials Triumphs and challenges, Guardian lecture July 4.

Medscape, A. (2003). *Handbook on Infertility:* London Rigent Press

Mbachukwu. H. (2011). "*Women Status and Fertility in South Eastern Nigeria":* A Comparative Study of some Selected Community. Research report.

Mbah, U. (1996). Socio-cultural Factors Affecting Health Delivery in Nigeria in Journal of Tropical Hygiene, Vol. 80 (11)

Mbah, U. (2006). Gender Perception of Native, Causes and Consequenses of Violence against Women Among Workers in Imo State in *Journal of Social Sciences* vol. 10 (6)

McCharthy, J. and Maina, D. (1992). A Framework for Analyzing the Determinants of Maternal Mortality in Studies in Family Planning, http://www.jsrr.org/journals/popcouncil.htsml retrieved on 26th December, 2017.

McDonnel, M. (2003). Enhancing the status of women U.K: Stone books.

Medscape, V. (2003). "*Sex Education and Women Sexualities*": London Brooks Books

Metiboba, B. (2008). Sociology of Health and Illness: Ilorin: Haco Publishing

Metro, S. (2006) *"Modification of 'O' Connort Techniques for the Treatment of VVF*": Retrieved on 10/3/2013

Mies, M. (1988). Patriarchy and Accumulation on a world scale: women in the International Diversion of Labour: London: zed press

Mitchel, M (1971). Patriarchal Attitude: New York: Stein and day press

Mnkwiguro, V. (1992). State of women in Africa: Nairobi: Heritage press.

Moir, J.C (1997). "*Vesico Vaginal Fistula".* Baslliere Tinda: Caselli: London.

Morgan, M. (1998). "*Cultural Identity and Global Process":* London: BSP Press.

Morolake, O. (2013). Gender Inequality in Nigeria: Ibadan Spectrum books

Muhammed, J.F. (2011). "*Perceived Causes, Prevalence and Effect of Vesico Vaginal Fistula Among Hausa/Fulani Women in Kano":* An M.Sc. Thesis Submitted Institute of Physical Health Education, Ahmadu Bello University, Zaria.

Muhammed, R.H. (1996). "*Facts-Sheets on Safe Motherhood":* Abuja Federal Ministry of Health.

Muhammed, R.H. and Braddack (1996). Federal Ministry of Health, Fact-Sheets on State Motherhood in Nigeria.

Muhammed, M. (2014). *Prevalence of VVF Among Hausa Women:* Unpublished BSc. Project University of Jos.

Muhammed, N. (2010). *A handbook On Genecology:* Kano Millan press

Munabi, B. and Sebwalu, S. (2011). *"Introduction to Basic Health Issue*": Ibadan: University Press

Mustapher, M. (2010). *Causes of Maternal Mortality in Nigeria:* Zaria Heritage Press

National Concord: (1998). "*Nigerian Women Battle VVF",* April 3.

Nigeria Health Review (2006). Health Reform Foundation of Nigeria.

National Demographic Health Survey (2008).

National Demographic Health Survey 2013.

National Population Commission 2008 Nigeria Demographic and Health Survey Abuja

Nehis, J. and Salman, U (2005). "The Management of Gynecological Fistula*": In Journal of Obstetrics and Gynecology Vol. (2).*

Njoku, A. (2011). The Under-development of Health or health of under-development. An analysis of the distribution in Nigeria. In *Journal of Health Science* Vol. 4 (1)

Njoku, U.C. (2012). *"Perception of Women About the Effects of Vesico Vaginal Fistula on their Health in Ebonyi State":.* An M.Sc. Thesis, Submitted to Department of Physical and Health Education ABU, Zaira.

Nnachi, U. (2012). *Principal elements of traditional Igbo role in African Symbols, proverbs and myths.* New York: Long publishing.

Nnachi, C.O. (2007). *"Female Circumcision in Igbo Land Nigeria".* Daily Tribune, June 19.

Nosike, A (1996). Violence against women and Sustainable Development: A Contemporary perspective in Y. Orumman (ed) Women Development and the Nigerian Environment Ibadan: Vintape press.

Nsofor, J. U. (2013). *Community Development In Nigeria:* Makurdi Staris Communication

Nwamalubia, J. (2010). *Socio-economic and Cultural Conditions of the Girl Child*: Lagos, Lewome Press

Nwodu, N (2006). Fundamentals of Research Methodology Enugu: Snapp Press

Nzeako, B. (1994*). Constrain to Family Planning:* Ibadan University Press

Obi, N. (2011). "*Early Marriage in Eastern Nigeria and the Health Consequences of*

Vesico Vaginal Fistula Among Young Mothers In Gerder & Development" Vol. III No. II

Obi, O. (2013). An Introduction to Medical Anthropology London: Macmillan

Obi, U. (2007). *Primary Healthcare in Nigeria.* Formal circumcision. Ibadan Codalap press.

Obi, U. (2008). Health Levels and Care in Nigeria: Delta Colors press

Ochi, O. (1991). *The Structure of the family: a social institution.*

Odinaka, O. (2007). *A hidden Agenda about Adolescence:* Enugu Oguyi Publishers

Odebiyi, O. (2007). *Socio-cultural factors affecting Health care delivery in Nigeria:* journal of tropical Medicine vol 32 no 4

Offoma, H. (2002). *"Primary Health Care For Sustainable Development":* Abuja Onge Press.

Ogedo, M. (2012). Women as social workers: Benin: J.H Books.

Ogbueshi, U. (2006). Women and the Where. Kano Continental Press.

Oghito, O. (2007). "*VVF and Women"*: Ibadan: Lagos Press.

Ogunbameru, O. (2008). "*Sociological Theory".* Ibadan: Penthouse Press

Ogunlade, O. (2010). Cultural Hindrances Imposed on Women: A Paper Presented on Women Conference in Ibadan, 13th October.

Ojie, A. E (2009). The problem of early childhood marriage: A Study of Ndokwa people of Delta State of Nigeria. *Benue Journal of Gender Studies, Series* Vol. I June. 11-17

Okeke, E. (2009). "*Health in Rural Areas": Enugu*: Forth Foundation Press

Okenwa, Z. (2010). "*Overcoming Women Subordination":* Enugu: Snap Press

Okolo C. And Baba A.T. (2010). *"Causative Factors of Vesico Vaginal Fistula"* A Paper Presented at 15th Annual Conference of NASA Ahmadu Bello University, Zaria April 6th-8th.

Okolo, V. (2012).Aspects of Traditional Practices and their Implications for the Development of Women in *Journal of Medical Science,* Vol. 9 (4) Enugu

Okoye, J. (2010). *"Female Circumcision and other Dangerous Practices to Women Health*": Zaria: Tamaza Press

Okoye, U. (2009). Forms of Birth Control: Enugu Celeline Press.

Okpeh, O.O (2007), Patriachy, Women's Quest for Political Leadership in Gender, power and politics in Nigeria: Makurdi: Aboki publishers.

Olabisi, S. (2009). Sociology: An Introduction Lagos Sury press

Olaedo, O. (2014). Discriminating Practical from Time Immemorial. Makurdi: Kings Publishing

Olajide,A. (2013). *Sexual Abuse Among Young Girls:* Unpublished Masters Thesis University of Jos

Olikaeze, N. (2009). "*Essay on Women in Development"*: Delhi: Oxford Press

Omenka, N. (2011). "*Traditional Medicine and Health Care in Nigeria":* Ibadan: Longman.

Omoregbe and Agbonmifo (1994). *"Nigeria Rural Women and the Challenges of Sustainable Development".* The Need to Eliminate Gender imbalance". *Pakistan Journal of Rural Development and Administration* 16 (2) 1-14.

Omu, M. (1981). Hitrogenesis of Modern Medicine and Medicalization: Uganda Satty Press

Onanuju, P. (2008). *Life, women and culture.* Lagos Nigeria: Africa Heritage Research.

Onuoha, H. (2015). *Basic Health Sciences for Teachers and Nurses*: Onitsha Peace Maker Books

Onoge, F.O (1995). "*Capitalism and Public Health in Nigeria"* Ingman; Longman and A. Thomas (ed). Topias and Utopias in Health: The Hargue Mouton: 219-235

Onoge, O. F (1995). Socio-cultural Development and the Gender Question: Ibadan: sibon books

Onuzuluike, M. N. (2006) Issues in Health: Owerri Mc Malians Publication

Onwachukwu, B. (2008) *A Sociology for Medical Practice*: Enugu Abak Press.

Onyegu and Essret, J. (2002). "*Update on Women's Socio-Economic Rights in Nigeria":* Lagos: Shelter Rights Initiative

Orabuchi O. (2014). Women and Development: Enugu Snap Press.

Orabueze, U. (2010). Developing Women's Potential. Lagos: Siki Press

Osaghia, G.V. (2015) A Survey of Patients Satisfaction with Cost of Treatment and Health Facilities in Two Public Hospitals in Benin City South-South Nigeria. *In Journal of sociology, Taraba state University. Vol. 1. No 2 (page 35 to 56)*

Otite, O and Ogionwo, W. (1990). "*An Introduction to Sociological Studies":* Ibadan University press.

Owo, C. (1994). "*Introduction to Sociology": Enugu: Hangs: Publishing*

Parsons, T. (1951). "*The Social System":* United Kingdom Free Press. New York.

Peil, O. (1982). Research Methodology in Social Sciences: Onitsha: Pacific Press.

Picket, P. (1979). *Sociology of Health and Illness:* London Storix Press.

Royshon, O., and Armstrong U. (1989). Maternal Motherly in Nigeria Lops: Station press.

Rumum, A. (2014). Understanding Sociology of health and Illness: An Introduction: Markudi: !A bee ventures.

Ritzer, G. (2006). "*Sociology Theory":* 7th Edition New York: Mc Graw Press.

Shar, U. (2008). Feminist perspective on power: London Stanford books.

Shehu, N. (1992). *Reproductive Health Problem:* Kano Samiu Press

Speber, U. (1973). *Whoslestic Health Care in Africa.* New York Gee press.

Spector, B. (2004), "*Medical Care in Developing Countries*": ZACON: India.

Studies": Heinemann Books: Ibadan.

Starrs, S. (1987). Concept of Health Status: New York: Norton Press.

Storis, U. (1987). *The Health Of Nations:* Monrovia Erikson Books

Sukuji (2013). "*Prevalence of VVF in Nigeria":* Abuja Sunrise Press.

Tahzid, F. (1989). "*VVF in Nigeria":* Carnage Foundation New York.

Tahzid, F. (2003). "*Social Factors in the Etiology of VVF in Women And the Family in Nigeria":* CODESRIA: Dakar.

Tahzid, F. (1981). *VVF and Its Health Consequences:* Zaria Hakima Press

Thomas, S. (1987). *Female Genital Mutilation in Anaeyo A E. (ed) Primary Health Care In Nigeria:* University of Ibadan.

Todaro, A. (1982). *"Economic Development*": London: London Press.

Uchem, R. (2001). Overcoming women's subordinations: An Igbo African and Christian perspective: Envisioning and Inclusive Theology with preference to women: Enugu: Snaap Press

Ugbem, C. E. (2017). *Illitracy as A Social Problem in Nigeria in Ode and Ikwuba (Eds) Readings in Nigeria Contemporary Social Problems (pp: 384-399):* Makurdi Ticky Colours Books

Ugwu, O. (2012). Gender and power in Nigeria: Oweri Bilten book.

Ugwumba, V. (2008) *"Primary Health Care Practice in Nigeria":* Ibadan Macmillan Press.

Umar, M. (2004). *A guide To Family Planning:* Illorin Serks Publishing

Unachukwu, V. (2002). "*Obstetric Fistula":* New York: Springer Verlag.

UNFPA (2005). *"State of the World's Population"*: Retrieved from the Web 20/07/ 2013

UNICEF (2005). *"Situation Assessment and Analysis of Women's Rights in Nigeria":* A Wake up call UNICEF (2007). Technical Report Series 711

UNIFPA (2006). African Medicine Report. Geneva.

United Nations Children Education Funds (2016). Development in Africa: Trends, problem and prospects.

United National Development Programme (2003). Q & A on the Fistula Fortnight 21st-6th March, Ebonyi Nigeria.

United Nations (2016): The state of the world's Children: Oxford and New York: Oxford University Press.

United Nations (2010). Facts Sheet on VVF

United Nations Population Funds UNFPA (2017) 39,000 Child Marriages hold every day New Telegraph Friday May 12, 2017.

United Nations Population Fund (2014) Report on Female Genital Mutilation (FGM).

Utulu, R.E (2009). The Impact of harmful traditional practices on the Educational development of the Girl-Child in Nigeria. Benue *Journal of Gender Studies, series* Vol. 1 June. B5 – 45.

Utulu, R.E. (2001). "*The Psycho-Social Burden of the Girl-Child in Nigeria". University Press: Ibadan.*

Uzeogbunam, S. (2005). "*Victims Management and Counseling of VVF*": Paper Presentation of the National Workshop Management of VVF patient. National Hospital Abuja, June 22 -25

Valley, (2006). Culture and Health: New York: Church Hill

Welto, V. (1987). Improving Women's Access to Health: Magazine p.4.

W. H. O. (1978). "*The Promotion and Development of Traditional Medicine".* Geneva. Technical Report Series, No. 622

W.H.O (2011). Obstetric Fistula- A Review of Available Information.

W.H.O (2006). *"A Traditional Practice that Threatens Health and*

W.H.O (2011). *"Women's Health in South-East Asia Report: Geneva*

W.H.O. (2006). "*Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development":* WHO Press Geneva.

W.H.O. (2006). Challenging Health Services, Technical Report Series 809 Geneva.

Wall, L. (1998). *"*Dead Mothers and Injured Wives: The Social Context of Maternal Mortality Among the Hausa of Northern Nigeria". *Studies in Family Planning Vol. 29 (4): 341-359.*

Walker, U. et al (1985). Medicine and Environment Australia: Paris Press

Wall, L. et al (2003). *Women's Health:* London Pacific Books

Wall, L. (2003). *Religion and Health Care:* Tanawa puppet books.

Weah, S. F. (2013). *"Beginning Anthropology*": Jos University Printing Press.

Welbay, A. (1990). Socio-economic values in fertility Behaviour of Nigerians: *Social science Journal.* Vol. 4 no 27

Welto, U. (1987). The Sociology Of Health And Illness: New York Random Books

Wilson, R. N. (1970). *The Sociology of Health*: An Introduction of New York: Random Press.

Wilson, R.N. (1970). "*The Sociology of Health":* An Introduction: Random House New York.

Wilson, U. (2007). *Models of Health socking behaviour:* Zaria Medision Press

World Bank (1995). *Assessment Report on Poverty in Africa.*

World Bank (1995). *Technical Report on Poverty rate among women and children in Africa.*

World Bank (2010). Assessment of Quality in Medical Education.

World Health Organization (2013). *Assessment Report on women and Children in Africa.*

Zacharin, C. (1988). "*Obstetric Fistula"*: New York. Ferguson Books.

Zacharin, U (2005). Toward an Anthropology of women. New York: Monthly Review Press

APPENDIX I

DEPARTMENT OF SOCIOLOGY
BENUE STATE UNIVERSITY, MARKUDI, NIGERIA

INFLUENCE OF VVF QUESTIONNAIRE (IVQ)

Dear Respondent,

This questionnaire is designed to investigate the Influence of Socio-cultural Factors on the Prevalence of VVF on Women of Ebonyi State, Nigeria. Please react to the following items by ticking against the option that best represent your view about the socio-cultural practices/factors that influence the prevalence of VVF in the state. Note that this is not a test and no option is right or wrong. Much depends on your honest responses and such responses will only be used for research purposes. To further assure you of confidentiality, you need not write your name. Please read the instruction carefully before completing the questionnaire.

SECTION A: Demographic Data

Age: (a) 15 – 19 ☐ (b) 20 – 24 ☐ (c) 25 – 29 ☐ d) 30 – 34 ☐ (e) 35 – 39 ☐

(f) 40 – 44 ☐ (g) 45 – 49 ☐ (h) 50 – above ☐

Marital Status: (a) Single ☐ (b) Married ☐ (c) Divorced/Separated ☐ d) Widow ☐

Educational Level: (a) No formal education ☐ (b) Primary Education ☐

(c) Secondary education ☐ d) Tertiary ☐ (e) Others:……

Occupation: (a) Farming ☐ (b) Business/Trading ☐ (c) Civil Servant ☐

(d) Housewife ☐ (e) Student ☐

Religion: (a) Christian ☐ (b) Muslim ☐ (c) Traditionalist ☐

SECTION B:Questions on VVF

1. Are you aware of the health condition called VVF? (a) Yes ☐ b) No ☐
   (c) I don't know ☐
2. Do you know anybody suffering from the health challenge? (a) Yes ☐ (b) No ☐
   (c) I don't know ☐
3. In which of the local government is the person from? _____
   _____
4. hat is VVF called in your community? _____
5. How many VVF patients do you know? (a) One ☐ b) Two ☐) Three ☐
   (d) Four ☐ (e) Five ☐ (f) None ☐
6. At what point did the VVF patient you know developed the health condition?
   (a) First pregnancy ☐ (b) Second Pregnancy ☐ (c) Third pregnancy ☐
   (d) Fourth pregnancy ☐ (e) I don't know ☐
7. How do you identify somebody with VVF in your community? (a) Smell of urine
   (b) Looking dejected ☐ (c) Wet clothes ☐ d) Sober looking ☐
8. Do you think there are socio-cultural factors influencing the prevalence of VVF?
   (a) Yes ☐ (b) No ☐ (c) I don't know ☐
9. If yes, what are the socio-cultural factors? (a) Female circumcision ☐ (b) Early marriage ☐ (c) Activities of traditional birth attendants ☐ (d) Lack of medical care ☐
10. Where do you think women suffering from this health challenge delivered?
    (a) Hospital ☐ (b) At home ☐ (c) Maternity home ☐ (d) Homes of Traditional birth attendants ☐
11. How would you describe the family background of VVF patients?
(a) Poor family ☐ (b) Average family ☐ c) Rich family ☐ (d) I don't know ☐
12. What age do you think women with this health condition got married?
    (a) Below 15 years ☐ (b) Between 15 & 18 ☐ (c) Above 18 ☐ (d) I don't know ☐

13. What do you think is the educational level of the husbands of the VVF victims?

(a) No formal education (b) Primary education (c) Secondary education (d) Tertiary (e) Others (Specify):_____

14. Do you think there are social implications of VVF on women?

(a) Yes ☐ (b) No ☐ (c) I don't know ☐

15. If yes, what do you think are the socio-cultural implications?

(a) Prevent siblings of the victims from getting married ☐

(b) Causes stigmatization ☐

(c) Family members are treated as outcast ☐

(d) family members feel ashamed ☐

16. How do you think husbands of VVF patients treat them?

(a) They are treated well ☐

(b) Some are divorced by their husbands ☐

(c) Some are abandoned in the hospital by their husbands ☐

(d) I don't know ☐

17. How will you rate the relationship between VVF victims and health workers?

(a) Very Cordial ☐ (b) Not always cordial ☐ c) Hostile ☐ (d) I don't know ☐

18. How do victims manage the health challenge?

(a) Taking regular birth ☐

(b) Use deodorant to avoid appalling odour ☐

(c) Use tissues, pads or napkins ☐

(d) I don't know ☐

19. Do victims know that VVF is treatable? (a) Yes ☐ b) No ☐

20. Who takes decision where to go for treatment? (a) Patient ☐ (b) Family members ☐

(c) Husband ☐ (d) I don't know ☐

21. In your opinion, what do you think is the solution to the problem of VVF?

(a) Discouraging early marriage ☐

(b) Promoting girl-child education ☐

(c) Sensitizing the general public on the causes of VVF ☐

(d) Discouraging other obnoxious cultural practices against women ☐

22. Do you think government is doing enough in tackling the problem of VVF?

(a) Yes ☐ (b) No ☐ (c) I don't know ☐

23. What role do you think government can play in the fight against VVF?

(a) Encouraging delivery in hospital rather than visiting untrained birth attendants or delivery at home. ☐

(b) Sponsoring free treatment of VVF cases as victims are usually poor and cannot afford the cost of treatment ☐

(c) Encouraging women to go for regular medical check-ups. ☐

(d) Sanctioning parents who give their underage daughters out for marriage. ☐

Thank You.

APPENDIX II

Interview Schedule

1. Are you aware of the Health Conditions called VVF?
2. Do you know anybody Suffering from the Health Challenge?
3. In which Local Government is the Person from?
4. What is VVF called in such Community?
5. At what point do you think the VVF victims developed the Health Condition?
6. What are the socio-cultural factors you think influence the Prevalence of VVF?
7. At what age do you think women with the Health Condition got Married?
8. Do you think there are Social Implications of VVF on women?
9. How do you think Husbands of VVF Patients Treat them?
10. Who takes the decision where to go for Treatment?
11. In your opinion, what do you think is the Solution to the Problem of VVF?
12. What Role do you think Government Can Play in the Fight Against VVF?