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Influence of Social Support and Health Locus of Control on Quality of Life among Fistula Patients in Ebonyi State, Nigeria

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ABSTRACT: This study assessed the level of quality of life of obstetric fistula patients and appraised the influence of social support and quality of life of obstetric fistula patients. It also, examined the influence of health locus of control on quality of life of fistula patients and assessed the influence of fistula types on quality of life of fistula patients in Nigeria. These were with the view to determining factors that influence the quality of life of obstetric fistula patients in Nigeria. Primary data were used in the study. The data were collected from fistula patients in Nigeria. A sample size of one hundred and sixty-four participants were selected through purposive sampling technique being a definite population. Three standardized scales were used for data collection. These are; Multidimension Perceived Social Support Scale (MPSSS), Multidimensional Health Locus of Control Scale (MHLCS) and World Health Organisation Quality of Life-BREF (WHOQOL-BREF). Data collected were subjected to percentile, Pearson Moment Correlation, multiple regression and independent sample-test. The results of the analysis revealed that majority (75%) of the fistula patients reported average quality of life. It also showed that there was statistically significant positive relationship between social support and quality of life of fistula patients in Nigeria ($r = 0.47$, $p<0.05$). It further showed that heath locus of control significantly predicted quality of life of fistula patients $F(4,149) = 18.061$, $p < 0.05$. Furthermore, the results revealed that there is no significant difference in the mean score of the vesico-vaginal fistula ($\bar{x}$ =49.39, SD = 8,30) with those of recto-vaginal fistula ($\bar{x}$ = 50.95, SD = 7.59) patients in terms of their quality of life ($t = -1.123$, $p>0.05$). The study concluded that social support and health locus of control were factors that influenced the quality of life of fistula patients in Nigeria.

Keywords: Fistula, Health Locus of Control, Quality of life and Social Support
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INTRODUCTION

Globally, over two million women are estimated to be living with fistula and majority of whom are in Sub-Saharan Africa and South Asia (Kelly & Kwast, 1993). The reported incidence of fistula patients in West Africa ranges between 1-4 per 1000 deliveries (Ijaiya, 2004; Margolis and Marcer, 2011; Ijaiya, 2002). The World Health Organization (2006) estimates that, in developing countries each year, five million women suffer severe maternal morbidity, obstetric fistula being on the top of the list. It is also estimated that, currently more than two million women are waiting for surgery worldwide and about 50 to 100, 000 new cases are added each year mostly in Africa and Asia (Nawaz, et al 2013). To meet only one of fistula patients is to be profoundly moved; mourning the stillbirth of their only baby, incontinent of their offensiveness and most often spurned by their husbands. They hopelessly bear their sorrows in silent shame with their miseries untreated.

The World Health Organization (2006) identified the following geographic areas where obstetric fistula prevalence is high: virtually all of Africa and South Asia, the less-developed parts of Oceania, Latin America, the Middle East, and remote regions of Central Asia. Fistulas in developing countries are attributed predominantly to

inadvertent bladder injury during pelvic surgery and prolonged labour (90%). In contrast to developing countries, countries that practice modern obstetric have a low rate of obstetric fistula (WHO, 2006). In developed countries on the contrary, wall (2011) reported that fistula is related to Gynecologic surgery or radiation therapy. In the year 2005, more than 500, 000 women died globally as a result of complication from pregnancy and childbirth (Nigerian Urban and Reproductive Health Intiative, 2014).

Fistula has far-reaching physical, social, economic, and psychological consequences for the women afflicted (Aboyeji, et al 2007). On note, a ureteric injury is identified in association with 10-15% of VVFs (Kochakarn & Pummangura, 2007). Recto-vaginal and Vesico-Vaginal Fistula represents a communication between the vaginal wall and the rectum and/or the urinary bladder.

A potentially determinant of quality of life is locus of control and social support. Locus of control as a determinant of quality of life entails the perception and attribution of factors to quality of life such as: friends, family and chance, while social support as determinant of quality of life entails the support received from members of one's family, friends and significant others on the course of illness or distress.

Statement of the Problem

Much medical attention has been emphasized in the management of fistula, without considerable attention to the highly relevant areas of psychological interventions. The clinical and psychological consequences of this morbidity are also very detrimental to women. This disrepair and demoralizing condition destroy the psychological well-being of the patients and, as such, loses confidence in enjoying a quality of life (Wall, 2011).

Health researchers in related studies (Umoiyoho, et al, 2011; Balogun, 1994; Balogun, 1995; Folashire, et al 2012, Bello, 2006; Murphy, 1981; and Harison, 1983) identified several demographic factors as determinant of quality of life of fistula patients while ignoring the roles of psychosocial factors such as health locus of control and social support as predictors of quality of life of fistula patients. However, there are no similar reviews that have concurrently examined three variables; social support, health locus of locus of control and quality of life together on fistula patients. From the above, there is evidence that there is still a gap in knowledge in relating psychosocial factors such as social support and health locus of control to the quality of life of fistula patients, hence, the study aims to examine the influence of type of fistula, social support and health locus of control on the quality of life of fistula patients in Nigeria.

Research Questions

i. What is the level of quality of life of fistula patients?

ii. What will be the relationship between social support and quality of life of fistula patients?

iii. How will health locus of control predict the quality of life of fistula patients? and

iv. Does the type of fistula influence the patient's quality of life?

Objectives of the Study

The main purpose of this study is to ascertain the quality of life of fistula patients. The specific objectives of this study are to:

i. assess the level of quality of fistula patients in Nigeria;

ii. appraise the relationship between social support and quality of life of fistula patients in the study area;

iii. examine the influence of health locus of control on the quality of life of fistula patients in the study area; and

iv. assess the influence of types of fistula on the quality of life of fistula patients in Nigeria.

Fistula is a medical condition in which a fistula (hole) develops between either the rectum or vagina (Recto-Vaginal Fistula) or between the bladder and vaginal (Vesico-Vaginal Fistula). The condition is due to a prolonged labour causing failed birth, especially when adequate medical care is not available (Tsui, et al 2007). Fistulas are caused by obstructed labour. Labour is obstructed when the fetus does not fit through the birth canal during the second stage of labour. This occurs either because the pelvis is too small, the baby is too large or a malpresentation renders normal obstetric mechanics impossible (Wall, 2011).

Historical understanding of fistula has shown that the condition is not a new phenomenon. As a matter of fact, this condition used to be a common scourge throughout the world. However, Muleta (2006) observed that fistula is almost oblivion in countries where there is universal health care, which takes women's health more seriously. Metro (2006) commented that obstetric fistula resulting in urinary incontinence in developing world countries centres on obstetric difficulties while 90% of such cases are caused by bladder trauma during surgery with hysterectomy.

Cause of Fistula: Just like the classification of fistula, it is also difficult to associate a particular cause to the scourge of fistula around the world. However, the study looks at the problem from both physical and socio-cultural perspectives. The physical causes are referred to as the direct cause, while the socio-cultural causes are termed the underlying or the contributing factor to the problem of fistula.

Physical causes: This relates to particular situations which directly expose young women to the scourge of fistula. One important and predominant cause of fistula is

a prolonged and difficult labour which sometimes last for days before a woman receives an obstetric care or dies. WHO (2006) reported that "if labour remains obstructed, the unrelenting pressure of the baby's head against the pelvis can greatly reduce the flow of blood to the soft tissues surrounding the bladder, vagina and rectum". This situation leaves the pelvic with injury which may rotten away, thus creating a hole or a fistula between the bladder and the urethra.

Socio-cultural cause: the socio-cultural circumstances in which Nigerian women find themselves is a predisposing factor to their poor maternity conditions, hence incidence of fistula. These socio-cultural factors are mostly responsible as the underlying behaviors and conditions that initiate and sustain the affliction of obstetric fistula on its patients. The paramount socio-cultural conditions include, but are not limited to the following: early marriage, harmful traditional birth practices, poverty, and illiteracy.

Early marriage: Girls or teenagers given out in marriage usually have small and narrow pelvis. As a result of this, early introduction to sexual activities in marriage leads to early pregnancy. This causes cephalopelvic disproportion, a condition in which the baby's head or body is too big to fit through the mother's pelvis (Ajuwon, 1997). Since the birth canal is too narrow for the baby to come out, a prolonged and obstructed labour occurs, threatening both the life of the mother and the child. WHO (2006) reported that, "In Ethiopia and Nigeria, for example, over 25% of fistula patients had become pregnant before the age of 15, and over 50% had become pregnant before the age of 18". Age at marriage no doubt affects pregnancy and labour complications among Nigerian women, a likelihood of fistula.

Female Genital Mutilation: Another important underlying factor to the problem of obstetric fistula in Nigeria is the customary birth practices. Most prominent is the female genital mutilation or simply put, female circumcision. For instance, the gishiri cut which is very popular in the Northern part of Nigeria and idabe common in southwestern Nigeria involves the incision of parts of the vagina with razor blade or a large curved knife. The cut is made against the pubic bone, endangering both bladder and urethra. The cuts are often handled by traditional healers or traditional birth attendants to prevent or treat numerous conditions including prolonged obstructed labour, infertility goiter, backaches, dysuria and coital difficulties (Ajuwon, 1997).

Poverty and illiteracy: poverty often plays an important role in predisposing Nigerian women to the problem of fistula. Poverty is linked to illiteracy, malnourishment, living condition, accessibility to good obstetric care and so on. WHO reported that women suffering from fistula come exclusively from poor families with subsistence farming background (WHO, 2006). To this end, small food rations are encouraged for pregnant women.

If and when fistula arises, patients equally find it impossible to afford medical services for repairs (Balogun, 1995). The cost of transporting fistula patients to the hospital, usually in major cities is also unaffordable by the family.

Psycho-Social Consequences of Fistula on Patients: Virtually all the studies into the cases of fistula are conducted from the medical point of view. Treatment, correction, and repair of fistula is possible. However, due to the high cost involved, majority of the fistula patients are unable to afford the cost for the treatment, in this case. By implication, their physical, social and mental conditions worsened.

Social Support

Social support is a human interaction in which social, emotional, tangible/instrumental and recreational resources are exchanged (Cohen & Syme, 1985; Thoits, 1986). Social support includes real or perceived resources provided by others that enable a person to feel cared for, valued, and part of a network of communication and mutual obligation. Social support can be defined and measured in many ways. It can loosely be defined as the feeling that one is cared for by other people. This also includes assistance available from other people, which is part of a supportive social network (Perceived support, Enacted support and Social Integration)**.**

Health Locus of Control

Health Locus of Control developed by Rotter in 1966 refers to an individual's generalized expectations concerning where control over subsequent events resides. It centers on whom or what is responsible for what happens. Rotter's (1966) locus of control formulation classified beliefs concerning who or what influences things along a bipolar dimension from internal to external control. Levenson (1973) offered an alternative theory. Whereas Rotter's conceptualization viewed locus of control as one-dimensional (internal to external), Levenson's model gave three independent dimensions: Internality, Chance, and Powerful

Lefcourt (1976) defined perceived locus of control as a generalized expectancy for internal as opposed to external control of reinforcements. These punishments and rewards in turn shape the way people interpret the results of their own actions. It refers to an individual's generalized expectations concerning where control over subsequent events reside. In other words, who and what are responsible for what happens. It is different from attribution theory.

The Multidimension Health Locus of Control Scale (MHLCS) developed by Wallston, Wallston & Devellis (1978) measure locus of control as a multidimensional construct instead of internality and externality as polar opposites. The MHLCS consists of three scales; one for internal health locus of control (HLC); one for chance health locus of control (CHLC) and the other for the health locus of control by powerful other (PHLC).

Quality of Life

According to the World Health Organization Quality of Life (WHOQOL GROUP, 1998), the quality of life of an individual is defined as an individual's perception of position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (WHOQOL GROUP, 1998). This is a broad ranging concept, affected in a complex way by a person's physical health, psychological state, level of independence, social relationships, and relationship to salient features of their environment (Skevington, Lofty & Connell, 2004). Objectively, quality of life may refer to health status, economic status and environmental quality. Subjectively, quality of life refers to the evaluation of one's status in life relative to one's expectations in life. Within the field of healthcare delivery, quality of life is often regarded in terms of how it is negatively affected, on an individual. In this study, quality of life of fistula patients will be examined using the WHOQOL-BREF (1998).

Rotter's theory of Locus of control: this theory developed from Rotter's (1998) social learning theory. Generally, social learning theory stresses the triadic relationship among "person's" (that is one's cognitive processes), behaviour, and environment through a "reciprocal determinism" or "reciprocal causality" process (Bandura, 1977; Rotter, 1964). In other words, whereas the environment largely determines or causes behaviour, the individual uses cognitive processes to interpret both the environment and his/her behaviour. As a result, she behaves in ways to change the environment and meet with more favourable behaviuoral outcomes.
Locus of control as a concept in Rotter's social learning theory is a belief whose main emphasis is on control (i.e., who determines the outcome or who should be held responsible). Rotter (1966) pointed out that labelling an individual as internal or external is not a reference to a trait or a type. In general, an internal locus of control is associated with optimism and physical health. People with an internal locus of control also tend to be more successful at delaying gratification. Internal or external attribution is also made with respect to other people (is another person personally responsible for a certain event, or is it caused by something beyond his or her control?) A person with chance locus of control will likely attribute events or situations to forces beyond one's control or a supreme being. Folasire, *et al* (2012) used the Rotter's theory while assessing vesico-vaginal fistula and psychosocial wellbeing of women in Nigeria. While using this study, fistula patients will be assessed to ascertain their locus of control whether they attribute the cause of their predicament or ill-health to self, powerful others or chance (fate).

Quality of Life Model

Ryff's model of well-Being: The convergence of numerous frameworks of positive functioning serves as the theoretical foundation that produced a multidimension model of wellbeing (Ryff 1989; Ryff & Keyes 1995). This model consists of six distinct dimensions of positive psychological functioning which encompasses a breath of wellness. The six components that comprise Ryff's model are Self-Acceptance, Positive Relations with Others. Autonomy, Environmental Mastery, Purpose in Life and Personal growth.

Hypotheses

The following hypotheses were stated to guide this study:
1. Social support will have no significant relationship with quality of life among fistula patients
2. Health locus of control will not significantly predict quality of life of fistula patients.
3. Fistula type will have no significant influence on quality of life of fistula patients.

METHODOLOGY

Research Design

The study adopted the descriptive survey design. The independent variables are types of fistula, with two dimensions (vesico-vaginal fistula and recto-vaginal fistula), social support (full support) and health locus of control with four dimensions (internal, external, doctors and chance locus of control) while the dependent variable is Quality of life with four components (physical, psychological, social interaction and environment).

Sample and Sampling Procedure

This study adopted purposive sampling technique and a sample size of 164 patients. The sampling was based on the availability of patients. They were selected using purposive sampling procedure. Patients awaiting

admission for surgical repair at the Fistula Centre in Nigeria. All the patients awaiting admission automatically qualified to participate in the study because of the homogenous nature of their illness.

Research Instrument

The instrument for this study consists of a questionnaire divided into four sections. These are the Socio-demographic Data which is section A of the research instrument. The World Health Organization Quality of life (WHOQOL) BREF Scale is the section B. The Multidimensional Health Locus of Control Scale (MHLCS) which makes the section C while The Multidimensional Scale of Perceived Social Support (MSPSS) is section D of the instrument.

Hypothesis Testing

The first objective of the study was to assess the level of quality of life of obstetrics fistula patients in Ebonyi State.

Table 4.2: Categorization of Quality of Life

Level	Percentage
Low	23(14.56%)
Average	119(75.3%)
High	16(10.13%)

The result suggests that the mean or average score of the fistula patients' quality of life is (X=49.83, Sd=8.10). further observation shows that approximately 23 (14.56%) of total patients reported low quality of life (one standard deviation below the mean). The analysis also shows that 16 (10.13%) of the total patients displayed above average level of quality of life. By implication, it was found that 119 (75.3%) of the total patients reported average quality of life. This result suggests that majority of the fistula patients enjoy normal life quality despite their situation.

Hypothesis One

Social support will have no significant relationship with quality of life of fistula patients

The analysis was done by compiling the patients' composite score on social support and their corresponding scores on quality of life. The scores were subjected to test of relationship using a Pearson Product Moment Correlation (PPMC) at 0.05% level of significance. The results of the analysis are summarized and presented in table 4.3.

Table 4.3: Pearson Product Moment Correlation analysis on the relationship between social support and quality of life

Variables	N		SD	df	r	p-val
Social support	158	51.63	8.68	156	0.471	0.0001
Quality of Life	158	49.84	8.10			
Social support	158	51.63	8.68	156	433	0.0001
Physical Health	158	11.84	2.15			
Social support	158	51.63	8.68	156	.255	0.0001
Psychological	158	9.38	1.82			
Social support	158	51.63	8.68	156	.336	0.0001
Social relationship	158	15.26	4.54			
Social support	158	51.63	8.68	156	324	0.0001
Environment	158	13.28	2.94			

{r (156) = 0.471, p<0.05}

Table 4.3 revealed that there is a significant positive relationship between social support and Quality of life {**r (156) = 0.41, p<0.05}.** The patients' mean scores on social support is (**N = 158, X =51.63, SD = 8.68)** and that quality of life is (**N = 158, X = 49.84, SD = 8.10).** This analysis shows that social support is positively correlated with Quality of life of fistula patients in Ebonyi State.

It was also found that social support significantly related to all dimensions of quality of life; physical health {**r (156) = 0.43, p<0.05}**, Psychological {**r (156) = 0.26, p<0.05},** social relationship {**r (156) = 0.34, p<0.05}** and environment {**r (156) = 0.324, p<0.05}.** The result suggests that as the level of social support increases, the level of life quality of these patients tends to rise. The null hypothesis which states that social support will have no significant relationship with quality of life is therefore rejected.

Hypothesis Two

Health locus of control will not significantly predict quality of life of fistula patients

Hypothesis two was tested and analyzed with a multiple regression analysis at 0.05% level of significance. The result of the analysis is presented in table 4.4a and 4.4b.

Table 4.4a: Multiple regression analysis of Quality of Life by Health Locus f Control

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	3319.261	4	829.815	18.061	0.0001
Residual	6845.874	149	45.945		
Total	10165.135	153			

Table 4.4b Coefficient of internality, chance, Doctors, other People by Quality of life

Model	*B*	*SE.B*	*Beta*	*T*	*Sig*
(Constant)	23.967	3.452		6.942	.000
Internal	.458	.263	.154	1.743	.083
Chance	.979	.275	.352	3.559	.001
Doctors	.923	.334	.224	2.769	.006
Other people	-.310	.417	-.065	-.742	.459

{F (4, 149) =18.061, p<0.05, R^2 = 0.327)

Summary of the analysis in table 4.4a and revealed that there is significant prediction of health locus of control on quality of life among fistula patients {**F(4, 149) = 18.061, p<0.05, R^2 = 0.33).** Further examination from the table indicates that the independent variable health locus of control revealed 32.7% variation in life quality f life fistula patients. Furthermore, it is observed from the table that chance health locus of control (**β=0.979, t = 3.56, p<0.05)** and doctors' dimension of health locus of control **(β = 0.923, t = 2.77, p<0.05)** have significant independent prediction on quality of life of the patients. However, internality or internal health locus of control **(β = 0.458, t = 1.74, p<0.05)** and other people dimension **(β = -0.31, t = -0.742, p<0.05)** have no significant independent prediction of quality of life. The analysis shows that the components of health locus of control, which include internal and other people, have no significant independent prediction of quality of life, while only chance and doctors' component independently predicted the participants' quality of life statistically.

Hypotheses Three

Fistula type will have no significant influence on quality of life of fistula patients

The analysis was done by estimating the mean score of patients who reported vesico vaginal fistula and that of their counterparts who reported rector vaginal fistula on quality of life. The scores were subjected to test of comparison by employing an independent sample t-test, tested at 0.05% significance level. The analysis is summarized in table 4.5 below

Table 4.5: showing the influence of fistula type on quality of life

Variables		N		SD	T	P-Value
Overall Quality of life	Vesico	111	49.37	8.30	1.123-	0.263
	Recto	47	50.95	7.59		
Physical Quality of Life	Vesico	111	11.99	2.015	1.392-	0.166
	Recto	47	11.48	2.419		
Psychological Quality of Life	Vesico	113	9.01	1.680	-4.257	0.001
	Recto	47	10.28	1.835		
Soc. Relationship Quality of Life	Vesico	111	14.87	4.628	-1.718	0.088
	Recto	47	16.21	4.217		
Environment Quality of life	Vesico	111	13.41	2.965	0.845	0.399
	Recto	47	12.98	2.882		

Table 4.5 presents the summary of the analysis. It revealed that patients who reported vesico vaginal fistula displayed similar level of quality of life **(= 49.39, SD = 8.30)** with those who reported recto vaginal fistula **(= 50.95, SD = 7.59), {t (156) = -1.12, p<0.05}.** The analysis indicates that there is no significant difference between Vesico and Recto vaginal fistula patients in terms of their quality of life. In other words, both Vesico and Recto vaginal fistula patients demonstrate similar level of quality of life.

Patients who reported Vesico fistula displayed similar level of physical quality of life **(= 11.97, SD = 2.01)** with those who reported Recto fistula **(= 11.48, SD = 2.42), {t (156) =-1.39, p<0.05).** This analysis by implication shows that there is no significant difference between Vesico and Recto fistula patients in terms of physical quality of life. In the same vein, patients who reported Vesico fistula displayed similar level of psychological quality of life **(= 9.01, SD = 1.68**) with those who reported recto vaginal fistula **(= 10.28, SD = 1.84), {t (156) = -4.26, p<0.05.** The analysis also revealed that the patients' quality of life is significant within psychological domain. Patients with Recto fistula have similar report within social relationship domain of quality of life **(= 14.87, SD = 4.63)** with those of recto vaginal fistula **(= 16.21, SD = 4.22), {T (156) = -1.72, p<0.05.** Therefore, there is no significant influence of social relationship domain of quality among Recto and Vesico fistula patients.

Furthermore, patients with Vesico fistula have similar domain of quality of life **(= 13.41, SD =2.96**) with those f Recto vaginal fistula **(= 12.98, SD = 2.88), {t (156) = -0.85. p<0.05.** Thus, the analysis indicates that there is no significant influence of fistula type on social relationship domain of quality of life among fistula patients. In other words, patients with Recto and Vesico fistula do not differ in their quality of life within social relationship domain of quality of life. Therefore, the hypothesis which state that fistula type will have no significant influence on quality of life of fistula patients is accepted, thus quality of life for these patients is only significant within psychological domain of quality of life. As a result, fistula type does not significantly influence quality of life of fistula patients.

DISCUSSION OF FINDINGS

The first objective of the study was to assess the level of quality of fistula patients in Ebonyi state and findings revealed that majority [75%] of the patients live an average level of quality of life. This finding corroborates report by Kabir, et al (2004) that 70% of the 220 fistula patients admitted for repair in selected fistula hospitals across Northern Nigeria felt satisfied with their quality of life prior to surgery. In the same vein, this finding supports Balogun (1994) who reported that fistula patient showed average quality of life in relation to personality factors in a study among 230 fistula patients in Nigeria. This may be due their beliefs and cultural values attached to life. In another study, Sarir et al (2007) examined the relationship between social support and quality of life of fistula patients in Kano, their findings revealed that majority (58%) of the 170 fistula patients studied reported average quality of life.

This finding however, contradicts the report by Umoiyhon et el (2011) that only 20% of the 150 fistula patients felt satisfied with their general quality of life before fistula repair, while it increased to 90% after successful repair. The present finding also contradicts the report by Kalembo and Zgambo (2012) that 33% of the fistula patients studied were psychologically depressed and about 51% were bitter about their quality of life before

fistula repair. This contribution may be due to differences in social environment of the study areas and perspectives of the patients.

Similarly, findings from the present study contradict the report of Murphy (1988) that 20% of the 150 women studied felt satisfied with their general state of health and quality of life before repair. This may be due to differences in cultural values attached to illness in the study area and the patient's perception of quality of life. Besides Murphy's work was done in Northern Nigeria about twenty-eight years ago when the economy was poor while this study was carried out.

The second objective of this study was to appraise the relationship between social support and quality of life of fistula patients in the study area. Findings in this study revealed that as the level of social support increases, the level of life quality also tends to increase. In other words, the analysis showed that social support was positively correlated with quality of life of fistula patients in the study area in Nigeria. This finding supports Balogun (1995) who reported that high percentage of patients reported receiving full social support from their husbands, society and others. 63% in zone 1 (Northern Nigeria) and 86.7% in zone 2 (Southern Nigeria) which tend to improve their wellbeing.

Report from the present study showed that social support positively correlated with quality of life of obstetric fistula patients. This corroborates with the findings of Balogun (1994) whom found that social support received by fistula patients from their family members and the society improves their quality of life. This also corroborates the report of Bello (2006) that subjects were who reported feeling socially competent, who received more practical support for fistula management and who cope more actively reported higher levels of functioning and wellbeing as well as global level of life satisfaction. The present study also corroborates the findings of Umoiyho et al (2011) that about 80% of the 150 patients studied reported receiving full social support from family and member of the society. They found positive relationship between social support and quality of life among fistula patients.

The third objective of this study was to examine the influence of health locus of control on the quality of life of fistula patients in the study area. Findings from this study showed that there is significant prediction of health locus of control on the quality of life among fistula patients. It also revealed that the component of health locus of control, which include 'internal' and 'other people' have no significant independent prediction of quality of life while "chance" and "doctors" component significantly predicted the patients' quality of life statistically.

The fourth objective of this study was to assess the influence of fistula type on the quality of life of fistula patients in the study area. This was guided by a hypothesis that fistula type will have no significant influence on the quality of life of fistula patients in the study area. Results from the findings showed that there is no significant difference in the mean score of vesico-vaginal fistula and recto-vaginal fistula patients in terms of their quality of life. Statistically, type of fistula has no significant influence on the quality of life of fistula patients.

CONCLUSION

The findings of this study indicated that social support significantly correlates with quality of life, as social support increases, the quality of life of fistula patients tend to increase too. Fistula type did not significantly influence quality of life as both vesico and recto-vaginal fistula reported similar domains of quality of life. However, a major contribution of this study is that it demonstrated the perceived health locus of control, social support and perceived quality of life of fistula patients in the study area and that their perceived quality of life was only significant within psychological domain while other domains like physical, social and environment were significant to their quality of life. The study however, showed the importance of social support for fistula patients, that as social support increases, quality of life of fistula patients also tends to increase.

REFERENCES

Aboyeji, et al (2007). Maternal mortality in a Nigerian teaching hospital – a continuing tragedy. *Tropical Doctor*, 37:83-85.

Adams, B. F., Bezner, G, H, & Steinhardt, J. (1997). The Wellness Model and Health Enhancing Behaviour. *Journal of Biosocial Sciences;* 14, (3) 127-132.

Ajaegbu H. I. (1976). Urban and Rural Development in Nigeria, London and Ibadan: Heineman Educational Books.

Ajuwon, A. (1997). Vesico Vagina Fistula in Nigeria: Extent of the problems and Strategies for prevention and control. In B. E. Owumi (Ed), Primary Health Care in Nigeria. Ibadan.

Arrowsmith, L. (1994). Genitourinary Reconstitution in Obstetric Fistula. *Journal of Urology* 152,403-406.

Balogun. S. K. (1994). The Buffering Effects of Social Support on Personality Dispositions of Patients of a Stressful Life Event: The case of fistula patients. *The Ife PsychologIA*. Ife, Nigeria.

Balogun. S. K. (1995). The VVF Patients, Stirling-Horden. Ibadan

Bandura, A. (1977). Self-efficacy: Towards a unifying theory of behavior change. *Psychological Review*, 84, 191-215.

Bello, K. (2006). A Selection of Essay: Vesico-vaginal fistula (VVF): Only to a woman accursed. www.churchill.com. Retrieved from the web August 16m 2014.

Cohen, S. & Syme, S. L. (1985); "Issues in the study and Application of social support Inc." in Cohen, S. and Syme, S. L. (eds) Social Support and Health, Orlando: Academic Presss.

Engender Health (2003). Epidemiology of vesico-vaginal fistula: No longer a calamity of teenagers. *Journal of Obstetrics and Gynaecoloy*. 28:432-433.

Folashire, O., Oluyemisi F., Achiaka, T., Erabor, H., Ayorinde, M., & Folashire, D. (2012): *African Journal of Primary Health Care and Family Medicine*; Vol. 4, No. 1, 294.

Gharoro, E. P., Abedi, H. O. (1999). & Vesico-vaginal fistula in Benin City, Nigeria. *International Journal of Gynaecology and Obstetrics* 64:313-314.

Harrison, K. A. (1983). Obstetric fistula: one social calamity too many. *British Journal of Obstetrics and Gynaecology*. 90:385-386.

Ijaiya, M. A. (2004). Posterior cervical lip for juxtacervical vesico-vaginal fistula closure (M. Ijaiya's technique). *International Urogynaecology Journal*. 15: 216-218.

Ijaiya, M.A., Aboyeji, A.P., & Ijaiya, Z.B. (2002). Epidemiology of Vesico-Vaginal Fistula at the University of Ilorin Teaching Hospital, Ilorin, Nigeria. *Tropical Journal of Obstetric Gynaecology*. 19: 101-103.

James, K., Barnabas, D., Tobias, A. F., & Solomon, E. S. (2013). Clinical Features of Patients Diagnosed with Vesico-Vaginal Fistula (VVF) in South East Nigeria. *Natural Science*; 11(12):110-115.

Kabir, M., Iliyasu, Z., Abubakar, I. S., & Umar, U. I. (2004). Medico-social problems of patients with vesico-vaginal fistula in Murtala Mohammed Specialist Hospital, Kano. *Annals of African Medicine;* 2:54-57.

Kelly, J., & Kwast, B. E. (1993). Epidemiologic study of Vesico-vaginal fistulas in Ethiopia. *International Urogynaecology Journal*, 4: 278-281.

Kochakan, W, & Pummangura, W. (2007). "A new dimension in vesico-vagina fistula management. An 8-year experience at Rahathidodi hospital". *Asian Journal of Surgery* 20 (4): 267-71.

Lefcourt, H. M. (1976); Locus of Control; Current- Trends in theory and Research. N. J. Lawrence, Eribaum Associates.

Levenson, H. (1973). Multidimensional Locus of Control in Psychiatric Patients. *Journal of Counseling and Clinical Psychology*, 41,397-404.

Margolis, T., & Marcer, L. (1994). Vesico-vaginal fistula Obstetric fistula. *Obstetrical Survey*; 49:840-846.

Metro, K. F. (2006). Modification of O'Connor's technique for the treatment of Fistula repair described. Retrieved from the web August 10, 2014. www.medicalnewstoday.com/medicalnews.php.

Murphy, M. (1981). Social consequences of vesico-vaginal fistula in northern Nigeria. *Journal of Biosocial Sciences;* 13(2): 139-50.

Nigerian Urban and Reproductive Health Initiative (2014). The circumferential vesico-vaginal fistula. *Journal of Obstetrics and Gynaecology, India. 15:441-447.*

Nawaz, H., Khan, M., Tareen, F. M., & Khan, S. (2010). Retrospective study of 213 cases of female urogenital fistulas at the Department of Urology and Transplantation Civil Hospital Quetta Pakistan. *Journal of Pakistan Medical Association;* 60: 28-34.

Rotter, J. B. (1964). "Some problems and misconceptions related to the constructs of internal and external control of reinforcement" *Journal of consulting and clinical psychology* 43: 56-57.

Rotter, J. B. (1966). Generalized expectancies of internal versus external control of reinforcements. *"Psychological Monographs*, 80, 66-69.

Ryff, C. D. (1989). Happiness is everything or is it Explorations on the meaning of Psychological Well-being? *Journal of Personality and Social Psychology*, 57(6), 1069-1081.

Ryff, C. D. & Keyes, C. L. M. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology*, 69(4), 719-727.

Sims, J. M. (1852). On the treatment of vesico-vaginal fistula. *American Journal of the Medical Sciences (new series)* 23:59-82.

Skevington, S. M., Lofty, M. O. & Connell, K. A. (2004). *The World Health Organization, Social Indicator Research*; 40:189-216. http://dx.doi.org/Retrieved 22nd, September 2014.

Tahzibi, H. (1983). Epidemiological determinants of vesico-vaginal fistulas. *British Journal of Obstetrics and Gynaecology* 90:387-391.

Thoits, P. A. (1986). Social Support as coping assistance. *Journal of consulting and Clinial Psychology*, 54, 416-423.

Tinuola, F., & Okau, A. (2009). Perceived causes of Obstetric fistula: Data from women of Reproductive Age in Nigeria. *European Journal of Social Science* Vol.10 (1):43.

Tsui, A. O, Creanga, A. A., Ahmed, S. (2007). The role of delayed childbearing in the prevention of obstetric fistulas. International Journal of Gynaecology and Obstetrics. S98-S107.

Umoiyoho, A. J., Inyang-Etoh, E. C., Abah, G. M., Abasiattai, A. M, & Akaiso, O. E. (2011). Quality of life following successful repair of vesico-vaginal fistula in Nigeria. *Rural and Remote Health*11 (13) 1734.

Wall, L. L. (2012). A framework analyzing determinants of obstetrics fistula formation. *Studies in family planning* 43, 255-272.

Wills, T. A. (1985). “Supportive Function of Interpersonal Relationships”. In S. Cohen and L. Syme. Social Support Health. Orlando, FL. Academic Press. 61-82.

World Health Organization (1998). Female Genital Mutation: An Overview. FHE/89.5 Geneva.

World Health Organization (2006). Obstetric Fistula. Guiding principles for clinical management and programme development. WHP Press; Geneva.