POLAC ECONOMIC REVIEW (PER)
DEPARTMENT OF ECONOMICS
NIGERIA POLICE ACADEMY, WUDIL-KANO

ASSESSMENT OF BARRIERS IN SEEKING TREATMENT AMONG WOMEN WITH OBSTETRIC FISTULA IN JOS NORTH LOCAL GOVERNMENT AREA OF PLATEAU STATE

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Abstract

Obstetric fistula is a debilitating complication of childbirth that affects many young women in developing societies. Disparities in access to and utilization of quality healthcare services contribute to the barriers women face in seeking treatment for obstetric fistula. This paper aims to examine these barriers and propose recommendations for improvement. The study adopts the health belief model as its theoretical framework and employs a cross-sectional descriptive survey design in Jos North L.G.A. A sample size of 400 women of reproductive age (15-49 years) was selected using the Taro Yamane formula, and data were collected through questionnaires. Out of the 400 distributed questionnaires, 375 were retrieved, and 367 were found to be valid for analysis using the Statistical Package for Social Sciences (SPSS). Key informant interviews were also conducted. The findings reveal that barriers include poor knowledge of available health services, lack of awareness about treatment centers, lack of spouse approval to seek treatment, fear of treatment costs, fear of stigmatization, and cultural beliefs favouring divine healing. The study recommends increasing public awareness, ensuring appropriate referrals to treatment centers, fostering effective doctor-patient relationships, providing counseling to address stigma, and engaging religious and traditional leaders in sensitization efforts. Supportive measures from husbands and healthcare personnel are also essential. These recommendations aim to enhance access to and utilisation of healthcare services for women with obstetric fistula.

Keywords: Obstetric Fistula, Women, Treatment, Health Seeking Behaviour Reproduction

1. Introduction

Over the years, obstetric fistula has remained a public health concern among women in developing nations. Globally, each year, more than half a million healthy young women die from complications of pregnancy and childbirth. Virtually all such deaths occur in developing countries (WHO, 2019). With an annual incidence of between 12, 000 cases to 150000 cases, Obstetric Fistula (OF) has become a major public health problem in Nigeria (Ojukwu, 2022). Obstetric fistula is an abnormal communication between a woman's genital tract and either the urinary tract or the rectum resulting in leakage of urine or faeces from the vagina following childbirth (Tebeu, Formulu, Khaddaj et al., 2012).

The disease is one of the worst childbirth injuries caused by prolonged obstructed labour which accounts for up to 95% of the cases seen in Nigeria (Melah, Massa, Yahaya, Bukar, Kizaya& El-Nafaty, 2007).Obstetric fistula is typically caused by prolonged obstructed labour. It forms when there is sustained pressure by the fetal skull against the maternal pelvic bone. This compromises blood flow to the soft tissues of the vagina and bladder which are trapped in-between, leading to ischemia then pressure necrosis. Subsequently, the affected tissues slough off and a hole (fistula) is formed between these body cavities leading to continuous and uncontrollable leakage of urine and/or faeces through the vagina (Wall, 2010).

Over the years, the Federal Ministry of Health has introduced rapid surgical interventions and service delivery approaches to reduce the burden of fistula in Nigeria (FMoH& UNFPA, 2019). Notable among these measures is the provision of free treatment for women with obstetric fistula at dedicated national centres (FMoH& UNFPA, 2019). However, majority of women with obstetric fistula present late for repair. In our environment, women leak urine or faeces for an average of 42 months before presenting for repair (Daniyan, Obuna, Daniyan et al., 2021).It is unclear why many sufferers of this condition delay coming for repair despite their harrowing experiences and the availability of free treatment in designated centres.

Women's medical help-seeking behaviour is influenced by several factors, including the general understanding and interpretation of the disease itself, type and severity of the medical condition, available information regarding treatment opportunities, economic reasons, and the type of health care financing system that operates in such health care settings (Basu, & uckett, 2009; Doshi, Van Den Eeden et al., 2010; Al-Azab, & haaban, 2010). Furthermore, the prevailing socio-cultural views of a particular medical condition could either be enabling or inhibiting to seeking help by the sufferer (Bradway & Barg, 2006; Al-Azab et al., 2010).

Previous studies have shown that women with obstetric fistula manifest their help-seeking behaviours in a different manner than women with other medical morbidities (Waaldijk, 2004; Sunday-Adeoye, Daniyan, Elohoh, 2017). Reasons for such behaviour include fear of surgery; embarrassment or humiliation; (Hagglund & Wadensten, 2007) lack of knowledge; apathy of health care workers; lack of convincing information and assurance that their health problem can be resolved; beliefs that the condition is not life-threatening, but rather is a normal part of aging process; failure of previous treatment; and impact on quality of life, among others (Koch, 2006; Howard & Steggall, 2010). Predictors for help-seeking behaviours by women complaining of obstetric fistula include education level, severity of symptoms, and the impact of symptoms (Koch, 2006).

However, the influence of age as an independent predictor varies. Yu et al (2006) found no age-related association with helpseeking behaviours, but Hannestad, Rortveit and Hunskaar (2002) reported increasing age as positive predictor of seeking treatment. While knowledge regarding help-seeking behaviours amongst women is advancing and has recently been better characterized, there appears to be lack of information from sub-Saharan Africa (SSA) on this topic.

Obstetric fistula disproportionately affects women in Nigeria, yet barriers to accessing critical medical care persist, prolonging their suffering and marginalization. Coordinated efforts to address this issue have been made, but major obstacles remain. This study aims to identify and explore these barriers to healthcare access in order to inform targeted treatments and policies to improve the well-being of affected women.

Research regarding help-seeking behaviour in this environment is necessary because there are some behaviours that may be peculiar or specific to this setting. Factors influencing help-seeking behaviours may include availability of specialists, 'out of pocket' health care financing, socio-cultural taboos, poor access to quality service, and popularity of traditional medicine practice. Additionally, poverty, ignorance, and disease are still prevalent in this region. The combination of these factors has placed women from Jos North Local Government, Plateau State on a different level than their peers in the developed world regarding behavioural adaptations and response to help-seeking among women with obstetric fistula. Thus, this study aims to identify factors affecting the help-seeking behaviours of women who are currently experiencing obstetric fistula in Jos North Plateau State, while discussing the factors that influence access to hospital care services. It alsodescribes the potential reasons why women with obstetric fistula may not wish to seek help.

Therefore, the main objective of this study is to examine the barriers to accessing healthcare services among women with fistula in Jos North Plateau State.

2. Literature Review

2.1 Conceptual Issues

Concept of Obstetric Fistula

Obstetric fistula is an abnormal hole in the vaginal wall which links into the bladder (vesico-vaginal fistula) or the rectum (recto-vaginal fistula) or both (WHO, 2006). This condition results when labour is prolonged, and the presenting foetus becomes impacted within the birth canal. The vaginal soft tissue is compressed against the bony pelvis of the woman during labour and, if there is no timely intervention (such as emergency caesarian section), the vaginal tissue becomes necrotic. The necrotic tissue sloughs off, usually within three to ten days postpartum, and a hole develops in the birth canal which subsequently results in uncontrollable leakage of urine and/or faeces through the vagina. This condition may be further complicated by infection, vaginal ulcers, scarring, and stillbirths, which are seen in 78 to 95% of cases (Wall, 2002; Mselle, Kohi, Mvungi, Evjen-Olsen &Moland, 2011; Tebeu, Fomulu, Khaddaj, De Bernis, Delvaux&Rochat, 2012). The vesico vaginal fistula is characterized by the leakage of the urine through the vagina, and recto vaginal fistula is characterized by the leakage of flatus and stool through the vagina. Both vesico vaginal and recto vaginal fistula are associated with a persistent offensive odour leading to the social stigma and ostracization of these affected women (Bangser, 2006; Cook, Dickens & Syed, 2004). For this paper, obstetric fistula is conceptual as injuries sustained by a girl/woman at the course of childbirth which is caused by prolonged labour and obstructed labour which causes damage to the vagina.

Concept of Health Seeking Behaviour

Health care seeking behaviour has been defined as "sequence of remedial actions that individuals undertake to rectify perceived ill health. In particular, the health seeking behaviour can be described with data collected from information such as the time difference between the onset of an illness and getting in contact with a healthcare professional, type of health care provides patients sought help from, how complaint the patient is with the recommended treatment, reasons for choice of health care professional and reasons for not seeking help from healthcare professionals" (Bhuiya, 2009). In this paper, the author is adopting this definition to explain health care seeking behaviour among women with obstetric fistula in Jos North, Plateau State.

Women Reproductive Health

Kotwal, Gupta and Gupta (2008) viewed reproductive health as a major aspect of general wellbeing, constituting a central feature of human development. It reflects one's state of healthiness during childhood through adolescence and adulthood and sets the stage for health beyond the reproductive years for both men and women and also impacts on the health of the subsequent generation. The World Health Organization [WHO] (2002) defined reproductive health as the state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity (WHO, 2002). Reproductive health therefore deals with the reproductive processes, functions and system at all stages of life cycle, not only at old age.

Similarly, Alubo (2001) defined reproductive health as the whole array of counsel, information and services required and necessary for safe and healthy sexual expression. It concerns health and illness in relation to the body's reproductive function. Therefore, sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Therefore, sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. Reproductive health therefore implies that people are able tohave a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health - care services that will enable women to go safely

through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

2.2 Theoretical Framework

The study is situated within the framework Health Belief Model. The Health Belief Model (HBM) is a Social Psychological Model that attempt to explain and predict health behaviours. This is done by focusing on the attitude and beliefs of individuals. The Health Belief Model was developed in the 1950s by Social Psychologists Hochbaum, Rosenstock and Kegels working in the USA public Health Services. This theory explains psychological health behaviour change, the model is developed to explain and predict health-related behaviours, particularly in regard to the uptake of health services (Janz; Marshall &Becker 1984, Rosenstock, 1974). The Health Belief Model suggests that people's beliefs about health problems, perceived benefits of action and barriers to action and self-efficacy explain engagement (or lack of engagement) in health-promoting behaviour (Rosenstock, 1974). A stimulus, or cue to action, must also be presented in order to trigger the health promoting behaviour.

According to MacKian (2003), the process of health care seeking involves identification of pathways to the formal health care system, often commencing with home care and traditional healers and extending to the formal system, pathways differing according to the present condition. In a review of Health Belief Model or theory, Chen (2012) demonstrated that the decision to engage with a particular medical channel is influenced by a variety of variables, including sex, age, the social status of the aged, the type of illness, access to services and perceived quality of the service. Health-seeking behaviour looks at illness behaviour more generally and focuses in particular on motivating factors of illness perception and health belief.

Applying the health belief model which is an individual opinion and perspectives about a certain health risk and their behaviour, the incidence of obstetric fistula can be prevented and managed when women become willing to seek appropriate healthcare services during pregnancy and at delivery. Just as the model suggest, when individuals find the need to seek healthcare service (maternal healthcare), incidences of Obstetric Fistula can be reduced through the services of skilled birth Attendants, the use of emergency obstetric cesarean and even through the uptake of contraceptives. This is a linked to the models postulation of perceived health need and the cue for action.

2.3 Empirical Review

In sub-Saharan Africa, qualitative studies over the last decade have explored multiple barriers faced by women living with fistula (Mselle & Kohi, 2015; Mselle & Kohi, 2016; Baker, Bellows, Bach, and Warren, 2017). Financial barriers observed across studies include actual and perceived costs of transportation to hospitals and ancillary services during surgery and the post-operative recovery period for women and accompanying family members (Warren, Sripad et al., 2018; Kaye, Sripad, Nwala& Warren, 2018). Women also face deterrents and delays in care-seeking related to health systems quality (such as inadequate ante-natal, childbirth and postnatal care and limited health worker knowledge) as well as gaps in individual and community awareness of fistula as a condition, its causes, consequences, and treatment options (Warren, Agbonkhese & Ishaku, 2016; Sripad & Warren, 2016). Additionally, psychosocial barriers intersect with gender dynamics in the household to leave many women isolated and reinforce a deep sense of shame and low self-worth. These barriers may affect women's ability to manage self-care in the home, engage in socioeconomic and cultural activities, or decide to seek repair and reintegration services (Kabayambi, Barageine, Matovu et al, 2014; Watt, Wilson, Joseph et al., 2014; Mselle et al., 2016). While barriers to fistula care have been described qualitatively in several low middle income countries, limited effort has been made to measure these factors quantitatively and comprehensively, in a standardized and comparable way.

Various quantitative fistula studies have been conducted to primarily focus on prevalence estimation (epidemiology) or profile experiences for clinical care (Adler, Ronsmans, Calvert &Flippi,

2013; Gaheu-Giroux et al., 2016; Meurice, Genadry, Bradley et al., 2016), however, only limited attention to measuring the range of barriers to fistula care. These studies have, however, demonstrated aspects of women's experience with fistula that are conceptually and empirically (cross-sectionally) associated with barriers to seeking, reaching, and receiving fistula care. In Nigeria and Uganda, according to a cross-country survey, the median length of time a woman lives with fistula before seeking care (1 and 2 years, respectively) is likely associated with the nature and magnitude of barriers she faces (Landry, Frajzyngler et al., 2013). A quantitative analysis of Demographic and Health Survey (DHS) data in sub-Saharan Africa, suggests that age and levels of education may have indirect associations with barriers and enablers of care; namely, those with higher education levels may be more likely to attend antenatal care, have better birth preparedness and elevated knowledge of fistula prevention and care options (Gebremedhin & Asefa, 2019).

The socio-cultural and health systems contexts of fistula care-seeking are important to consider, including spousal, family, community social support or lack thereof on the one hand and formal and informal care alternatives (such as surgical/rehabilitation services and/or traditional healers) on the other (Maheu-Giroux, Filippi, Maulet, Samadoulougou, Castro, Meda, et al.2016, SripadArnoff, et al., 2020). Given the often-hidden nature of the population living with fistula, limited data on the fistula burden in low middle income countries, and backlog of cases awaiting surgical treatment at hospitals, our current study relies on women who have reached care to make inferences about those who have not. Composite measures (scales and indices) offer an opportunity to better understand barriers to fistula care and design interventions aimed at reducing obstacles and increasing equity-promoting solutions. While the cross-country DHS study showed seven discrete reasons for not seeking fistula care-ranging from unawareness of fistulas repairability and service locations, to expense and distance, to embarrassment, to limited permission to seek care, and poor quality care– these were not cumulatively analyzed at the level of the woman herself (Gebremedhin et al, 2019). Composite measures are of growing interest in maternal, newborn, and child health globally, such as, related to the increased focus on experienced quality of care (Tripathi, Stanton, Strobino & Bartlett, 2015; Sheferaw, Mengesha &Wase, 2016; Vedam, Stoll et al., 2016).

Scales measure latent concepts like "barriers" and are recognized as acceptable in health program settings that focus on marginalized or stigmatized populations as seen in the HIV and mental health fields (Clement, Brohan et al., 2012; Wklander, Brannstrom, Svedhem & Eriksson, 2015). Given the layered, interrelated, yet conceptually congruent nature of the barriers experienced by women with fistula across low income countries (Baker, Bellows, Bach and Warren, 2017) and documented in Nigeria and Uganda in particular (Warren, Agbonkhese & Ishaku, 2016; Sripad &Warren, 2016), composite scales related to this maternal morbidity may deepen our understanding of a complex psychometric phenomenon and offer measurement tools for wider research and programmatic use.

A previous study in our environment revealed poor awareness of obstetric fistula among health workers in primary and secondary facilities (Obuna, Madubueze et al, 2021). Another reason for delay in accessing treatment of obstetric fistula was lack of information that treatment was free. After becoming aware of the availability of treatment or after a referral to the centre, patients and relations delay treatment while trying to source money for the treatment of obstetric fistula. Lack of finance is a known barrier to obstetric fistula treatment (Baker et al., 2017) Belief in divine healing is also a cause of delay in accessing free repair of obstetric fistula even after a doctor's referral to a treatment centre. This may be because some women believe their problem is not medical but spiritual or because they do not want to undergo surgery. Such religious belief has also been identified as a cause of delay in accepting surgical repair of fistula (Nalubwama, Ayadiet al., 2020). Hoping that urine leakage will stop may also be associated with a patient's belief system. Religious belief is one of the coping mechanisms among obstetric fistula patients (Watt, Wilson et al., 2014).

3. Methodology

3.3 Study Design

The study employed a cross-sectional descriptive survey design among women in Jos north Local Government Area of Plateau State Nigeria.

3.2 Population and Sampling

The target populations for this study are women within the reproductive age of 15-49 years in Jos North Local Government Area of Plateau State totaling 211,072 women (NPC, 2022). The study took a sample size of 400 women using the Taro Yamane formula of sample size determination, 95% confidence level and 5% margin of error allowed (Adam, 2020). Using multistage sampling technique, a total of 400 women were selected between May and July 2023. The first stage involved selection of a district area from the different district in the LGA by balloting. In the second stage, two communities in the districts were selected by balloting. All households in the chosen communities with eligible respondents (women between ages 15-49 years) were selected for the study. In houses where there are more than one household with eligible respondents, a household was randomly selected by balloting.

3.3. Method of Data Collection

Data were obtained using questionnaire and key informant interview. The questionnaire and interview guide was developed based on the objective of the study. Data were collected on socio-demographic characteristic of the respondents, and the barriers to seeking healthcare treatment among women with obstetric fistula in Jos North Plateau State. The questionnaires were interviewed administered to help respondents who are not able to read and write. The questionnaire was pretested in another district of the LGA to test the validity of the instrument. Ambiguous questions observed during pretesting were either rephrased or removed in line with the study objectives. Four research assistants were recruited and trained for the purpose of data collection.

3.4 Method of Data Analysis

The data were field edited daily and Statistical Package for Social Sciences (SPSS, version 25) was used for analysis. Initial analyses were done by generating frequency tables. Qualitative data of the study were also thematically analysed together with the results of the quantitative study.

4. Results and Discussion

Out of the four hundred questionnaires distributed, three hundred and seventy-five(375) were answered and retrieved but only three hundred and sixty-seven (367) representing 96.3percent of the questionnaires were valid and so are being used for analysis.

Table 1 Awareness of obstetric fistula (Urinary leakage)

Response	Frequency	Percentage
Aware	329	89.6
Not aware	38	10.4
Total	**367**	**100.0**

Source: Field Survey, 2023

Table 1 reveals the level of awareness of obstetric fistula among women within the reproductive age in Jos North Local Government Area of Plateau State. 89.6 percent of respondents affirm that they have heard of obstetric fistula. This was further reiterated by the response of the participants of the KII who unanimously agreed that the knowledge of obstetric fistula is common among women in the study area. Using the words of one of the participants of the KII;

The issue of fistula is common among women here as there are numerous women in the community who are a suffering from the disease. Although some of these women are not willing to report the cases, as a result of shame and the stigma associated to the disease, it's still

common that a lot of women have had about the disease or are even suffering from it at the moment. (41-year-old mother of 12 children, Rikkos-Kwanga, Jos North)

Table 2: Knowledge, and Health Seeking Behaviourof Women with Obstetric Fistula

Ever had urinary leakage (obstetric fistula)	**Frequency**	**Percentage**
Ever had	197	53.7
Never had	170	46.3
Total	**367**	**100.0**
Knowledge of available treatment for obstetric fistula	**Frequency**	**Percentage**
Self Medication	120	36.7
Healthcare centre	130	34.4
Traditional medicine	54	14.7
None of the above	**63**	**17.2**
Total	**367**	**100.0**
Aware that treatment for obstetric fistula is free	**Frequency**	**Percentage**
Aware	51	13.9
Not aware	316	86.1
Total	**367**	**100.0**
Respondent'swillingness toseek medical care for obstetric fistula	**Frequency**	**Percentage**
Willing	263	71.7
Not willing	104	28.3
Total	**367**	**100.0**

Source: Field Survey, 2023

Table 2 shows that 53.7 percent of women in the study are have ever experienced urinary leakage (Obstetric fistula).It further reveals that only 34.4 percent of respondents from the sampled area are not aware of medical treatment for obstetric fistula. More so, 86.1 percent of the women are not aware of the treatment of obstetric fistula is free. However, 71.7 percent of the respondents are willing to seek medical treatment for fistula in the area. Furthermore, the findings from the KII further revealed that women are aware of the existence of treatment of obstetric fistula, however, only a few of them are aware that the treatment is free. They also showed willingness to undergo treatment if giving the opportunity to seek medical help for the disease.

In their words:

"Sincerely, I know that there is a treatment for the urinary leakage I am going through, but the issue is that I am concerned about the cost of the treatment. I have always assumed that the treatment of the disease would be very expensive, and I just got to know now from you that the treatment is free. (31-year-old mother of 4 children from AngwanRogo in Jos North)

Well, even though I did not just come to the hospital when I started experiencing the urinary leakage, I knew that there must be a treatment for the disease. This is because I thought the treatment might may expensive but when some missionaries came to my community to create awareness, I learnt that the treatment was free and so I accepted to come to this place where I have been undergoing treatment. (17-year-old patient, Bingham, University Teaching Hospital, Jos North)

Table 4: Barriers to accessing treatment among women with obstetric fistula in Jos North

Lack of awareness of specialised treatment centres	**Frequency**	**Percentage**
Yes	308	83.9
No	59	16.1
Total	**367**	**100.0**
Lack of spousal approval for treatment	**Frequency**	**Percentage**
Yes	315	85.8
No	52	14.2
Total	**367**	**100.0**
Fear of cost of treatment	**Frequency**	**Percentage**
Yes	329	89.6
No	38	10.4
Total	**367**	**100.0**
Fear of associated stigma associated to the disease	**Frequency**	**Percentage**
Yes	256	69.8
No	111	30.2
Total	**367**	**100.0**
Incorrect advice from health personal	**Frequency**	**Percentage**
Yes	312	85.0
No	55	15.0
Total	**367**	**100.0**
Belief in divine healing for obstetric fistula	**Frequency**	**Percentage**
Yes	120	32.7
No	247	68.3
Total	**367**	**100.0**
Negative attitude from healthcare personnel	**Frequency**	**Percentage**
Yes	193	52.6
No	174	47.3
Total	**367**	**100.0**

Source: Field Survey, 2023

The table shows that among the barriers for accessing treatment for treatment of obstetric fistula among women are; lack of awareness of treatment centres (83.9%), lack of spousal approval (85.8%), fear of the assumed cost of treatment (89.6%), fear of associated stigma associated with the disease(69.8%), belief in divine healing (85.0%) and the negative experiences with healthcare providers(52.6%).

The responses from the KII also revealed that there are certain socio-cultural factors that affect the utilization of health care services among women with obstetric fistula in Jos North Local Government Area of Plateau State. In the words of the respondents;

I have been suffering from this urinary leakage since the delivery of my last child a year ago. I have not been able to go for treatment as I do not have the money for treatment. (44 year old mother of 12, AnganRogo, Jos North)

I have been suffering from this ailment since the last time a had miscarriage, even though I am willing to visit health care center for treatment, my husband has not really supported or agreed as he consider the case an embarrassment to

him. I also do not have the money to go by myself as I am a stay-at-home mother. (32 years mother, Rikkos-Kwanga, Jos North)

I developed the issue after I got married and had a tear after having sexual relation with my husband. The urinary leakage became a part of my daily life and my husband refused to take me to the hospital. After a little while, he divorced me and I only got to know that the issue was fistula after some missionaries came over to my community and also told us that there is a free treatment for the disease. (14 year old patient at Bingham University Teaching Hospital, Jos North)

4.1 Discussion of Findings

The findings from the study revealed that most of the respondents are aware of obstetric fistula. However, the findings revealed that only a fair percentage of respondents have heard of treatment for obstetric fistula. More so, most of the women are not aware of the treatment of obstetric fistula is free. It can be inferred that the knowledge of available treatment for obstetric fistula among women is abysmally low especially as it relates to provision of free treatment for the disease.Most women suffering from obstetric fistula are not aware of availability of treatment facilities (FMOH, 2019). This implies that a good number of the women affected are literarily suffering in silence and ignorance.This agrees with the result of a Tanzanian study which reported that inadequate knowledge about obstetric fistula contributes to delay in seeking treatment (Lyimo&Mosha, 2019). While the findings show that most of the women have a positive attitude towards undergoing the treatment, only a minute proportion of the women have had treatment for obstetric fistula in the area.

The observed barriers in seeking healthcare among women with obstetric fistula is associated to numerous socio-economic factors ranging from poor knowledge of healthcare services, lack of awareness of treatment centres, lack of spousal approval, fear of the assumed cost of treatment, fear of associated stigma associated with the disease, belief in divine healing and the negative experiences with healthcare providers. This agrees with previous studies that reported that the reason for delay in accessing treatment of obstetric fistula was lack of information that treatment was free. After becoming aware of the availability of treatment or after a referral to the centre, patients and relations delay treatment while trying to source money for the treatment of obstetric fistula. Lack of finance is a known barrier to obstetric fistula treatment (Baker et al., 2017). Also, Nalubwana et al (2020) also assert that belief in divine healing is also a cause of delay in accessing free repair of obstetric fistula even after a doctor's referral to a treatment centre. This may be because some women believe their problem is not medical but spiritual or because they do not want to undergo surgery. They added that such religious belief has also been identified as a cause of delay in accepting surgical repair of fistula (Nalubwama, et al., 2020). Hoping that urine leakage will stop may also be associated with a patient's belief system.Watt et al., 2014). Furthermore, other scholars have reported that socio-cultural factors such as spousal, family, community social support or lack thereof on the one and the associated stigma that is associated to fistula are also barriers to seeking healthcare services among women with fistula (Maheu-Giroux, et al. 2016, and Sripad et al., 2020). Also, some scholars further reiterated that the actual and perceived costs of transportation to hospitals and ancillary services during treatment and the post-operative recovery period for women with obstetric fistula is also a barrier to seeking treatment among women with fistula (Warren, et al., 2018; Kaye, et al., 2018).

5. Conclusion and Recommendations

Evidence from the study has shown that there is an alarming lack of healthcare utilization among women with obstetric fistula. More so, study has shown several barriers that hinder women from getting help if they continue to experience issues associated with urinary leakage and obstetric fistula. This has a significant impact on women in the community can have a lower quality of life because of recurring symptoms for which they are not seeking treatment. Thus, it is recommended that:

i. There should be increased public awarenessespecially among women on the availability of free treatment of obstetric fistula in the area.
ii. Healthcare centers should ensure that appropriate referral is made to women suffering from obstetric fistula to designated healthcare centers that provided treatment for them.
iii. There is need for effective doctor-patient relationship, to ensure a cordial relationship between healthcare workers and patients with fistula.
iv. There should be effective counselling prior to referrals as that will help reduce the perception of women on the associated stigma for the disease and further help reduce these delays.
v. Religious and traditional leaders should sensitize members of their communities on the need to enhance and support women who may experience the ailment. In this regard, husbands should support their wives who have experienced this health problem.
vi. Relevant stakeholders in the health sector should sensitize their medical personnel to support and assist women with obstetric fistula who regularly visit health clinics for treatment.

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