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Perceived Stigmatization and Its Psychosocial Effects Among Women Living with Vesicovaginal Fistula at Vvf Centre, Gesse, Kebbi State, Nigeria

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Abstract- ***Vesicovaginal fistula (VVF) is a severe maternal health condition characterized by involuntary continuous leakage of urine through an abnormal opening between the bladder and vagina. Beyond its physical consequences, VVF may result in stigma, social isolation, emotional distress, low self-esteem, and disruption of family and community relationships. This study assessed perceived stigmatization and its psychosocial effects among women living with VVF at VVF Centre, Gesse, Kebbi State. A descriptive cross-sectional design was adopted. The target population comprised 64 women living with VVF and receiving care at the centre, from which 55 respondents were selected using Taro Yamane's formula and convenience sampling. Data were collected using a structured questionnaire and analysed using descriptive statistics with SPSS version 27. The instrument had a test-retest reliability coefficient of 0.90. Findings showed high perceived stigmatization (grand mean = 3.18), high psychological effects (grand mean = 3.16), and substantial social effects (grand mean = 3.22). The study concludes that women living with VVF experience important psychological and social consequences in addition to physical effects. VVF care should therefore incorporate psychosocial assessment, counselling, family education, peer support and social reintegration before and after surgical treatment.***

Index Terms - vesicovaginal fistula, perceived stigmatization, psychological effects, social effects, psychosocial wellbeing.

I. INTRODUCTION

Vesicovaginal fistula is an abnormal communication between the urinary bladder and vagina that causes involuntary and continuous leakage of urine. Obstetric fistula is particularly associated with prolonged or obstructed labour when timely and appropriate obstetric intervention is unavailable. Although VVF is preventable and treatable, it remains concentrated in low-resource settings where access to quality maternal healthcare is inadequate. It is therefore both a clinical condition and an important social and public-health problem [1, 2].

The consequences of VVF extend beyond urinary incontinence. Women may experience recurrent infections, skin problems, unpleasant odour and difficulty maintaining personal hygiene. These physical consequences can contribute to shame, social isolation and reduced participation in community life. Nigerian evidence has documented stigmatization, discrimination, social rejection, abandonment, depressive symptoms, loneliness and reduced self-esteem among women affected by obstetric fistula [3, 4].

Perceived stigmatization refers to the belief or expectation that other people will judge, reject, discriminate against or devalue an individual because of a condition. Among women with VVF, fear of negative evaluation may influence social interaction, disclosure, and participation in community activities. Evidence from Nigerian women undergoing VVF treatment has demonstrated an association between health-related stigma and poorer psychological well-being [5].

The social burden may include disrupted marital relationships, isolation from family and friends, inability to work, and reduced participation in community life. In Kebbi State, Wali et al. documented psychosocial and economic consequences among women with VVF. At the same time, evidence from North-Central Nigeria indicates

that rehabilitation and reintegration can reduce stigma and improve socioeconomic independence, self-esteem, and confidence [6, 7].

Despite specialized fistula services, local evidence on the psychosocial experiences of women receiving care at VVF Centre, Gesse, is important for planning patient-centred interventions. This study therefore assessed perceived stigmatization and its psychosocial effects among women living with VVF at VVF Centre, Gesse, Kebbi State.

Study Objectives

- To determine the level of perceived stigmatization among women with VVF.
- To assess the psychological effects of VVF on affected women.
- To examine the social effects of VVF among affected women.

II. MATERIALS AND METHODS

Research design

A descriptive cross-sectional design was used to assess perceived stigmatization and psychosocial effects at a single point in time, without manipulating variables.

Study setting

The study was conducted at VVF Centre, Gesse, Kebbi State, a specialized facility providing management and treatment of vesicovaginal fistula, including surgical repair, counselling, and rehabilitation.

Population and sample size

The target population consisted of 64 women living with VVF and receiving care at the centre. Taro Yamane's formula at 0.05 precision yielded a sample size of 55 respondents.

Sampling technique

Convenience sampling, a non-probability sampling technique, was used. Eligible women present during data collection who consented and were physically and mentally stable to respond were included. Women who declined consent, were absent, were critically ill, medically unstable, or had other types of fistula were excluded.

Instrument

A structured, closed-ended questionnaire was developed from the study objectives and literature. It comprised four sections: socio-demographic characteristics, perceived stigmatization, psychological effects, and social effects.

Validity and reliability

The instrument was reviewed by supervisors for relevance, clarity, and appropriateness. Test-retest reliability produced a coefficient of 0.90, indicating high consistency.

Data collection and analysis

Self-administered questionnaires were used after an explanation of the study and informed consent. Data collection lasted two weeks. Data were analysed using SPSS version 27, with frequencies, percentages, and mean scores used to summarize findings.

Ethical considerations

Ethical approval was obtained from the Research and Ethics Committee of Kebbi State College of Nursing Sciences, Birnin Kebbi. Administrative permission was obtained from the hospital management and VVF Centre. Participation was voluntary; informed consent was obtained, confidentiality and anonymity were maintained, and participants could withdraw without penalty.

III. RESULTS

A total of 55 respondents participated in the study. Findings are presented according to the study objectives.

Table 1. Socio-demographic characteristics of respondents

Variable	Category	n	%
Age	Below 20 years	6	10.9
	20–29 years	18	32.7

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	30–39 years	20	36.4
	40 years and above	11	20.0
Marital status	Single	5	9.1
	Married	20	36.4
	Divorced	22	40.0
	Widowed	8	14.5
Religion	Islam	50	90.9
	Christianity	4	7.3
	Traditional religion	1	1.8
Education	No formal education	20	36.4
	Primary	15	27.3
	Secondary	14	25.5
	Tertiary	6	10.9
Occupation	Housewife	25	45.5
	Farmer	12	21.8
	Trader	10	18.2
	Civil servant	3	5.5
	Others	5	9.1
Duration with VVF	Less than 1 year	12	21.8
	1–2 years	17	30.9
	3–5 years	16	29.1
	More than 5 years	10	18.2

The largest age group was 30–39 years (36.4%). Divorced respondents represented 40.0%, while 36.4% were married. Most respondents were Muslim (90.9%). No formal education was reported by 36.4%, and housewives constituted 45.5%. The largest duration category was 1–2 years (30.9%).

Table 2. Perceived stigmatization among women living with VVF

Statement	SA n (%)	A n (%)	D n (%)	SD n (%)	Mean
People avoid interacting with me because of my condition	25 (45.5)	17 (30.9)	8 (14.5)	5 (9.1)	3.13
I feel ashamed because I have VVF	28 (50.9)	16 (29.1)	7 (12.7)	4 (7.3)	3.24
People look down on me because of my condition	24 (43.6)	19 (34.5)	8 (14.5)	4 (7.3)	3.15
I avoid social gatherings because I fear rejection	27 (49.1)	15 (27.3)	9 (16.4)	4 (7.3)	3.18
I feel people discriminate against me because of my condition	23 (41.8)	20 (36.4)	8 (14.5)	4 (7.3)	3.13
I feel embarrassed whenever I am in public	29 (52.7)	15 (27.3)	7 (12.7)	4 (7.3)	3.25
My condition has changed the way people treat me	26 (47.3)	18 (32.7)	7 (12.7)	4 (7.3)	3.20
Grand mean					3.18

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Perceived stigmatization was high, with a grand mean of 3.18. Feeling embarrassed in public had the highest mean (3.25), followed by shame because of VVF (3.24).

Table 3. Psychological effects of VVF

Statement	SA n (%)	A n (%)	D n (%)	SD n (%)	Mean
I often feel sad because of my condition	26 (47.3)	18 (32.7)	7 (12.7)	4 (7.3)	3.20
I feel anxious about my future	25 (45.5)	19 (34.5)	7 (12.7)	4 (7.3)	3.18
I have lost confidence in myself	23 (41.8)	20 (36.4)	8 (14.5)	4 (7.3)	3.13
I feel emotionally distressed because of my condition	27 (49.1)	17 (30.9)	7 (12.7)	4 (7.3)	3.22
I often feel lonely	24 (43.6)	18 (32.7)	9 (16.4)	4 (7.3)	3.13
My condition has lowered my self-esteem	25 (45.5)	19 (34.5)	7 (12.7)	4 (7.3)	3.18
I find it difficult to enjoy life because of my condition	22 (40.0)	20 (36.4)	9 (16.4)	4 (7.3)	3.09
Grand mean					3.16

Psychological effects were high, with a grand mean of 3.16. Emotional distress recorded the highest item mean (3.22), while sadness was reported by 80.0% of respondents as either strongly agreed or agreed.

Table 4. Social effects of VVF

Statement	SA n (%)	A n (%)	D n (%)	SD n (%)	Mean
My condition has affected my relationship with my husband or partner	29 (52.7)	14 (25.5)	8 (14.5)	4 (7.3)	3.24
I avoid attending social functions because of my condition	27 (49.1)	17 (30.9)	7 (12.7)	4 (7.3)	3.22
I have been isolated by family or friends because of my condition	22 (40.0)	20 (36.4)	9 (16.4)	4 (7.3)	3.09
My condition has affected my ability to work or earn a living	30 (54.5)	15 (27.3)	6 (10.9)	4 (7.3)	3.29
I find it difficult to participate in community activities	25 (45.5)	19 (34.5)	7 (12.7)	4 (7.3)	3.18
My condition has negatively affected my overall quality of life	31 (56.4)	14 (25.5)	6 (10.9)	4 (7.3)	3.31
Grand mean					3.22

Social effects recorded the highest grand mean (3.22). The strongest reported effect was negative impact on overall quality of life (mean = 3.31), followed by reduced ability to work or earn a living (mean = 3.29).

IV. DISCUSSION

The study found high perceived stigmatization among women living with VVF. Shame, embarrassment, perceived discrimination, altered treatment by others, and avoidance of social gatherings were prominent. Embarrassment in public had the highest item mean. This finding is consistent with evidence that urinary leakage and associated odour can expose women to stigma and social withdrawal. Amazue et al. reported a significant association between health-related stigma and poorer psychological wellbeing among women receiving VVF treatment [5].

Psychological effects were also substantial. Respondents reported sadness, anxiety about the future, emotional distress, loneliness, reduced confidence, low self-esteem, and difficulty enjoying life. These findings are consistent with the systematic review by Nduka et al., which identified depression, low self-esteem, social withdrawal and loss of identity

among women affected by obstetric fistula [3]. Wali et al. similarly documented persistent emotional and psychosocial consequences among women with VVF in Kebbi State [6].

Social effects were particularly prominent, with a grand mean of 3.22. Respondents reported affected marital or partner relationships, avoidance of social functions, isolation, reduced ability to work, difficulty participating in community activities, and poorer quality of life. These findings agree with evidence from Kebbi State showing social rejection, marital problems, and economic hardship among women with VVF [6]. They also support the argument that rehabilitation and social reintegration should accompany fistula repair [7].

Overall, the findings support Goffman's Stigma Theory, which explains how socially discredited conditions may lead to shame, self-stigma, withdrawal, and loss of social opportunities. For women with VVF, perceived negative evaluation may reinforce social avoidance and psychological distress. Consequently, VVF services should address physical, psychological and social needs together.

V. CONCLUSION AND RECOMMENDATIONS

The study demonstrates that VVF has substantial psychosocial consequences for women receiving care at VVF Centre, Gesse, Kebbi State. Perceived stigmatization was high, while psychological and social effects were also considerable. Shame, embarrassment, fear of rejection, sadness, anxiety, emotional distress, loneliness, low self-esteem, marital or partner difficulties, social isolation, reduced economic participation and poorer quality of life were commonly reported. Comprehensive VVF care should therefore extend beyond surgical repair to include counselling, family support, peer support, community education and social reintegration.

Recommendations

- Strengthen counselling and psychosocial services for women living with VVF.
- Integrate routine psychosocial assessment into nursing and other clinical care.
- Establish peer-support programmes at the VVF Centre to promote coping and emotional support.
- Provide family education to reduce misconceptions, rejection, and abandonment.
- Strengthen community health education to present VVF as a preventable and treatable medical condition.
- Include social rehabilitation and reintegration as components of VVF management.
- Expand access to VVF treatment and rehabilitation, especially for women in rural and economically disadvantaged communities.
- Continue psychological support after successful surgical repair because stigma and low self-esteem may persist.

Study Limitations

The study was conducted at one VVF Centre in Gesse, Kebbi State, limiting generalizability. The sample size was relatively small (55 respondents). Data were self-reported and may have been influenced by reluctance to disclose sensitive experiences. The cross-sectional design also limits conclusions about causal relationships.

Contribution to Knowledge

The study provides local evidence on perceived stigmatization and psychosocial consequences among women receiving VVF care in Kebbi State. It reinforces the importance of holistic nursing and midwifery care that combines physical treatment with psychological support, stigma reduction, rehabilitation, and social reintegration.

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