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INFLUENCE OF PERCEIVED STIGMA ON HEALTH-SEEKING BEHAVIOUR AMONG WOMEN LIVING WITH OBSTETRIC FISTULA IN KAJIADO SOUTH SUB- COUNTY, KAJIADO COUNTY, KENYA.

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Abstract
Obstetric fistula remains a major maternal health challenge, particularly in low-resource settings, where social stigma continues to hinder timely healthcare utilization. This study investigated the influence of perceived stigma on health-seeking behaviour among women living with obstetric fistula in Kajiado South Sub-County, Kajiado County, Kenya. The study was anchored on Stigma Theory and the Health Belief Model and adopted a convergent parallel mixed methods research design. The target population comprised 255 participants, including 200 women living with obstetric fistula, 25 healthcare providers, and 30 Community Health Volunteers. A sample of 133 women was selected using simple random sampling, while five key informants were selected purposively. Data were collected using structured questionnaires and key informant interview guides. A pilot study involving 13 women and three key informants at Kenyatta National Hospital was conducted to ascertain the validity and reliability of the research instruments. Quantitative data were analyzed using IBM SPSS version 29 through descriptive statistics, Pearson's Product Moment Correlation, and simple linear regression analysis, while qualitative data were analyzed thematically. The study established that perceived stigma was prevalent among women living with obstetric fistula, with respondents reporting fear of negative judgement, gossip, ridicule, social rejection, and discriminatory treatment. Inferential analysis revealed a strong negative and statistically significant relationship between perceived stigma and health-seeking behaviour ($\mathbf{r = -0.684, p < 0.001}$). Simple linear regression further showed that perceived stigma significantly predicted health-seeking behaviour ($\mathbf{\beta = -0.684, p < 0.001}$), explaining **46.8%** of the variation in health-seeking behaviour ($\mathbf{R^2 = 0.468}$). The study concludes that perceived stigma is a significant barrier to timely healthcare utilization among women living with obstetric fistula. It recommends that the Ministry of Health, Kajiado County Government, and development partners strengthen community-based stigma reduction interventions, enhance respectful and confidential obstetric fistula care, and expand community outreach programmes to encourage early identification, referral, and treatment of affected women.

Keywords: Perceived stigma, health-seeking behaviour, obstetric fistula, maternal health, Kajiado South Sub-County, Kenya.

Background to the Study

Health-seeking behaviour is a critical determinant of maternal health because it influences how individuals recognize health problems, make decisions to seek care, and utilize available healthcare services (Ghimire et al., 2026). In the context of obstetric fistula, timely health-seeking behaviour is essential because early diagnosis and surgical repair can prevent prolonged physical disability, psychological distress, and social exclusion (Weldu et al., 2025).

However, healthcare utilization is influenced not only by the availability and accessibility of services but also by psychosocial factors that shape individuals' decisions to seek treatment. Among these factors, perceived stigma has increasingly been recognized as an important determinant of health-seeking behaviour. Perceived stigma refers to the expectation of being rejected, discriminated against, blamed, or socially devalued because of a health condition (Liamputtong & Rice, 2021). Women living with obstetric fistula who anticipate such negative reactions may conceal

their condition, delay disclosure, and postpone seeking appropriate medical care even where treatment services are available (Cantor et al., 2024).

Globally, obstetric fistula remains one of the most neglected maternal morbidities despite being both preventable and treatable. Ndoye et al. (2025) estimates that between 50,000 and 100,000 new cases occur annually, while more than two million women continue to live with untreated fistula worldwide. Although improvements in emergency obstetric care and surgical repair have reduced the incidence of fistula in many settings, delays in seeking treatment remain common. Increasing global evidence suggests that anticipated shame, fear of discrimination, and concerns about social rejection continue to discourage affected women from utilizing available healthcare services, highlighting perceived stigma as an important barrier to treatment uptake (Dolezal, 2022).

Internationally, countries that have made significant progress in maternal healthcare continue to report challenges related to treatment-seeking among women living with obstetric fistula. In China, improvements in institutional deliveries and emergency obstetric care have substantially reduced maternal mortality, yet fear of social humiliation and discrimination continues to discourage some women from seeking timely treatment (Qiao et al., 2021). Similarly, in India, expanded maternal health programmes have not completely eliminated delays in healthcare utilization because many women continue to anticipate shame, family rejection, and negative community perceptions associated with obstetric fistula (Vellakkal& Singh, 2021). These experiences demonstrate that strengthening healthcare systems alone may not improve healthcare utilization unless psychosocial barriers such as perceived stigma are also addressed.

Across sub-Saharan Africa, obstetric fistula remains a major public health challenge because of limited access to emergency obstetric care and delayed treatment seeking. Beyond health system constraints, socio-cultural beliefs surrounding obstetric fistula often expose affected women to anticipated rejection, marital instability, and social exclusion (Bulndi et al., 2022). Consequently, many women conceal their condition and delay seeking surgical repair because they fear negative reactions from their families and communities (Bello et al., 2020). Similar patterns have been reported in Uganda, where perceived stigma contributes to delayed healthcare utilization despite the availability of fistula treatment programmes (El Ayadi, 2023). These findings suggest that perceived stigma remains a persistent obstacle to improving health-seeking behaviour across the African region.

In Kenya, obstetric fistula continues to affect women's health despite national efforts to strengthen maternal healthcare services. Approximately 3,000 new cases are estimated to occur each year, yet fewer than half of affected women receive timely surgical repair (Pollaczek et al., 2022). Government initiatives such as the Free Maternity Services Programme and the Reproductive, Maternal, Newborn, Child and Adolescent Health Investment Framework have expanded access to maternal healthcare (Ministry of Health [MoH], 2023). Nevertheless, delayed treatment seeking remains common because many women fear ridicule, discrimination, and social isolation following disclosure of their condition, thereby limiting utilization of available fistula repair services (Nendela et al.,2023).

In Kajiado South Sub-County, improving maternal health remains a priority under both national and county health strategies. However, the predominantly rural and pastoralist setting, together with prevailing socio-cultural norms, may increase women's fear of negative community perceptions and discourage timely healthcare utilization among those living with obstetric fistula. Although perceived stigma has increasingly been recognized as a barrier to healthcare utilization, little empirical evidence exists on its specific influence on health-seeking behaviour among women living with obstetric fistula in Kajiado South Sub-County, Kajiado County. Addressing this knowledge gap is important for informing context-specific interventions aimed at reducing stigma-related barriers and improving timely utilization of obstetric fistula treatment services.

Statement of the Problem

Obstetric fistula remains a major maternal health challenge that undermines women's physical, psychological, and social well-being despite being

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largely preventable and treatable through timely surgical intervention (Abebe et al., 2026). In Kenya, approximately 3,000 new cases are reported annually, yet fewer than half of affected women receive timely surgical repair (Pollaczek et al., 2022).In Kajiado South Sub-County, the predominantly rural and pastoralist setting, coupled with socio-cultural factors, continues to hinder timely healthcare utilization among women living with obstetric fistula (Muvengei, 2026).

Despite efforts by the Government of Kenya, county governments, development partners, and healthcare providers to improve access to maternal and fistula repair services, timely health-seeking behaviour among affected women remains below expectations. Consequently, many women continue to live with untreated obstetric fistula, exposing them to prolonged physical complications, psychological distress, and social exclusion (Ministry of Health [MoH], 2023).

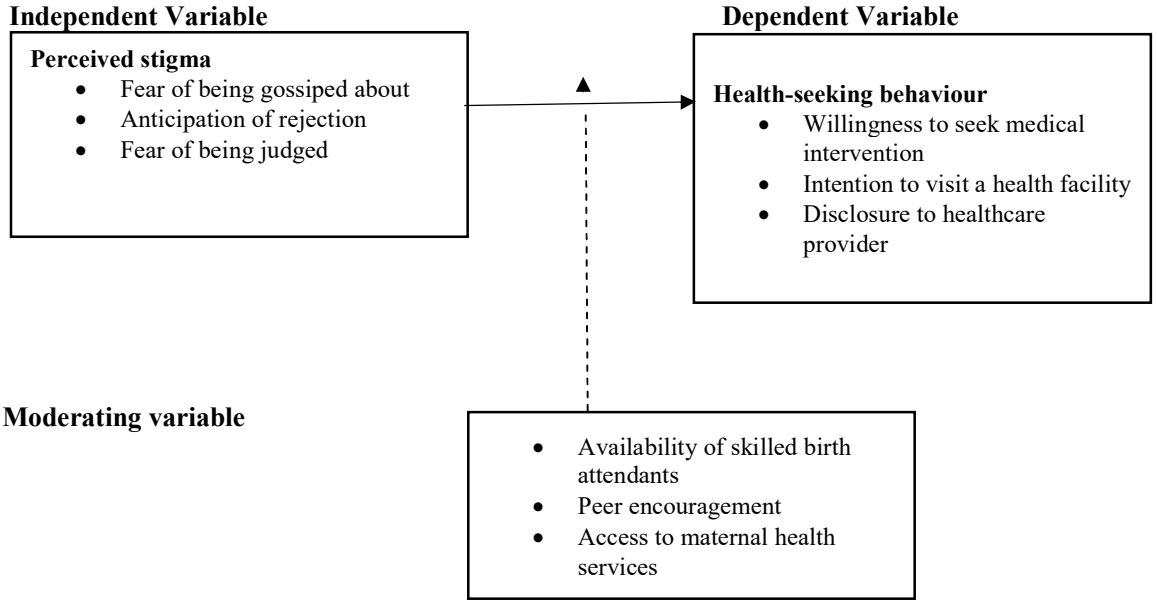
Perceived stigma has increasingly been recognized as an important factor influencing health-seeking behaviour because fear of rejection, discrimination, and negative community judgement discourages women from seeking timely treatment (Khisa &Nyamongo, 2022). However, limited empirical evidence exists on the influence of perceived stigma on health-seeking behaviour among women living with obstetric fistula in Kajiado South Sub-County, Kajiado County. This study therefore examined the influence of perceived stigma on health-seeking behaviour among women living with obstetric fistula in Kajiado South Sub-County, Kajiado County, Kenya.

Research Objective

To examine the influence of perceived stigma on health-seeking behaviour among women living with obstetric fistula in Kajiado South Sub-County, Kajiado County, Kenya.

Conceptual Framework

The figure below presents the conceptual framework of the study. The independent variable is perceived stigma, while the dependent variable is health-seeking behaviour. The study also acknowledges the mediating variable, which may influence the relationship between the independent and dependent variables but are not the primary focus of the study.



Source: Researcher (2026)

Literature Review

This chapter reviews the theoretical and empirical literature on perceived stigma and health-seeking

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behaviour. It examines relevant concepts, discusses previous studies, identifies knowledge gaps, and presents the conceptual framework guiding the study.

Theoretical Framework

This study was anchored on Stigma Theory and the Health Belief Model (HBM). Stigma Theory draws on Goffman's (1963) foundational work and later conceptualizations by Link and Phelan (2001) and Parker and Aggleton (2003), explaining how labelling, discrimination, and social exclusion shape the experiences and behaviours of individuals living with stigmatized conditions. The HBM originated in the 1950s through work by social psychologists in the U.S. Public Health Service and was subsequently elaborated by Becker and Maiman (1975). It explains how individual perceptions of susceptibility, severity, benefits, and barriers influence health-related decision-making and healthcare utilization. The two theories provide a basis for understanding how perceived stigma influences health-seeking behaviour among women living with obstetric fistula.

Stigma Theory

Stigma Theory was developed by Erving Goffman (1963) and later expanded by Link and Phelan (2001). The theory posits that individuals possessing socially undesirable attributes may experience labelling, stereotyping, discrimination, and social exclusion**,** which shape their attitudes, behaviours, and interactions within society. Social exclusion occurs when negative labels and stereotypes lead others to distance, reject, or treat affected individuals differently, thereby limiting their participation in social relationships and access to social support. In turn, individuals may anticipate such rejection and withdraw from social interaction or conceal their conditions as a means of protecting themselves from further stigma. The theory has therefore been widely applied in public health research to explain how stigma influences healthcare utilization among individuals living with stigmatized health conditions.

The theory is relevant to this study because women living with obstetric fistula may be labelled or negatively judged because of their condition, resulting in anticipated rejection, isolation, and reluctance to disclose their condition. Such experiences of exclusion may discourage women from interacting with others, seeking social support, and accessing healthcare services. Women who anticipate rejection, discrimination, and negative community judgement may therefore conceal their condition and delay seeking medical care despite the availability of surgical repair services. Empirical studies have shown that perceived stigma discourages timely healthcare utilization and contributes to delayed treatment-seeking among women living with obstetric fistula (Cantor et al., 2024). Similarly, Asmare et al. (2024) found that fear of social judgement significantly reduces the likelihood of women seeking obstetric fistula treatment.

Despite its relevance, the theory has been criticized for emphasizing social processes while giving limited attention to individual cognitive factors and structural barriers, such as poverty and access to healthcare, that also influence health-seeking behaviour (Mitchell et al., 2021). Nevertheless, Stigma Theory provides an appropriate framework for explaining how social labelling and anticipated rejection can produce exclusion, concealment, and withdrawal, which may subsequently hinder health-seeking behaviour among women living with obstetric fistula in Kajiado South Sub-County, Kajiado County, Kenya.

Health Belief Model

The Health Belief Model, originally conceptualized in the 1950s by social psychologists at the U.S. Public Health Service by Irwin Rosenstock, Godfrey Hochbaum, and S. Stephen Kegeles, and subsequently refined by Becker and Maiman in 1970 to explain and predict health-related behaviours (Devi, 2022). Irwin Rosenstock published a definitive and widely cited comprehensive refinement of the model in 1974. The model posits that individuals are more likely to adopt recommended health behaviours when they perceive themselves to be susceptible to a health condition, recognize its severity, believe that the benefits of taking action outweigh the perceived barriers, receive cues to action, and possess sufficient confidence (self-efficacy) to undertake the recommended behaviour (Rosenstock et al., 1974). The model has been widely applied to explain healthcare utilization and health-related decision-making (Jia et al., 2025).

The Health Belief Model is relevant to this study because it explains how women assess different factors and make behavioural decisions about seeking

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healthcare for obstetric fistula**.** A woman who perceives obstetric fistula as serious, believes that surgical repair can improve her condition, and has confidence in her ability to access treatment is more likely to seek healthcare. Conversely, perceived barriers such as fear of stigma, ridicule, rejection, treatment costs, or difficulties accessing services may reduce the likelihood of seeking care. Thus, health-seeking behaviour results from an individual's assessment of the perceived severity and benefits of treatment against the perceived barriers to accessing it(Rosenstock et al.,1974).

In the context of this study, perceived stigma represents an important behavioural barrier. When fear of judgement, gossip, social rejection, or differential treatment outweighs the perceived benefits of treatment, women may choose to conceal their condition, postpone disclosure, or delay healthcare seeking. This proposition is consistent with Carpenter (2010), who identified perceived benefits and barriers as important predictors of health behaviour, and Jones et al. (2015), who demonstrated the importance of self-efficacy in healthcare decision-making. The model therefore helps explain not only whether women seek healthcare but also why they may delay or avoid care despite recognizing the seriousness of obstetric fistula**.**

Despite its extensive application in health behaviour research, the Health Belief Model has been criticized for emphasizing individual cognitive processes while giving limited attention to broader social, cultural, and structural influences on health behaviour (Glanz et al., 2015). This limitation is important in the present study because women's health-seeking decisions may also be shaped by community attitudes and social exclusion. Nevertheless, the model remains appropriate for explaining the individual behavioural decision-making process, while Stigma Theory explains the social processes through which anticipated rejection and exclusion create perceived barriers.

The two theories complement each other by explaining different but interconnected processes through which perceived stigma may influence health-seeking behaviour. Stigma Theory explains how social labelling, negative stereotypes, anticipated judgement, and exclusion create fear of rejection, concealment, and social withdrawal among women living with obstetric fistula. The HBM, in turn, explains how women perceive these experiences as barriers and weigh them against the perceived severity of obstetric fistula and the benefits of treatment when deciding whether to seek care. Thus, Stigma Theory explains how social stigma creates barriers, whereas the HBM explains how women perceive and respond to those barriers**.**

Review of Empirical Literature

Perceived stigma is an important psychosocial determinant of health-seeking behaviour because it shapes how individuals anticipate being judged, rejected, labelled, or discriminated against because of a health condition (El Khoury-Malhame et al., 2025). Unlike enacted stigma, which refers to actual experiences of discrimination, perceived or anticipated stigma operates prospectively by creating expectations of negative social consequences. These expectations may influence decisions about disclosure, healthcare attendance, treatment initiation, and continuity of care even before an individual interacts with the health system (Loehr, Lytle and Adefris, 2022). The relevance of perceived stigma to health-seeking behaviour is therefore not limited to whether discrimination actually occurs; rather, the anticipation that it might occur can itself constitute a barrier to healthcare access.

A consistent theme across the empirical literature is the relationship between anticipated stigma and delayed healthcare utilization. Evidence from HIV and tuberculosis populations suggests that fear of rejection, gossip, social labelling, and disclosure can discourage individuals from seeking care despite the availability of health services. Perger (2025), for example, found among 512 adolescents living with HIV in Canada that fear of peer rejection and anticipated discrimination was associated with reduced clinic attendance and treatment adherence. Similarly, Powell (2023), using a mixed-methods design involving 384 tuberculosis patients in India, reported that fear of gossip and negative community perceptions contributed to delayed diagnosis and treatment-seeking.

These studies suggest that perceived stigma can function as a psychological barrier that operates before contact with healthcare providers. However, the strength and applicability of this evidence should be

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interpreted cautiously. Perger's study was conducted among adolescents in a high-income healthcare environment, whereas Powell's study focused on tuberculosis in a different epidemiological and social context. Thus, although both demonstrate an association between anticipated social judgment and delayed care, neither adequately captures the distinctive social consequences associated with obstetric fistula, including its association with childbirth injury, incontinence, marital disruption, and social isolation.

The evidence from African settings reinforces the relationship between anticipated stigma and healthcare avoidance but also exposes important contextual limitations. Ndwiga (2024), studying 426 patients with chronic illnesses in Ethiopia, found that fear of negative community judgment discouraged the use of formal healthcare services even where services were available. Similarly, Shenderovich et al. (2021), in a cross-sectional study of 1,046 adolescents in South Africa, found that anticipated stigma from peers, schools, and healthcare providers reduced willingness to undertake HIV testing.

The convergence of these findings indicates that perceived stigma may operate through multiple social sources rather than through community attitudes alone. However, the studies also differ in their populations and health conditions, making direct generalization to obstetric fistula problematic. Moreover, their predominantly urban or peri-urban settings provide limited insight into contexts where social relationships are more closely interconnected and where cultural expectations may exert stronger influence over women's decisions concerning disclosure and healthcare utilization.

Disclosure is an important pathway through which perceived stigma may influence health-seeking behaviour. Fear of gossip, rejection, marital conflict, and social labelling may lead women to conceal their condition and delay seeking professional care. This is particularly relevant to obstetric fistula, given its potentially embarrassing symptoms and effects on social and marital relationships. In Kenya, Odonkor and Yeboah (2023), based on 30 in-depth interviews with women experiencing stigmatized conditions, including obstetric fistula, found that fear of gossip, marital conflict, and social rejection delayed disclosure and treatment-seeking. However, the qualitative design focused on women's experiences and did not quantify the relationship between perceived stigma and health-seeking behaviour, limiting its ability to establish the magnitude of this influence.

The relationship between community expectations, cultural norms, and perceived stigma further complicates health-seeking decisions. Kinuthia (2025), using a mixed-methods study of 286 women of reproductive age in Kajiado County, found that social networks, cultural expectations, and fear of community judgement influenced maternal healthcare utilization.

These findings show that health-seeking behaviour in Kajiado is influenced not only by service availability and individual knowledge but also by social expectations. However, the study focused broadly on maternal healthcare and did not examine perceived stigma as a distinct factor among women with obstetric fistula. This limits its ability to explain how anticipated judgment or rejection specifically influences health-seeking behaviour.

The empirical literature shows that perceived stigma can discourage health-seeking through fear of judgment, rejection, disclosure, and social consequences. However, studies vary in how perceived stigma is conceptualized and measured, limiting comparison across findings. Most studies use cross-sectional or qualitative designs, providing limited evidence on the specific influence of perceived stigma on healthcare utilization. Evidence from other countries may also have limited applicability to pastoralist communities in Kenya because of differences in cultural norms, social structures, and healthcare access. Moreover, few studies distinguish perceived stigma from enacted, internalized, and community stigma, leaving a gap in understanding its specific influence on health-seeking among women living with obstetric fistula.

Research Methodology

This study adopted a convergent parallel mixed-methods research design to examine the influence of perceived stigma on health-seeking behaviour among women living with obstetric fistula in Kajiado South

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Sub-County, Kajiado County, Kenya. The target population comprised 255 participants, including women living with obstetric fistula, healthcare providers, and community health volunteers. Using Yamane's (1967) formula, a sample of 133 women was obtained, while five key informants were selected purposively. Simple random sampling was used to select questionnaire respondents, whereas purposive sampling was employed to select key informants.

Data Collection Instruments

Quantitative data were collected using a structured questionnaire, while qualitative data were collected using a semi-structured interview guide. The questionnaire contained 35 items, with seven items measuring each of the five constructs: enacted stigma, perceived stigma, internalized stigma, community stigma, and health-seeking behaviour. The items were measured using a five-point Likert scale ranging from 1 = Strongly Disagree to 5 = Strongly Agree. For the present study objective, the perceived stigma scale comprised seven items assessing anticipated negative judgment, gossip, social avoidance, discomfort with discussing the condition, fear of ridicule, differential treatment, and community judgment. The health-seeking behaviour scale also comprised seven items assessing respondents' healthcare-seeking practices. The questionnaire items were informed by the reviewed empirical literature and adapted to the context of women living with obstetric fistula in Kajiado South Sub-County.

Validity of the Research Instruments

Both face and content validity were established. Content validity was assessed quantitatively using the Content Validity Index (CVI). A panel comprising healthcare providers and community health volunteers reviewed the questionnaire items for relevance, clarity, and representativeness of the study constructs. The Item-Level Content Validity Index (I-CVI) was calculated as the proportion of experts who rated an item as relevant (3 or 4 on a four-point scale), while the Scale-Level Content Validity Index (S-CVI) was calculated as the mean of the I-CVI scores. An I-CVI of ≥ 0.78 and an S-CVI of ≥ 0.80 were considered acceptable (Lynn, 1986; Polit & Beck, 2006). The overall S-CVI was 0.87, exceeding the recommended threshold and confirming strong content validity.

Face validity was further established during the pilot test by obtaining participants' feedback on the clarity, language, and interpretability of the questionnaire and interview guide. Ambiguous or unclear items were modified accordingly. Construct validity was supported by aligning the questionnaire items with the conceptual dimensions of the study variables and the theoretical framework underpinning the study.

Reliability of the Research Instruments

A pilot study was conducted among 13 women with characteristics similar to those of the target population but who were excluded from the main study. Pilot data were analyzed using SPSS Version 29, and internal consistency was assessed using Cronbach's alpha coefficient. A coefficient of 0.70 or higher was considered acceptable (Kennedy, 2022).

The perceived stigma scale, comprising seven items, recorded a Cronbach's alpha of $\alpha = 0.83$, indicating good internal consistency. The health-seeking behaviour scale, also comprising seven items, recorded $\alpha = 0.90$, indicating excellent internal consistency. The other constructs in the broader questionnaire also demonstrated satisfactory reliability: enacted stigma ($\alpha = 0.87$), internalized stigma ($\alpha = 0.81$), and community stigma ($\alpha = 0.84$). These results confirm that the questionnaire items consistently measured their respective constructs and were reliable for the main study.

Table 1: Reliability Testing Results

Variable	Cronbach's Alpha	Number of Items	Interpretation
Enacted stigma	0.87	7	Good reliability
Perceived stigma	0.83	7	Good reliability
Internalized stigma	0.81	7	Good reliability
Community stigma	0.84	7	Good reliability
Health-seeking behaviour	0.90	7	Excellent reliability

Source: Field Data (2026)

Data Analysis

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Quantitative data were coded and analyzed using SPSS Version 29. Descriptive statistics included frequencies, percentages, means, and standard deviations. Pearson's correlation analysis was used to determine the direction and strength of the relationship between perceived stigma and health-seeking behaviour. Simple linear regression analysis was then used to determine the influence of perceived stigma on health-seeking behaviour, with perceived stigma as the single independent variable and health-seeking behaviour as the dependent variable. Statistical significance was assessed at the 5% level ($p < 0.05$).

Qualitative data from the key informant interviews were analyzed thematically. Emerging themes and quotations were integrated with the quantitative findings to provide contextual explanations and strengthen interpretation through triangulation.

Regression Diagnostic Tests

Prior to conducting simple linear regression, the assumptions of normality, linearity, and homoscedasticity were assessed. Normality was examined to determine whether the study variables were approximately normally distributed, while linearity was assessed to establish whether a linear relationship existed between perceived stigma and health-seeking behaviour. Homoscedasticity was examined to determine whether the variance of the residuals was approximately constant across the predicted values. Since Multicollinearity was not applicable because the regression model contained only one independent variable, perceived stigma, multicollinearity was not applicable. The regression analysis was therefore conducted after assessing the assumptions relevant to a simple linear regression model.

Findings

A total of 138 participants were targeted, comprising 133 questionnaire respondents and 5 key informants. Of these, 130 participants responded, resulting in an overall response rate of **94.2%**. Specifically, 125 out of 133 women living with obstetric fistula completed the questionnaires, yielding a response rate of **94.0%**, while all five key informants participated, representing a **100%** response rate. The high response rate indicates strong participant engagement and provides a reliable basis for the study findings, exceeding the 70% threshold recommended by Saunders et al. (2023) for social science research. The high response rate indicates excellent participation and provides a reliable basis for data analysis, conclusions, and recommendations regarding the study.

Table 2: Response on Perceived Stigma
n=125

Statements	SD % F	D % F	N % F	A % F	SA % F	Mean	Std Dvt
I worry that people will judge me negatively because of my condition.	9 (7.2%)	14 (11.2%)	18 (14.4%)	44 (35.2%)	40 (32.0%)	3.74	1.14
I fear that others will gossip about me if they know about my condition.	10 (8.0%)	15 (12.0%)	20 (16.0%)	42 (33.6%)	38 (30.4%)	3.66	1.18
I am concerned that people will avoid me if they know about my condition.	8 (6.4%)	16 (12.8%)	19 (15.2%)	45 (36.0%)	37 (29.6%)	3.69	1.15
I feel uncomfortable discussing my condition with people in my community.	12 (9.6%)	18 (14.4%)	22 (17.6%)	38 (30.4%)	35 (28.0%)	3.53	1.24
I fear being mocked when seeking treatment at a health	7 (5.6%)	13 (10.4%)	21 (16.8%)	45 (36.0%)	39 (31.2%)	3.76	1.11

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facility							
I worry that people will treat me differently if they know about my condition.	9 (7.2%)	14 (11.2%)	20 (16.0%)	43 (34.4%)	39 (31.2%)	3.71	1.17
I feel that people in my community would judge me negatively if they knew about my condition.	8 (6.4%)	12 (9.6%)	18 (14.4%)	48 (38.4%)	39 (31.2%)	3.79	1.10
Composite Mean and Standard Deviation						**3.70**	**1.16**

Source: Field Data, 2026

As presented in Table 8, the findings yielded a composite mean of **M = 3.70 (SD = 1.16)**, indicating generally high perceived stigma among women living with obstetric fistula. The expectation of negative judgment was substantial, with 40 (32.0%) strongly agreeing **and** 44 (35.2%) agreeing that people would judge them negatively because of their condition (**M = 3.74, SD = 1.14**). This finding indicates that perceived stigma is largely anticipatory rather than dependent on actual discriminatory encounters. Such anticipation may encourage concealment and reduce willingness to disclose symptoms or seek professional assistance. The finding is consistent with Loehr et al. (2022)**,** who associated anticipated negative judgement with delayed healthcare utilization among women with stigmatized reproductive health conditions. From a Stigma Theory perspective, the expectation of rejection reflects felt stigma, whereby individuals modify their behaviour to avoid anticipated negative social evaluation. K1's observation that women *"avoid interacting with others even when they do not experience stigma directly"* further illustrates how anticipated rather than actual discrimination can shape behaviour.

Fear of gossip also emerged as an important dimension, with 38 (30.4%) strongly agreeing **and** 42 (33.6%) agreeing that others would gossip about them if they knew about their condition (**M = 3.66, SD = 1.18**). In a closely connected community, anticipated gossip may increase the perceived social cost of disclosure and consequently encourage women to conceal their condition. This interpretation is supported by Perger (2025) **and** Powell (2023**)**, who identified fear of gossip and social labelling as mechanisms through which stigma discourages healthcare utilization. The qualitative findings provide contextual support: K3 explained that *"even before disclosure, many women assume people will gossip about them, which makes them hide their condition."* The convergence of these findings indicates that gossip is not merely a social concern but may influence disclosure decisions and indirectly delay treatment.

Similarly, social avoidance was relatively high, with 37 (29.6%) strongly agreeing **and** 45 (36.0%) agreeing that people would avoid them if they knew about their condition (**M = 3.69, SD = 1.15**). This pattern demonstrates that anticipated rejection may extend beyond disclosure to expectations of social exclusion. Such expectations can promote isolation and reduce women's engagement with social networks that might otherwise facilitate information, emotional support, or referral to healthcare services.

The finding is comparable to Shenderovich et al. (2021) **and** Ndwiga (2024)**,** who reported that anticipated social rejection was associated with withdrawal from social and healthcare activities. Within the Health Belief Model, anticipated rejection represents a perceived barrier capable of outweighing perceived benefits of seeking care. K2's observation that *"the fear of being avoided is one of the strongest reasons women isolate themselves from community activities"* provides further evidence that anticipated exclusion has behavioural consequences.

Discomfort with discussing the condition within the community recorded the lowest, although still elevated, mean (**M = 3.53, SD = 1.24**), with **35 (28.0%)** strongly agreeing **and** 38 (30.4%) agreeing. The comparatively lower score implies that some women are willing to discuss their condition despite broader concerns about stigma; nevertheless, the overall response suggests substantial reluctance to

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communicate openly. Limited disclosure can restrict access to social support and delay referral or encouragement to seek treatment. This finding is consistent with Odonkor and Yeboah (2023), who found that stigma constrained discussions and disclosure among women experiencing stigmatized health conditions, including obstetric fistula. Stigma Theory helps explain this reluctance as a self-protective response to anticipated negative evaluation. K4 captured this dynamic, noting that *"many women prefer to remain silent because they do not feel safe discussing their condition publicly."*

The fear of mockery at health facilities recorded a high mean (**M = 3.76, SD = 1.11**), with **39 (31.2%)** strongly agreeing **and** 45 (36.0%) agreeing that they feared being mocked when seeking treatment. This finding is particularly important because it reveals that perceived stigma may persist beyond the community and extend into healthcare environments. Consequently, the availability of treatment does not necessarily translate into utilization when women anticipate humiliating or disrespectful encounters. The finding is consistent with Kinuthia (2025), who reported that anticipated mistreatment could delay healthcare seeking among women experiencing stigmatized conditions. From the Health Belief Model, anticipated ridicule constitutes a perceived barrier that may reduce the perceived benefits of formal healthcare. K1 reinforced this interpretation, explaining that *"some women do not want to be laughed at or poorly treated at health facilities, which delays their decision to seek care."*

Concern about differential treatment was also high, with **39** (31.2%) strongly agreeing and 43 (34.4%) agreeing that people would treat them differently if they knew about their condition (**M = 3.71, SD = 1.17**). These finding highlights that perceived stigma encompasses expectations of altered social treatment rather than only overt rejection. Such expectations may encourage concealment, withdrawal, and reduced interaction with both community members and healthcare providers. The finding supports Loehr et al. (2022), who linked anticipated discriminatory treatment with concealment and delayed healthcare utilization. Consistent with Stigma Theory, the expectation of differential treatment reflects the anticipation of devaluation associated with a stigmatized condition. K3 similarly reported that *"women expect to be treated differently, and because of this they withdraw from normal social interactions."*

The strongest dimension was anticipated negative community judgment, with 39 (31.2%) strongly agreeing and **48 (38.4%)** agreeing, yielding **M = 3.79 (SD = 1.10)**. This finding indicates that community perceptions may constitute the most prominent source of perceived stigma among the respondents. It also illustrates the importance of the social environment in shaping women's decisions about disclosure and healthcare utilization. The finding is consistent with Powell **(2023)** and Perger (2025), who demonstrated that anticipated community judgment can reinforce concealment and avoidance of healthcare. In the context of Stigma Theory, the expectation of community judgment reflects the internalization of negative social meanings attached to a stigmatized condition. K2's observation that *"women feel that even when no one has spoken to them directly, the community will judge them harshly"* illustrates how anticipated judgment can influence behaviour even without direct discriminatory encounters.

Discussion

Inferential Statistical Findings

This section presents the inferential statistical findings on the influence of perceived stigma on health-seeking behaviour among women living with obstetric fistula. Pearson's Product Moment Correlation and simple linear regression analyses were conducted to determine the relationship and predictive influence of perceived stigma on health-seeking behaviour.

Table 3: Correlation between Perceived Stigma and Health-Seeking Behaviour

Variables	Health-Seeking Behaviour
Perceived Stigma	-0.684**
Sig. (2-tailed)	0.000
N	**125**

** Correlation is significant at the 0.01 level (2-tailed).

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Source: Field Data (2026)

Pearson's Product Moment Correlation analysis revealed a strong negative and statistically significant relationship between perceived stigma and health-seeking behaviour among women living with obstetric fistula (**r = -0.684, p < 0.001**). This indicates that higher levels of perceived stigma are associated with lower levels of health-seeking behaviour. The findings suggest that women who anticipate negative judgment, discrimination, or social rejection are less likely to seek timely healthcare services.

Table 4: Model Summary

Model	R	R^2	Adjusted R^2	Std. Error of the Estimate
1	0.684	0.468	0.464	0.412

Predictors: (Constant), Perceived Stigma

Source: Field Data (2026)

The model summary indicates a strong relationship between perceived stigma and health-seeking behaviour (**R = 0.684**). The coefficient of determination (**R^2 = 0.468**) shows that perceived stigma explained **46.8%** of the variation in health-seeking behaviour among women living with obstetric fistula, while the remaining **53.2%** was attributable to other factors not included in the model.

Table 5: ANOVA Results

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	18.426	1	18.426	108.520	0.000
Residual	20.889	123	0.170		
Total	**39.315**	**124**			

Dependent Variable: Health-Seeking Behaviour

Source: Field Data (2026)

The ANOVA results indicate that the regression model was statistically significant (**F = 108.520, p < 0.001**). This implies that perceived stigma significantly predicts health-seeking behaviour among women living with obstetric fistula.

Table 6: Regression Coefficients

Predictor Variable	B	Std. Error	Beta	t	Sig.
Constant	4.865	0.224	–	21.719	0.000
Perceived Stigma	-0.542	0.052	-0.684	-10.417	0.000

Dependent Variable: Health-Seeking Behaviour

Source: Field Data (2026)

The regression results indicate that perceived stigma had **a** negative and statistically significant influence on health-seeking behaviour (**β = -0.684, t = -10.417, p < 0.001**). This implies that an increase in perceived stigma leads to a corresponding decrease in health-seeking behaviour among women living with obstetric fistula. The regression equation is expressed as: Health-Seeking Behaviour = 4.865 − 0.542 (Perceived Stigma).

Discussion

The study established that women living with obstetric fistula experienced relatively high levels of perceived stigma, as reflected by the overall composite mean of M = 3.70 (SD = 1.16). Community judgement recorded the highest mean (M = 3.79, SD = 1.10), followed by fear of mockery at health facilities (M = 3.76, SD = 1.11) and anticipated negative judgement (M = 3.74, SD = 1.14). Fear of gossip (M = 3.66, SD = 1.18), social avoidance (M = 3.69, SD = 1.15), differential treatment (M = 3.71, SD = 1.17), and discomfort discussing the condition (M = 3.53, SD = 1.24) were also elevated. The findings indicate that perceived stigma was primarily characterized by anticipation of negative social evaluation, rejection, and altered treatment rather than only by direct experiences of discrimination. The qualitative findings reinforced this pattern by indicating that women may anticipate negative reactions even before disclosing their condition, thereby encouraging concealment and withdrawal.

The prominence of anticipated community judgement demonstrates the importance of the social environment in shaping women's perceptions of obstetric fistula and their subsequent healthcare decisions. This finding is consistent with Powell (2023) and Perger (2025), who reported that anticipated judgement and negative social labelling contribute to concealment and avoidance of healthcare among individuals with stigmatized health conditions. From the perspective of Stigma Theory, anticipated judgement reflects the internalization of

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negative social meanings associated with a stigmatized condition. Such expectations may lead women to modify their behaviour to avoid possible rejection, thereby reducing disclosure and interaction with social networks that could facilitate information, emotional support, and referral for treatment. The qualitative findings similarly indicated that anticipated community reactions were an important concern among respondents; strengthening the interpretation that stigma operates through expectations of social exclusion.

Fear of gossip and social avoidance further demonstrate the social consequences of perceived stigma. The mean scores for fear of gossip (M = 3.66) and anticipated social avoidance (M = 3.69) indicate that respondents were concerned about both negative discussion and possible withdrawal by others following disclosure. These findings correspond with Perger (2025) and Powell (2023), who identified gossip, social labelling, and anticipated rejection as mechanisms through which stigma discourages healthcare utilization. The qualitative evidence similarly indicated that anticipated gossip could encourage women to conceal their condition, while fear of avoidance could promote social isolation. Such concealment and withdrawal may reduce access to social support and health information and consequently limit opportunities for early referral and treatment.

Discomfort discussing the condition recorded the lowest mean among the seven dimensions (M = 3.53, SD = 1.24), although it remained above the neutral midpoint. This indicates that reluctance to communicate about obstetric fistula was present but less pronounced than concerns about community judgement, mockery, or differential treatment. Nevertheless, limited disclosure remains consequential because it may restrict access to emotional support, treatment information, and assistance in navigating healthcare services. The finding is consistent with Odonkor and Yeboah (2023), who reported that fear of gossip, rejection, and social consequences constrained disclosure and treatment-seeking among women experiencing stigmatized health conditions, including obstetric fistula. The qualitative findings similarly demonstrated that some women were reluctant to discuss their condition publicly because of anticipated negative reactions. Within Stigma Theory, such reluctance represents a self-protective response to anticipated social devaluation.

Fear of mockery at health facilities recorded a relatively high mean (M = 3.76, SD = 1.11), indicating that perceived stigma extended beyond community interactions to anticipated encounters within healthcare settings. This finding is particularly significant because it demonstrates that service availability alone may not ensure healthcare utilization when women perceive healthcare environments as potentially judgemental or humiliating. The finding is consistent with Kinuthia (2025), who reported that anticipated mistreatment in healthcare settings could delay treatment-seeking among women experiencing stigmatized conditions. The qualitative findings further indicated that fear of ridicule or poor treatment could discourage women from seeking care. According to the Health Belief Model, anticipated ridicule constitutes a perceived barrier that may reduce the likelihood of taking health action when the perceived social costs of seeking care outweigh its anticipated benefits.

Concern about differential treatment also remained high (M = 3.71, SD = 1.17), indicating that perceived stigma involved expectations of altered interpersonal treatment rather than only overt rejection. This finding is consistent with Loehr et al. (2022), who associated anticipated discriminatory treatment with concealment and delayed healthcare utilization. From the perspective of Stigma Theory, expectations of differential treatment reflect anticipated devaluation arising from negative social meanings attached to a stigmatized condition. The qualitative findings similarly indicated that expectations of being treated differently could lead women to withdraw from normal social interactions. This reinforces the interpretation that perceived stigma can influence behaviour even in the absence of direct discriminatory encounters.

The inferential findings provide further evidence of the behavioural significance of perceived stigma. Pearson's correlation revealed a strong negative and statistically significant relationship between perceived stigma and health-seeking behaviour ($r = -0.684$, $p < 0.001$). This indicates that higher perceived stigma was associated with lower health-seeking behaviour. Simple linear regression further demonstrated that perceived stigma significantly predicted health-seeking behaviour ($B = -0.542$, $\beta = -0.684$, $t = -10.417$, $p < 0.001$). The regression model was statistically

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significant ($F = 108.520$, $p < 0.001$) and explained 46.8% of the variance in health-seeking behaviour ($R^2 = 0.468$). The strength and direction of the relationship indicate that perceived stigma constitutes an important factor in healthcare decision-making among women living with obstetric fistula.

The quantitative and qualitative evidence therefore converge around a consistent pathway linking perceived stigma to healthcare behaviour. Anticipated judgement may generate fear of disclosure; anticipated gossip and rejection may encourage concealment and social withdrawal; while fear of ridicule within healthcare settings may increase the perceived cost of seeking treatment. These processes can collectively discourage timely healthcare utilization. The qualitative evidence provides contextual support for this interpretation by demonstrating that concerns about judgement, rejection, disclosure, and treatment within healthcare settings are embedded in women's experiences of the condition.

The findings also demonstrate the complementary explanatory value of Stigma Theory and the Health Belief Model. Stigma Theory explains how social labelling, negative stereotypes, anticipated judgement, and exclusion create social and psychological barriers. The Health Belief Model explains how these experiences are subsequently interpreted as perceived barriers within individual healthcare decision-making. Thus, Stigma Theory accounts for the social origin of the barrier, whereas the Health Belief Model explains how the barrier influences the decision to seek, delay, or avoid healthcare. Their integration provides a more comprehensive explanation of the observed negative relationship between perceived stigma and health-seeking behaviour.

The finding that perceived stigma explained 46.8% of the variance in health-seeking behaviour also demonstrates that stigma is an important but not exclusive determinant of healthcare utilization. The remaining 53.2% of the variance may reflect other factors not included in the model, including economic circumstances, healthcare accessibility, cultural expectations, knowledge of treatment options, family support, and health-system experiences. This reinforces the need to interpret perceived stigma within the broader social and structural context in which healthcare decisions are made.

Conclusion

The study established that perceived stigma significantly influences health-seeking behaviour among women living with obstetric fistula in Kajiado South Sub-County, Kajiado County. Women who anticipated negative judgement, gossip, ridicule, social rejection, and discriminatory treatment were less likely to seek timely healthcare services. The significant negative relationship between perceived stigma and health-seeking behaviour demonstrates that fear of adverse social reactions remains a major barrier to healthcare utilization. These findings underscore the need to address perceived stigma as part of comprehensive obstetric fistula interventions to improve timely treatment seeking and ultimately enhance maternal health outcomes.

Recommendations

The Ministry of Health, Kajiado County Department of Health, and development partners should implement sustained community-based stigma reduction programmes that raise public awareness about obstetric fistula, address misconceptions surrounding the condition, and promote supportive community attitudes toward affected women.

Health facilities should strengthen stigma-free obstetric fistula services by training healthcare providers in respectful and confidential care, thereby creating an environment that encourages women to disclose their condition and seek treatment without fear of judgement or discrimination.

Community Health Promoters and local community leaders should strengthen community outreach and referral programmes to identify women living with obstetric fistula, provide psychosocial support, and facilitate early linkage to appropriate treatment services.

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