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Views of health care providers on factors hindering women with obstetric fistula in seeking fistula repair services in Zambia: The case of Muchinga, Luapula, Eastern and Southern provinces

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Poor use of fistula repair services has contributed to the continued consequences of obstetric fistula that are physical, psychological, social, financial and economic among the afflicted women. The study was designed to assess views of health care providers on factors hindering women with obstetric fistula in seeking fistula repair services. A descriptive cross sectional design was used. Sixty-five (65) health care providers were selected through convenient sampling method to participate in the study. A structured interview schedule was used to collect data. Reliability was ensured using test retest and alpha value of 0.7 for the views scale Statistical analysis was performed with the IBM SPSS Statistics 20 software. Data was expressed as descriptive summary measures. Factors found to be hindering women in seeking fistula repair services were lack of knowledge that repair services exist, anxiety, loss of dignity, stigma, transportation challenges, financing for the procedure, myths and misconception on obstetric fistula and health systems barriers. Therefore, there is need to engage the individual, communities, organisations and policy makers in order to improve women's use of fistula repair services.

Key words: Health care providers, women with obstetric fistula, fistula repair services, obstetric fistula, Views, Zambia.

INTRODUCTION

Obstetric fistula is a childbirth complication in which a hole develops between the bladder and vagina or between the rectum and vagina (Gele et al., 2017). It occurs after a prolonged and neglected labour without adequate assistance or might happen as a complication after caesarean delivery, and causes a constant leaking

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of urine and/or faeces through the vagina (Gele et al., 2017). Fistula occurs roughly in 50,000 –130,000 girls and women occurring living in Africa annually (Alkire et al., 2012).

However, treatment consists of surgical repair of the fistulas, though it sometimes requires multiple surgeries to get a complete resolution of the problem (Wall, 2012a). Women with fistula may be unaware that repair is possible, or lack the resources to seek care, and may face delays in receiving appropriate treatment due to personnel or facility shortages and poor quality of care (Fiander et al., 2013). Also, many women and girls may not seek fistula surgery despite realising the urine leakage soon after delivery (Turan et al., 2007)

Several studies (Aliyu and Esegbona, 2011; Mselle et al., 2011) have revealed failure to seek care as a result of women with obstetric fistula not being accompanied to the treatment facilities by their husbands, families, or communities. Women normally have to travel long distances to reach the few facilities that conduct fistula surgery. The woman may also lack the resources needed to seek care, as distances to health facilities may be great and travel to facilities may be costly (Bangser et al., 2010; Fiander et al., 2013). Sometimes, even if awareness, financial and transportation barriers to care are overcome, women may experience delays in seeking repair due to a number of factors including lack of skilled fistula surgeons, and long hospital waiting times (Bellows et al., 2013).

In addition, bad treatment of women and girls with obstetric fistula in health facilities can deter them from going for follow-up care or seeking further medical treatment in case of unsuccessful surgery (Odhiambo, 2010). Also, afflicted women experience anxiety, loss of dignity, and low self-worth that inhibits their agency and motivation for seeking treatment (Bangser, 2011). Previous research have also shown that some of the morbidities related to delay in seeking treatment are neurological damage in the lower limbs, such as foot drop, development of contractures, disuse atrophy, genitourinary infections, renal failure, and dermatitis. Other factors too include a disproportionately high prevalence of depression (Mselle et al., 2011).

Furthermore, research has shown that in the quest for healing, women wandered between different modern health structures before being directed to an effective fistula repair centre, a few initially consulted witchdoctors before turning to modern health care and some women resorted to traditional care for lack of proper referral or in an attempt to maintain some social support by complying with local practices and family advice (Maulet et al., 2015). Seeking repair services from other sources further delays women in seeking modern treatment.

Given the above factors of which some have also been identified in this current study, the aim was to assess views of health care providers on factors hindering afflicted women in seeking fistula repair services.

MATERIALS AND METHODS

This was a descriptive cross sectional study. The study population included were policy markers working in the Reproductive Health Unit at the Ministry of Health, program planners at the Provincial Health Offices in the four provinces of Zambia (Muchinga, Luapula, Eastern and Southern provinces) and UNFPA and program implementers working in the four fistula repair centres (Mansa General Hospital, Chilonga, Katete and Monze Mission hospitals).

A total of 65 respondents participated in the study from October 2017 to September 2018. Data were collected using a structured questionnaire. Data collection instrument was pre-tested in Lusaka province on program planners working at Lusaka Provincial Health Office and program implementers at the University Teaching Hospitals - Women and Newborn Hospital. The results were then used to reframe the questionnaire for final collection of data. The interview took 30–45 minutes.

Validity and reliability of the instrument

To ensure validity, data collection instruments were subjected to scrutiny by clinical experts and research supervisors. Same data collection tool was used on all the respondents in the same way. To ensure reliability, each interview question was tested using test retest and the average alpha value was above 0.7 for the views scale.

Ethical approval

The proposal was approved by the Biomedical Research Ethics Committee of the University of Zambia. Written permission was granted by the National Health Research Authority under the Ministry of Health. Written permission was also sought from the Provincial Health Directors (Muchinga, Luapula, Eastern and Southern Provinces), Senior Medical Superintendent at the University Teaching Hospital and Medical superintendents in the four fistula repair centres (Mansa General Hospital, Chilonga Mission Hospital, Katete Mission Hospital and Monze Mission Hospital). Respondents were asked to give their consent to participate. Only those who consented participated in the study. Privacy, anonymity and confidentiality were maintained and participation in the study was purely voluntary. Collected data were securely kept in a locked cupboard and only accessible to the researcher.

Data was entered in a computer and analysed using SPSS version 20 computer statistical package to summarise the quantitative data with consequent generation of frequencies and proportions.

RESULTS

A total of 65 health care providers participated in the study. The age of the participants ranged from 20 to 59 years (Table 1)**.** The results of the study have been presented using frequency tables.

Socio demographic characteristics of sample

Majority 35 (53.8%) of the respondents were aged 20 to 35 years while those aged above 50 years were 7 (10.8%). More than two thirds 51 (78.5%) of the respondents were females. Majority 42 (64.6%) were were married. Almost all 64 (98.5%) of the respondents

Table 1. Demographic data (n=65).

Variable (n=65)	Frequency (f)	%
Age		
20-35 years	35	53.8
36--50 years	23	35.4
51 years and above	7	10.8
Sex		
Females	51	78.5
Males	14	21.5
Marital status		
Married	42	64.6
Not married	23	35.4
Religion		
Christians	64	98.5
Non-Christians	1	1.5
Qualification		
Degree	10	15.4
Diploma	37	56.9
Certificate	18	27.7
Department working from		
Surgical Ward	12	18.5
Gynecological Ward	40	61.5
MOH/ PHO/UNFPA	13	20.0
Number of years working in that department		
0 – 5 years	50	76.9
6 years and above	15	23.1

were Christians. Majority 37 (56.9%) were diploma holders. More than half 40 (61.5%) of the respondents married. Almost all 64 (98.5%) of the respondents were Christians. Majority 37 (56.9%) were diploma holders. More than half 40 (61.5%) of the respondents were working in gynecological wards. More than two thirds 50 (76.9%) of the respondents have been working in the same departments for 0-5 years.

Respondents rating of views on factors hindering women in seeking fistula repair services

Table 2 shows respondents ratings of views on factors hindering women in seeking fistula repair services. Below are the views of health care providers on factors hindering women in seeking fistula repair services.

DISCUSSION

Our study brings a new perspective, that of the healthcare providers view on factors hindering women with obstetric fistula in seeking fistula repair services. Policy makers, program planners and program implementers participated in the study.

The respondents were asked to assess each factor hindering women with obstetric fistula in seeking fistula repair services and provide their views. Regarding lack of knowledge that fistula repair services exist, it is not surprising that majority (73.8%) of the respondents stated that fistula centres should be built in villages in order to facilitate education on the condition and also to have the fistula repaired. This issue of building more centres has been documented by Cam et al. (2009) who indicated out that establishing dedicated fistula centres in high prevalence areas is an effective strategy in supporting women living with obstetric fistula rather than a hospital committed to fistula repair. In our study, a minority of healthcare providers (33.3%) expressed education of all pregnant women during antenatal care on obstetric fistula and fistula repair services. This may result in women who sustain a fistula in seeking fistula repair services in good

Table 2. Health care provider views (n=65).

View	Yes		No	
	n=65	%	n=65	%
Lack of knowledge that repair services exist				
Build fistula centres in villages	48	73.8	17	26.2
Sensitise chiefs, community leaders, community based volunteers, religious leaders, local government officials and non-governmental organisation	38	58.5	27	41.5
Educate all pregnant women during antenatal clinics on obstetric fistula and fistula repair services	22	33.3	43	66.2
Mobile clinics to include obstetric fistula repair	24	36.9	41	63.1
Anxiety				
Target families of afflicted women and give them information on obstetric fistula	33	50.8	32	49.2
Families to escort the afflicted woman for fistula repair	22	33.8	43	66.2
Loss of dignity				
Counselling to afflicted women and their relatives pre- and post-fistula repair on obstetric fistula	56	86.2	9	13.8
Stigma				
Formulation of fistula support groups in the community	6	9.2	59	90.8
Government to improve on the tracking system	43	66.2	22	33.8
Transportation challenges				
Afflicted women should be recruits on social cash transfer	21	32.3	44	67.8
Transport refund for those who seek repair services using own resources	48	73.8	17	26.2
Government to build proper road networks	12	18.5	53	81.5
Keeping women who sustain a fistula until repaired	2	3.1	63	96.9
Financing for the procedure				
Government to provide free fistula services	65	100	0	0
Educate men not to abandon their wives after sustaining a fistula so as to support their wives financially	65	100	0	0
Myths and misconception				
Sensitise the communities on myths and misconception on obstetric fistula	65	100	0	0
Engage Ministry of traditional affairs	5	7.7	60	92.3
Health systems barrier				
Train surgeons on how to repair afflicted women	47	72.3	18	27.7

time. It is important to note that education may directly improve an individual's knowledge, as well as ability to process information. Therefore, during antenatal clinic visits, nurse midwives and public health nurses should educate women on the risks of developing an obstetric fistula (Sullivan, 2014). Further, over half of the respondents (58.5%) felt that there was need to sensitise chiefs, community leaders, community based volunteers, religious leaders, local government officials and non-governmental organisations on fistula repair services so that they can in turn assist in informing their communities on obstetric fistula and repair services. This may result in seeking fistula repair services among women with fistula. According to Cam et al. (2009), many women who suffer from obstetric fistula do not know what fistula is, that their condition is treatable, or where to get treatment. Also, with regards to lack of knowledge that repair services exist, health care providers (36.9%) stated that mobile clinics must include fistula repair services. Mobile health services are a complimentary service delivery made to people in hard to reach areas and remote parts (Zambia National Health Strategic Plan- 2017-2021).

The respondents were also required to provide their views on anxiety as a cited factor hindering women in seeking fistula repair services. Slightly more than half (50.8%) of the respondents thought that target families of women with obstetric fistula should be targeted and given information on obstetric fistula. Less than half (33.8%) of the respondents stated that families must escort the women with obstetric fistula for fistula repair which is not

surprising, since escorting fistula patient for repair services has been a growing problem. However, it is striking to note that there is a small number of respondents who opted that afflicted women should be escorted. If women had never travelled out of their villages, they may want to be accompanied by a relative (Bangser, 2007).

While loss of dignity is common among women with obstetric fistula and making afflicted women not to seek repair services, majority (86.2%) of the respondents cited counselling as one element that would help women to know more about the condition and to seek repair services. The importance of counselling of women with obstetric fistula cannot be over emphasised as it would increase ones knowledge and benefit the afflicted women in keeping clean, avoiding the smell and easily mix with others in the community. Counselling would be done through local radio stations, individual psychosocial counselling provided by health care providers and by successfully repaired women. Successfully repaired women who have undergone a similar situation would be living examples to easy loss of dignity. A study done by Meurice et al. (2016) noted that having successfully treated women to teach others about obstetric fistula is an important resource and mass media a major channel of communication (Were, 2015).

When asked about stigma as a contributing factor hindering women in seeking fistula repair services, worthy of attention is the large percentage of respondents (90.8%) that do not regard formulation of fistula support groups in the community as one way that could motivate women with obstetric fistula to seek fistula repair services. While interpreting these views, despite a small proportion of respondents reporting formulation of fistula support groups in the community, it is important to note that this could assist in finding women who isolate themselves and not seek fistula repair services. This finding is supported by a study done by Landrya et al. (2013) who revealed that revealed that community-based groups engaged in addressing the needs of afflicted women are well placed to address stigma. Fistula support groups would sensitise the afflicted women on the importance of repair services and this could motivate them to seek fistula repair service. Moreover, it was also viewed by the health care providers (66.2%) that Government should improve on the tracking system of women with obstetric fistula as a way to help identify women who could be isolating themselves.

Transportation challenges play an important role in hindering women with obstetric fistula in seeking fistula repair services. It is important to note that less than one-third (32.3%) of the respondents mentioned that the afflicted women should be recruits on social cash transfer to enable them raise funds for fistula repair services while 73.2% commented on the transport refund for those who seek repair services using their own resources. Despite a small proposition of respondents suggesting that afflicted women should be recruited on social cash transfer, such would be helpful for those women who express an interest in starting small businesses thereby improving their financial situations and consequently utilise money to seek repair services. On the one hand, providing transportation or transportation fees would make accessing treatment easier (Meurice et al., 2016). In addition, respondents (18.5%) felt that Government should build proper road networks to easy access to fistula repair services. This is in agreement with Gele et al. (2017) who suggested that fistula centres should be established, and access to these facilities has to be guaranteed for all patients who need these services. Further, only 3.1% viewed keeping women who sustain fistula following delivery without discharging them until repaired. This is supported by Meurice et al. (2016) who revealed that perhaps rather than sending women home to recover, they could be referred immediately to minimise delay and need for funds for transportation.

It is not particularly surprising that financing for the procedure is a factor that would make women with obstetric fistula not to seek care. Quite encouraging is the fact that all the respondents (100%) in the current study talked about Government providing free fistula services as a way to encourage women to seek fistula repair services. However, fistula services in Zambia and elsewhere are offered free of charge as the government supports donor-funded fistula repair camps. These camps offer free repair surgeries though do not cover all associated costs and hospitals where repair services are conducted have to subside the costs. It is also important to note that routine fistula repairs are conducted in fistula repair centres. On the other hand, all respondents (100%) were of the view that husbands of women with obstetric fistula must not abandon their wives following development of a fistula. Women who are abandoned by their husbands may find it more difficult to acquire funds for financing the procedure or transportation costs to fistula repair centres (Bellows et al., 2015).

When asked about their views on myths and misconception as a factor hindering afflicted women in seeking fistula repair services, all respondents (100%) overwhelmingly stated that sensitisation of the communities with regard to myths and misconception was cardinal. This is because fistula is often considered a sexually transmitted disease and viewed as a punishment from God (Were, 2015). If that is the belief held by women with obstetric fistula, they are unlikely to be interested in seeking treatment at a health facility. This is supported by Kasamba et al. (2013) who noted that misconception and negative belief might hinder afflicted women in seeking fistula repair services and certain herbs could be used to cure obstetric fistula. Further, another (7.1%) of the respondents stated that engaging the Ministry of Traditional Affairs would be of benefit. The small percentage of respondents citing engagements of the Ministry of Traditional Affairs is not well understood.

Health systems barriers were also cited as factors hindering women in seeking fistula repair services. Majority (72.3%) of the respondents were of the view that Government should train fistula surgeons as unsuccessful repairs could have an impact on seeking fistula repair services. This is in line with Sullivan (2014) who reported that the ability of healthcare providers to provide comprehensive, holistic, and quality care is important and is influenced by available resources, acceptability to the culture, and institutional regulations. Perceived poor quality of care is a commonly cited barrier involving multiple facets of cares (Bellows et al., 2015).

Conclusion

This study showed that all the respondents viewed provision of free fistula services, educating men not to abandon their afflicted women, and sensitising the communities on myths and misconception of obstetric fistula would enable women to access fistula repair services. Also, most of the respondents viewed counselling of afflicted women and their relatives on obstetric fistula, building fistula centres in village, training of surgeons on how to repair fistulas and transport refund for those who seek repair services using their own resources as way that would encourage women to seek fistula repair services. More than half of the respondents reported sensitising chiefs, community leaders, community based volunteers, religious leaders, local government officials and non-governmental organisations as well as improvement on the tracking system of women with obstetric fistula by government as very important contributing factors in seeking fistula repair services. In addition, less than half of the respondents viewed educating all pregnant women during antenatal clinics on obstetric fistula and fistula repair services, mobile clinics to include fistula repair services, families escorting women with obstetric fistula for fistula repair, formulation of fistula support groups in the community, recruiting women with obstetric fistula on social cash transfer, building of proper road networks by governments and keeping women who sustain fistula until repaired as other ways to assist women with obstetric fistula to seek fistula repair services. There is thus need for consented efforts to be put in place by all stakeholders so as to enhance utilisation of fistula repair services by women with fistula.

Limitations of the study

There are limitations, which include the (unavoidable) fact that the views expressed in the study are speculative rather than based on experience or knowledge. The other limitation is that this study includes the viewpoints of one stakeholder group, that of healthcare providers. Another important limitation of this study is its cross sectional design, hence making it difficult to establish a causal relationship among the factors and views of the health care providers.

Implications of the study

Several strategies to overcome the factors hindering women with fistula in seeking fistula repair services could be implemented as a result of this study.

Firstly, sensitization programmes on the condition and repair services by health care providers may be beneficial. Secondly, Government should participate in the transportation of women with obstetric fistula for repair services and continue investing in the training of fistula surgeons.

Recommendations

(i) Mass sensitization of communities on obstetric fistula and fistula repair services to assist women with obstetric fistula in seeking fistula repair services.
(ii) Support systems for women with obstetric fistula are crucial for these and play an important role in a woman deciding whether to seek fistula repair services or not.
(iii) Involvement of husbands of afflicted women because of their pivotal role in decision making process.
(iv) Adequate funding of obstetric fistula services for the procurement of medical supplies as well as equipment and training of fistula surgeons.
(v) Government should ensure physical proximity of health care facilities that conduct fistula repairs so that women with obstetric fistula do not have to travel long distances to seek the service.

CONFLICTS OF INTERESTS

The authors have not declared any conflicts of interests.

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