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Barriers in seeking fistula repair services among women with obstetric fistula in Zambia: The case of Muchinga, Luapula, Eastern and Southern Provinces

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Abstract
Background & Aim: Obstetric fistula is a condition in which a hole develops in the birth canal as a result of childbirth resulting in leakage of urine and/or stool through the vagina. Once obstetric fistula occurs, it requires reconstructive surgery as fistulas usually cannot heal by themselves. However, most afflicted women do not seek fistula repair services.
Objective: To explore barriers in seeking fistula repair services among women with obstetric fistula.
Methods: This was a qualitative study. The study was conducted between October, 2017 and September, 2018. The study setting was Muchinga, Luapula, Eastern and Southern provinces of Zambia. A purposive sample of 16 participants was recruited and interviewed in their homes. In-depth interviews were conducted. Data was analyzed manually using thematic content analysis.
Results: The age of the participants ranged from 19 - 87 years. Four thematic areas were identified that included individual, household, community and health systems barriers.
Conclusion: Women either delayed in seeking fistula repair services or did not seek the service at all. Strategies such as addressing barriers at individual, family, community and health facility levels must be implemented in order to improve access to fistula surgical repair services.

Keywords: Barriers, afflicted women, obstetric fistula, fistula patients, fistula repair services, women with obstetric fistula

Introduction
Obstetric fistula is one of the most severe childbirth injuries and a physically and socially disabling obstetric complication that affects many women and girls annually (Mselle *et al*., 2011) [1]. World Health Organisation (2010) [2] estimates more than two million girls and women worldwide living with obstetric fistula, with an additional 50,000–100,000 new cases occurring every year. Up to 130,000 new cases occur each year in sub-Saharan Africa and South Asia (UNFPA, 2008) [3]. Over 2000 women await surgery each year (UNFPA, Zambia Annual report, 2014) [4].
Obstetric fistula treatment is critical to the health and survival of the women. Delaying treatment has an impact on the prognosis and it may cost more money when compared with treatment for women who came earlier for repair (Raassen, Verdansdonk and Vierhout, 2008) [5]. Girls and women live with the condition up to 50 years even if most of them realize the urine leakage soon after delivery and view it as normal (Turan, Johnson and Polan, 2007) [6]. Although, services for repair of fistula are available, it is estimated that 80% of women with obstetric fistula never seek treatment (Gessessew and Mesfin, 2003) [7].
Despite the benefits of surgical repair, women with obstetric fistula have reported significant barriers to care including transportation to surgical centres, financially challenges and surgical intervention that are not well known (Obed, 2010) [8]. Furthermore, the challenge standing between women and fistula treatment is information (Holme, Breen and MacArthur, 2006) [9] or lacking decision power and attitudes for seeking care (Velez *et al*., 2007; Ramsey *et al*, 2007) [10, 11]. Additionally, studies by Kijugu (2009) [12] and Muleta (2008) [13] found travelling alone to seek repair services a difficult thing to do in some cultures especially for women who are incontinent (Yeakey *et al*., 2009) [14]. Maulet *et al*., (2015) [15] also reported a few afflicted women as initially consulting witchdoctors before turning to modern health care or in an attempt to maintain some social support by complying with local practices and

family advice. Also, in low-income countries, women have less access to appropriate surgical care for repair due to the limited availability of health facilities with repair services and lack of surgical training for fistula repair (Bangser, *et al*., 2011; Rushwan *et al*., 2012) [16, 17] and limited available surgeons (Velez *et al*., 2007; Wall *et al*., 2005; Ramsey *et al*. 2007) [10, 18, 11].

Some afflicted women believe that doctors cause fistulas during deliveries (Bellows *et al*., 2014) [19] and that fistula is a curse or a punishment from God (Naidu and Donnay 2003, Muleta *et al*. 2008) [20, 21]. When fistula is believed to be caused by a doctor's actions or a curse, a woman living with fistula is unlikely to be interested in seeking treatment at a health facility (Naidu and Donnay 2003; Muleta *et al*. 2008; Bellows *et al*., 2014) [20, 21, 19].

To our knowledge, data on barriers to seeking fistula repair services in Zambia are sparse and obstetric fistula has not been well researched. The purpose of this study was to explore barriers in seeking fistula repair services among afflicted women.

Material and Methods

A qualitative design was used to collect data on barriers of women with obstetric fistula in seeking fistula repair services. The study was conducted between October, 2017 and September, 2018. The study population included a purposive sample of 16 women with obstetric fistula recruited from the four provinces (four each at Muchinga, Luapula, Eastern and Southern provinces). Maximum variation purposive sampling was done. In maximum variation sampling, participants who had never been for fistula repair, had been either once, twice, thrice, fourth and fifth were included in the in-depth interviews. This helped to identify common challenges and barriers to seeking fistula repair services in these women. It also highlighted common experiences in living with obstetric fistula.

The inclusion criteria included consenting women with obstetric fistula aged 18 years and above and diagnosed by the gynaecologist upon delivery or during postnatal visits, living in Muchinga, Luapula, Eastern and Southern provinces of Zambia. The exclusion criteria included women with obstetric fistula below 18 years, not living in the four provinces of Zambia and those who were not willing to participate in the study.

The study sites were chosen because there have fistula repair centres and women with obstetric fistula were easily traced through hospital records for easy follow up. A list of eligible participants was compiled in readiness for the study. Community Health Volunteers (Safe Motherhood Action Groups-SMAGs) who are involved in mobilising and supporting obstetric fistula clients for repairs helped to identify homestead of women with obstetric fistula. Once traced, the researcher arranged for in-depth interviews. The aim of the study was explained to the participants and they were informed that participation was voluntary. Participants were asked to give their consent to participate. Only those who consented participated in the study. Participants confidentiality was ensured. The participants were encouraged to speak about their experiences in seeking fistula repair services. The interviews took about 30 to 60 minutes in afflicted womens homestead.

Before commencing data collection, the study received ethics approval from the University of Zambia Research Ethics Committee. Written permission was granted by the National Health Research Authority of the Ministry of Health. Written permission was also sought from the Provincial Health Directors (Lusaka province) for the pilot study in order to test the practicability of the tool and (Muchinga, Luapula, Eastern and Southern provinces) for the main study. Also, permission was obtained from the Medical Superintendents in the four fistula repair centres (Mansa General Hospital, Chilonga, Katete and Monze Mission Hospitals) to access obstetric fistula records.

Data were analyzed manually using thematic content analysis. Themes were identified using the five steps of Qualitative Content Analysis (Graneheim and Lundman, 2004) [22].

Rigor of the study

An assessment of trustworthiness was done according to Lincoln and Guba (1985) [23], Trustworthiness of data includes credibility, dependability, transferability and confirmability. Credibility involves prolonged engagement, persistent observation, triangulation, peer briefing, negative case analysis, referential adequacy and member checking. Dependability involves the inquiry audit (interaction with participants), a detailed descriptive information of the process of data collection, and analysis. Transferability involves thick description of the context, the study participants and the themes (analytic generalisation). Confirmability involves confirmatory audit, audit trail, triangulation and reflexivity. Trustworthiness of the study was ensured by taking participants through the same questions and debriefing and any additional information was taken into consideration during data analysis. The participants were interviewed to the point of data saturation and the interviews were tape recorded and transcribed. To enhance the credibility of findings, findings were taken back to eight participants to see whether the results compared with their accurate responses and changes obtained from participants were incorporated into the final descriptions. The researcher also made sure that there was no shift in the meaning of the codes during the process of coding. This was achieved by comparing data with the codes and by writing memos about the codes and their definitions. All interview materials, transcriptions, documents, findings, interpretations and recommendations were kept, to be available and accessible to the supervisors and any other researchers for the purpose of conducting an audit trail. Furthermore, writing detailed field notes and discussing the findings helped ensure trustworthiness of the study.

Results

The results of this study are summarized as demographic characteristics of the participants and themes as shown below. The participants were numbered (1 to 16) and the number after each quotation shows who was talking.

Demographic Characteristics of the Participants

Demographic characteristics of the study participants are summarized in Table 1. Age ranged from 19 - 87 years. Thirteen participants were in the childbearing age (15 to 49 years). Eight participants were married, twelve had children and nine were self employed. Seven had no source of income.

Table 1: Demographic Data (n=16)

Participant No	Age	No of children	Marital status	Occupation	Income
P1	33	3	Divorced	None	Nil
P2	64	10	Widowed	Small scale farmer	K500.00 ($50)
P3	87	0	Widowed	None	Nil
P4	19	0	Single	None	Nil
P5	37	4	Married	None	Nil
P6	33	3	Married	Sales lady	More than K200.00 (>$20)
P7	37	1	Married	None	Nil
P8	33	0	Divorced	Small scale farmer	K500.00 ($50)
P9	36	1	Married	Small scale farmer	K500.00 ($50)
P10	52	3	Divorced	Business	K200.00 ($20)
P11	45	6	Married	Farming	K500.00 ($50)
P12	37	2	Married	None	Nil
P13	26	1	Divorced	None	Nil
P14	32	3	Married	Farming	Less than K500.00(<$50)
P15	37	6	Married	Business /Farmer	K200.00 ($20)
P16	42	0	Divorced	Farming	K180.00 ($18)

The mode of delivery, fistula type, gravid when sustained a fistula, number of years living with fistula, number of fistula repair attempts and partner support for the participants are summarized in Table 2. Eight were delivered by Caesarean section during pregnancy that resulted in obstetric fistula while the other eight women had spontaneous vaginal delivery at home. Fourteen women had Vesico- Vaginal Fistula (VVF) while two had Recto Vaginal Fistula (RVF). Nine participants sustained a fistula during their first pregnancy. The number of years women had been living with an obstetric fistula ranged from 1 year to 70 years. Thirteen had one or more attempts at fistula repair while three had never been for fistula repair services. Six were supported by their partners.

Table 2: Mode of delivery, fistula type, gravid, number of years living with fistula, number of fistula repair attempts and partner support for the participants (n=16)

Participant No	Mode of Delivery	Type of fistula sustained	Gravid when sustained a fistula	No of years living with fistula	No of fistula attempts	Partner support
P1	C/S	VVF	3	3	1	N/A
P2	SVD	VVF	4	41	4	N/A
P3	SVD	VVF	1	70	1	N/A
P4	SVD	VVF	4	4	2	N/A
P5	SVD	VVF	1	22	3	Yes
P6	C/S	RVF	4	5	5	Yes
P7	SVD	VVF	1	1	2	Yes
P8	C/S	VVF	4	7	3	N/A
P9	C/S	VVF	1	10	4	Yes
P10	SVD	VVF	1	25	2	N/A
P11	SVD	RVF	1	17	1	Yes
P12	SVD	VVF	2	5	3	Yes
P13	C/S	VVF	1	10	3	N/A
P14	C/S	VVF	1	6	0	Nil
P15	C/S	VVF	8	1	0	Nil
P16	C/S	VVF	1	18	0	N/A

The analysis of the qualitative data gave rise to four main themes which were individual, household, community and health systems barriers. Themes are reported as results of the study.

Individual barriers

Participants did not know that they suffered from an obstetric fistula hence did not seek fistula repair services. This is what participants said, *"I thought it is normal that a woman after delivery leaks faeces and/or urine. At the hospital no one talked about it. I went home thinking leakage was normal." (P11)*

Another one said, *"I have never gone for surgical repair. I delivered in hospital but health care providers did not tell me anything about the urine leakage despite them knowing that I sustained a fistula."* (P14)

Participants who had never been for fistula repair reported that they did not access the service because they did not know that fistula repair services were available in the country despite having delivered the baby in hospital that resulted in them sustaining a fistula. This is what they said, "*I did not know that fistula repair services exist despite delivering in hospital. That is why I did not seek fistula repair services." (*P14, P15, P16*)*

Participants also reported that they did not know that there were doctors who would repair obstetric fistulas in the country despite delivering in the hospital. This is what one participant who has never been for fistula repair services said "*I did not know whether doctors were available who would treat fistula that is why I have not been to the hospital to seek the service." (P16)*

Afflicted women reported that they had no source of income because of not being in formal employment. This made them not to seek repair services due to transportation cost.

This is what one participant said, "*I have never gone back for fistula repair services ever since I had a third attempt at repair. This is because I was sent to the tertiary hospital in the country to seek repair services. I did not have money to pay for transport."* (P13)

For those who managed to seek fistula repair services, the uncontrolled leakage of urine and/or stool caused transportation problems. One afflicted woman reported how she suffered using public transport. *"When the bus stopped, I could quickly go and change my pads which were wet. After changing the pad, I had to put in the bag I carried. I did that the whole way until we arrived. It is a sacrifice that is why I cannot continue seeking repair services." (P7)*

In addition, some participants reported that they were anxious to travel alone to seek fistula repair services. Hence, they delayed seeking repair services for fear of travelling all the way without anyone to accompany them. This is what participants said, "*I am anxious to travel alone to seek fistula repair services, that is why I have just been once for repair. It is a big sacrifice especially that urine smells and people look at you with bad eyes. You have no one to talk to all the way to the hospital that offers repair services." (P1, P3)*

Some participants reported experiencing loss of dignity. They mentioned the embarrassment of leaking as tormenting and discouraging them from seeking fistula repair services. This is what participants said; "*When you go to seek fistula repair services. People in the bus will start saying "It smells there." They just look at where you are seated. They sit behind or in front of you. No one will sit next to you until the bus is full. They start talking among themselves. How can you continue seeking fistula repair services if you have to experience such a thing? Dying is better than being alive." (P8, P9, P11)*

Two other participants had this to say regarding the uncontrollable leakage of urine. "*Urine smells. It is not even possible to sit around people. Private transport is needed as when leaking is too much; you need private vehicles to bring you to the hospital for surgical repair." (P1, P2)*

Participants mentioned that the fistula wound does not come without problems such as pain. The pain makes it difficult to sit on modes of transport such as the bicycle if that is the only means to reach the hospital that conduct fistula repair. Participant number 11 had this to say, *"Fistula is a painful condition. It is not possible to access treatment as I do not even manage to sit on the bicycle because of the pain I experience."*

Some participants also said, "*I feel bad, I feel sick, I always have backaches and sleep almost all the time. The body feels cold, very cold and weak. Sometimes I would feel as if I have something sitting on my back. This hinders me from seeking care." (*P1, P2)

Afflicted women also used alternative treatment instead of seeking fistula repair services. This is because they had different views about the causes of obstetric fistula. Some reported that since fistula was as a result of witchcraft, only traditional medicine would heal it. Use of traditional medicine made afflicted women delay in seeking fistula repair services as reported in the excepts below;

"I went to the witch doctor who gave me medicine to drink and I have gone from one witch doctor to another just to seek help. The witch doctor said people took my clothes and threw them in water and that is the water I am leaking to date. The witchdoctor also told me that I will recover after finishing the whole course of traditional medicine. "(P7, P9, P11, P12)

Another woman with fistula said, "*The traditional healer said it is "Mukunko" meaning leaking urine from the vagina. The traditional healer said it occurs due to childbirth following witchcraft where the witch is jealousy of someone marriage and would want it to end. The witchdoctor emphasised that I must sit in the medicine for hours so that the urine leakage can lessen. I sit in the medicine in the morning, at lunch time and in the evening. The urine leakage has reduced. I am able to manage my situation. Seeking fistula repair services is not an issue anymore."* (P2)

Afflicted women reported the need to pay for unforeseen circumstances while at the hospital. Considering the poverty levels among these afflicted women, some preferred not to seek repair services anymore as they could not manage to pay for other services such as laboratory investigations. This is what one fistula patient said; "*At the hospital, I once tried to ask for financial support. I explained to them that I did not have a job and I tried by all possible means to survive. I cannot go to the hospital now because they will ask me to pay for other services such as blood tests." (P13)*

Household barriers

Most of the participants reported that they needed financial support from their family members and partner to enable them seek repair services. Some participants had this to say; *"What I need from my family is transport money to enable me seek repair services. I really want to heal completely" (P5, P6)*

Afflicted women also reported that seeking repair services was a challenge because of not staying with their partners. Two participants had this to say; *"Money was difficult to find because of the way I was staying with my husband. He was working in another town but because of my fistula he married another woman and stopped supporting me. There was nothing I could do." (P7, P12)*

Due to lack of husband support to seek fistula repair services, my family advised that I seek alternative treatment. This is what the participant said; *"They (my family) told me that what had happened to me was a mystery. They had never seen such a thing happen to anyone and they had never heard about such a thing. They decided that we go to the witch doctor to seek help." (P12)*

Community barriers

Most participants reported that their communities did not have any idea on what obstetric fistula is and on the availability of fistula repair services in the country. According to the participants this hindered them from seeking fistula repair services. This is what participants said, "*In the village, people are ignorant. It is only those who are educated on fistula who could know and identify the problem fast and advise us to seek repair services. The community health workers should sensitize the community on the condition and repair services." (P2, P5, P6,* P14, P15*)*

Some participants who had informed their communities about their condition felt that they were of no help. If communities were of help in terms of taking them to the hospital for repair services, then they could have accessed care. This is what participants said," *The community should help us access treatment. If the family has no resources,*

then the community should be able to help afflicted women. They should take us to the hospital for repair services in any way possible." (P2, P5, P6)

Participants reported that after informing their communities about their condition, they were stigmatised. They could no longer interact as they used to before revealing their problem. Being stigmatised made them not to seek fistula repair services. This is what participants said; *"Some people I have told about my condition in the community have told other people that I leaks urine. It makes me feel very bad about it." (P5, P12)*

Health systems barriers

Participants reported that health care providers did not about their condition which contributed to their failure in seeking fistula repair services. Participant number 15 said**, "***When I sustained a fistula, health care providers just put a catheter on me without telling me anything about why the catheter was inserted. What they only said is that all those who had caesarean section were fine apart from me. So I was discharged without knowing anything about my condition."*

Participants who had been for fistula repair services reported distance to fistula repair centres as a barrier in seeking fistula repair services. This is what participant number 12 and 13 said; "*It is not easy to seek repair services due to distance to hospitals that offers repair. So I have not gone back to the hospital to date."*

Another one said, *"I was leaving very far away from the fistula repair centre where I could travel for a day because of the distance. Those who can walk or travel for few hours are able to seek repair services in good time." (P7)*

Also, absence of treatment centres near where afflicted women stay was reported as a significant contributory factor for delay in seeking treatment**.** One woman wished fistula repair services would be at her door steps. This is what she said, *"Hospitals that offer repair services should be near our doorsteps. Really, I would like to stop leaking urine completely, that is the treatment I want." (P1)*

Some participants reported shortage of fistula surgeon. Shortage of fistula surgeons resulted in those who had been to seek repair services not to continue seeking the service. Fistula patients said, "*Sometimes you can be lucky to find doctors conducting repairs. Like what has been happening to me, whenever I hear that there are doctors doing repairs, I would go for fistula repair. I wanted to be healed completely. I needed to chance the doctor because only a few doctors are able to conduct repairs. But I cannot continue going for the service if doctors are not available." (P5, P6)*

Another one said, "*I have been repaired three (3) times though sometimes when I went for repair services, I was told it is not now when the Doctor conducting repair is coming but at times I was missing the doctor."* (P8)

Participants also reported that as a result of shortage of doctors, they were given appointment. Appointments were not maintained and this discouraged afflicted women in seeking fistula repair services. This is what participants said, *"I was given an appointment when to seek repair services. The appointment given was for several months. I will never seek fistula repair services." (P5, P6)*

For those that were repaired, most of them reported having unsuccessful repairs. Having unsuccessful repairs discouraged them from seeking repair services. This is what fistula patients said "*I fear that the Doctor would make another mistake which would worsen my situation. Iam* scared *in the sense that I have had three repairs done and the doctor made mistakes during each operation. I am still leaking. So, I have not gone back to that hospital for the operation up to now." (P5, P12)*

Other fistula patients put it like this, *"I did not go for another attempt at repair because I did not heal previously and I got discouraged because of lack of skilled fistula surgeon." (P9, P10, P13)*

Some participants also felt that they were not given instruction from the hospitals or clinics on where else to seek fistula repair services after failed attempts at their usual source of care. Fistula patients had this to say, "*The hospitals and clinics should be able to refer us where we can successfully be repaired. It is important to heal completely. This is why I have failed to seek fistula treatment." (P4, P5)*

Other afflicted women felt that the timing for repair was not appropriate for them. A fistula patient said, *"The timing for repair services is bad. Like now women are supposed to go for repair. There is a camp but most of us have decided to go "kufishimu" (fetch caterpillars) so that we make abit of money to sustain ourselves and families." (P11)*

Some fistula patients felt that healing was not a must. Due to unsuccessful repairs, women decided to stay with the leaking urine and/ or stool. This is what participants said, *"I was repaired and went back home. I continued leaking. Years came and went until there came a time when I heard that there were doctors who were doing repairs again. I went. Even the second, I could not heal completely. I continued coming to the hospital until I had all the four repairs but without recovering. I am still leaking. So I have just decided to stay like this without seeking repair services." (P9)*

Another one said, "*Once you are repaired even if it is not successful the leakage minimizes and so I am able to cope with the situation. There is no more need to seek fistula treatment." (P6)*

Discussion

The age of women with obstetric fistula who participated in the study ranged from 19-87 years. This could mean that after sustaining an obstetric fistula, women stay for many years without seeking repair services and /or without having successful repairs. This is in agreement with a study done by Turan, *et al.*, (2007) [6] who found out that afflicted women live up to 50 years without surgical repair. Repair of fistula is recommended within 3 months of woman first experiencing fistula symptoms; if women delay seeking treatment for more than 3 months, the condition tends to be difficult to repair and results in more delay in healing and possible reoccurrence of fistula (Dennis *et al*., 2016; Mohamed, Ilesanmi and Dairo, 2018) [24, 25]. Eight participants were married. Therefore, the large proportion of women that were still married in this study is difficult to explain, but may be due to differences in the case or acceptability of divorce in Zambia, compared with other countries. One other possibility is that in communities that practice polygamy, the husband may take another wife without having to divorce the existing wife. Similar results were reported by previous studies conducted in other African countries where not all women were divorced following sustaining a fistula (Yeakey, *et al*., 2011; Mehta and Bangser, 2006) [26, 27]. Nine afflicted women were self-

employed. This could be attributed to the fact that women with fistula are not education and could not be in formal employment. Lack of employment resulted in the women having no source of income unless those that was still married and supported by their partners. Thirteen participants were of the childbearing age and some women have had children following a pregnancy that resulted in an obstetric fistula. This may mean that women would still get pregnant and have children regardless of having unsuccessful repairs. This is supported by (Bishinga *et al*., 2013) [28] who noted that delivery has been reported to be associated with the recurrence of fistula after surgical repair.

In this study, findings showed that some women had never been for fistula repair services while those that had been for fistula repair services had unsuccessful repairs. In support of the findings, some women had no idea that treatment is available. According to literature, an estimation of 80% of afflicted women never sought treatment because they lacked knowledge that repair services exist (WHO, 2006) [29]. If women are not aware of the service, they would not utilise it. It is therefore, suggested that reliable information on where and when treatment is available be disseminated to the afflicted women and communities consistently to promote seeking fistula repair services.

Study findings showed that distance, limited availability of fistula repair centres and poor road infrastructure also prevented women from seeking repair services. Similar findings are reported from a study conducted by Abokaiagana, (2010) [30] who found out that long distances to health facilities contributed to delay in accessing health care services. Limited availability of fistula centres contribute to women staying at home despite any complications that they may have. Hence, establishing a dedicated fistula centres in high prevalent areas is an effective strategy in supporting women living with obstetric fistula rather than a hospital committed to fistula repair (Cam *et al*., 2009) [31]. Also, study findings by Gele *et al*. (2017) [32] suggested that fistula centres should be established, and access to these facilities has to be guaranteed for all afflicted women who need these services.

Findings also showed that all women that had been repaired before had unsuccessful repair hence the perceived poor quality of care by women with obstetric fistula. This has an impact in seeking repair services. Therefore, trained fistula surgeons repair should conduct repair services since they have the knowledge and skills on how to perform the procedure. Unsuccessful surgery led to the women staying home for long periods before they could attempt another visit to the hospital or not seek repair services at all. This is in agreement with a study done by Khisa, *et al.,* (2017) [33] who revealed that women expressed frustration with multiple surgery and unsuccessful repairs. It is worth noting that multiple visits for treatment are costly and women with no source of income could not afford it. Similar results were reported by Tilahun, *et al.,* (2014) [34] who indicated that unsuccessful repairs made afflicted women give up and learnt to tolerate their situation.

Study results showed that financial barriers such as transportation cost and the cost of health care made some afflicted women not to seek fistula repair services. Failure to pay for transportation and repair services were caused by the fact that most women were self-employed and hence had minimum or no income. Assisting afflicted women with transportation or transportation fees would make accessing treatment easier (Meurice *et al*., 2016) [35]. In support of the above findings, Woldeamanuel (2012) [36] indicated that afflicted women had to think twice before going to the hospital in fear of paying huge sums of money. These findings suggest that services and transport to treatment should be available and affordable, ideally at no cost to the woman and her family.

Several studies (Aliyu *et al*., 2011; Mselle *et al*., 2011) [37, 1] have revealed failure to seek care as a result of women with obstetric fistula not being accompanied to the fistula repair centres by their husbands, families, or communities. In addition, afflicted women experience anxiety, loss of dignity, and low self-worth that inhibits their agency and motivation for seeking treatment (Bangser, 2011) [16]. In support of the findings, it was noted that stigmatization by the communities hindered women from seeking fistula repair services. This finding concurs with the results by Arora, Mullan and Lawton (2010) [38] who reported that the stigma associated with fistula make the afflicted women to live in a state of denial and hiding from the public.

Findings also suggested that afflicted women do not seek repair services because of their physical illness and use of traditional medicine. These findings portrayed that women experienced loss of body control, body weakness and felt fatigued most of the times. This is in agreement with a study done by Khisa, *et al.,* (2017) [34] who revealed that the onset of fistula illness and patient's recognition of symptoms are a crisis that the individual resolves through staying home with the illness or reaching out to the formal and informal systems for treatment. Similar results were noted by (Kavai, Chepchirchir and Kayugira, 2010) [39], who reported that cultural beliefs and traditional practices reduced the use of medical care by women with obstetric fistula. These findings suggest that afflicted women and their communities must be given information on the condition to enable them make informed decisions about repair services.

Conclusion

Based on the findings of this study, there is evidence that women who seek fistula repair services have had unsuccessful repairs. However, a notable number of women with obstetric fistula did not seek fistula repair services because they did not know that fistula repair services existed despite delivering the baby in hospital that resulted in them sustaining a fistula. Thirteen women were of the childbearing age. Therefore, it is important that current approaches to improving knowledge on condition and repair services available are addressed. Also, availability of skilled fistula surgeons to conduct repairs is necessary in order to encourage women to seek repair services. In the absence of such an understanding, it is difficult to map out the interventions that would help women access surgical repair.

Study limitations

The study was subject to the following limitation: First, the study was only limited to four provinces of Zambia which may not be representative of other provinces which were not included since there are different in terms of geographical location. Secondly, only rural women with obstetric fistula were interviewed which could not be representative of the urban women living with obstetric fistula. However, the fact that this study contained time-specific information in four provinces of Zambia does not mean that the findings would be inapplicable and have no meaning in other contexts.

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Conflict of Interest
The author declares no competing interest in the study.

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