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Exploring the Post-Repair Health Outcomes Among Women Treated for Obstetric Fistula at the Women and Newborn Hospital in Lusaka, Zambia

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Abstract
Obstetric fistula remains a significant public health problem in low-resource settings, with profound physical, social, and psychological consequences for affected women. While surgical repair is the primary treatment, little is known about the lived experiences of women following repair, particularly in the Zambian context. This study aimed to explore the experiences of women after obstetric fistula repair at The Women and Newborn Hospital (UTH) in Lusaka, Zambia, with specific focus on physical health outcomes, social reintegration, and access to follow-up care. A qualitative study using a phenomenological design was conducted among women who had undergone obstetric fistula repair. Participants were selected through purposive sampling, and data were collected using in-depth, semi-structured interviews. Interviews were audio-recorded, transcribed verbatim, and analyzed using thematic analysis to identify key patterns and themes. The findings revealed that although many women experienced successful fistula closure, a significant number continued to report residual urinary incontinence and related physical challenges. Social reintegration was often difficult, with participants describing experiences of stigma, marital instability, and challenges in resuming economic activities. Barriers to accessing follow-up care were also identified, including financial constraints, long distances to health facilities, and limited availability of structured psychosocial support services. Despite these challenges, many participants demonstrated resilience through coping mechanisms such as family support, faith, and gradual reintegration into community life. The study concludes that recovery following obstetric fistula repair extends beyond surgical intervention and requires a holistic, patient-centered approach that addresses physical, social, and psychological needs. Strengthening follow-up care, integrating psychosocial support, and addressing barriers to healthcare access are essential for improving long-term outcomes among fistula survivors.

Keywords: Obstetric-fistula, Fistula-repair, Lived-experiences, Phenomenology, Social-reintegration.

1. Introduction

Obstetric fistula is one of the most devastating childbirth injuries affecting women in low-resource settings. The World Health Organization (WHO, 2018) defines it as an abnormal opening between the birth canal and the urinary tract or rectum, typically caused by prolonged or obstructed labor without

timely access to emergency obstetric care. It is described as "one of the most serious and tragic childbirth injuries," particularly in communities where a woman's social value is closely tied to marriage and childbearing. This definition highlights not only the physical trauma but also the profound social and emotional consequences that follow, especially in contexts where reproductive roles are central to a woman's identity and status. Globally, obstetric fistula remains a major public health concern. UNFPA (2023) estimates that over two million women and girls live with untreated fistula in Asia and sub-Saharan Africa, with 50,000 to 100,000 new cases occurring each year. These figures reflect persistent gaps in maternal health systems and underscore the urgent need for accessible, high-quality obstetric care. The burden of obstetric fistula is not solely clinical; it extends to social exclusion, psychological distress, and economic vulnerability, affecting not only the women themselves but also their families and communities. In many cases, women are left to cope with chronic incontinence, stigma, and abandonment, often without access to rehabilitation or reintegration support.

In Zambia, the condition continues to affect women, particularly those in rural areas with limited access to emergency obstetric services. The Women and Newborn Hospital at the University Teaching Hospital (UTH) in Lusaka serves as the country's primary referral center for obstetric fistula repair. A recent study conducted between 2017 and 2023 reported a surgical success rate of 88.1%, indicating strong clinical outcomes (Mutola et al., 2025). However, surgical closure alone does not equate to full recovery. There is limited evidence on the long-term health status of women post-repair, particularly in Zambia. A regional review by Bashah et al. (2018) found that post-repair research often neglects critical dimensions such as mental health, fertility, and coping mechanism areas that are essential to holistic recovery. Although their review focused on countries like Ethiopia, Uganda, Nigeria, and Malawi, the findings resonate with Zambia's context, suggesting a broader regional gap in post-repair care research. This lack of outcome tracking undermines the long-term effectiveness of fistula care and contradicts national policy, which asserts that "rehabilitation and reintegration of fistula survivors is critical to restoring dignity and improving quality of life" (Ministry of Health Zambia, 2022, p. 10). Without systematic follow-up, many women may continue to suffer in silence facing unresolved physical complications, social exclusion, and economic hardship even after undergoing surgery. If Zambia does not address this evidence gap, it risks falling short of its national goal to eliminate obstetric fistula by 2030, leaving many women without the full recovery and reintegration they deserve.

2. Research Questions

The study was guided by the following research questions.

- What physical health challenges do women face within 12 months of undergoing obstetric fistula repair at the Women and Newborn Hospital, UTH?
- How do women navigate social reintegration in the year following obstetric fistula repair at UTH?
- How do women describe the quality and adequacy of follow-up care and rehabilitation received from the Women and Newborn Hospital, UTH, within 12 months post-repair?

3. Literature Review

Obstetric fistula remains one of the most debilitating maternal health conditions in sub-Saharan Africa, disproportionately affecting women in low-resource settings. In Zambia, the Women and Newborn Hospital at the University Teaching Hospital (UTH) serves as the country's main referral center for fistula repair. While surgical interventions have improved over the years, the broader recovery experience encompassing physical health, social reintegration, and follow-up care remains underexplored. Most existing studies focus on surgical success rates, often overlooking the lived realities of women post-repair. This review synthesizes literature across three key themes: physical health challenges within 12 months of repair, social reintegration, and the adequacy of follow-up care. It draws primarily from Zambian sources, with selected regional comparisons, to highlight gaps and tensions in current knowledge and to justify the relevance of a patient-centered, context-specific study at UTH.

3.1 Physical Health Challenges Within 12 Months Post-Repair

Surgical closure of the fistula is often considered the endpoint of clinical success, yet many women continue to face persistent physical health issues long after discharge. Imakando et al. (2022) reported that 83% of women achieved anatomical closure two weeks after surgery at UTH, but 17% continued to experience urine leakage or infections. Mutola et al. (2025) found a slightly higher closure rate of 88.1%, yet stress incontinence persisted in a significant number of women six months post-repair. These findings align with regional data from Azeze et al. (2025), who reported that 18–25% of women across sub-Saharan Africa remain incontinent even after successful repair. While these studies agree on the prevalence of post-repair complications, they differ in follow-up duration and scope. Imakando et al. focused on short-term outcomes, whereas Mutola et al. extended their analysis to six months, revealing more nuanced challenges. This study builds on that by examining outcomes over a full year, addressing the gap in long-term monitoring. Bashah et al. (2018) in Ethiopia found that women treated in poorly equipped facilities experienced more complications than those treated in referral hospitals. Zambia's referral hospitals like UTH demonstrate relatively strong surgical outcomes, but most studies only track women for short periods, potentially missing late-emerging issues. The Ministry of Health (2022) acknowledges that limited follow-up capacity and poor tracking systems hinder the ability to monitor outcomes over time. In addition, factors such as travel costs, poverty, and distance from health facilities further complicate sustained recovery. These realities reinforce the need for longer-term follow-up, as recommended in Zambia's National Obstetric Fistula Strategic Plan (2022–2026), which outlines check-ups at two weeks, three months, and six months post-surgery. This study, by focusing on the 12-month period, offers a more comprehensive view of physical recovery and contributes to the national goal of improving post-repair care.

3.2 Social Reintegration Following Obstetric Fistula Repair

Reintegration into family and community life is a critical yet poorly conceptualized aspect of post-repair recovery. Tembo (2022), in a multi-province Zambian study, found that many women struggled to resume marital relationships, reclaim maternal roles, or participate in social activities due to lingering stigma and emotional trauma. UNFPA (2023) reported that up to 80% of women with fistula were divorced or abandoned before surgery, and many did not rebuild relationships afterward. Mutola et al. (2025) found that

only half of the women were back in stable marriages six months after surgery, and fewer than 40% were engaged in income-generating activities. These findings contrast with studies from Uganda and Ethiopia, where reintegration programs are more robust. Byamugisha et al. (2015) reported that women in Ugandan community programs had higher reintegration rates than those discharged without support. Azeze et al. (2025) found that training and peer-support groups in Ethiopia improved women's confidence and acceptance. In relation, Zambia's National Strategic Plan (2022–2026) recognizes reintegration as a priority, but inconsistent funding and limited programming have hindered implementation. Chanda and Mweemba (2021) argue that reintegration should be viewed as a gradual process rather than a binary outcome. Their qualitative study revealed that women often relied on personal resilience and informal support networks to navigate social re-entry. This contrasts with earlier programmatic literature that framed reintegration as a checklist of outcomes marriage, employment, community acceptance without acknowledging the emotional and relational work involved. This study contributes by documenting how these women experience reintegration over time, offering evidence that can inform more sustainable and inclusive support models.

3.3 Quality and Adequacy of Follow-Up Care and Rehabilitation

Follow-up care is essential for sustained recovery, yet in Zambia it remains inconsistent and poorly attended. Imakando et al. (2023) noted that while surgical services at UTH are well-coordinated, post-repair rehabilitation including counseling, physiotherapy, and community outreach is underdeveloped. Mutola et al. (2025) found that fewer than half of the women returned for scheduled reviews, and only a small fraction received structured rehabilitation. The Ministry of Health (2022) attributes this to limited follow-up capacity and poor tracking systems, which make it difficult to monitor outcomes or re-engage patients. Tembo (2022) observed that women often lacked transport, financial support, or awareness of their entitlement to follow-up care. These findings suggest that improving attendance requires more than scheduling it demands systemic changes in communication, outreach, and patient empowerment. This study can inform such reforms by providing evidence on what women perceive as adequate and accessible care. Mental health is another neglected dimension of follow-up. Imakando et al. (2023) found that even women with successful surgeries reported shame and anxiety about recurrence. UNFPA (2023) and Bashah et al. (2018) reported that 30–60% of women continued to experience symptoms of depression post-repair. Yet, most Zambian studies do not use validated tools to assess psychological wellbeing, making it difficult to quantify the burden or design appropriate interventions. In contrast, El Ayadi et al. (2020) found that programs offering counseling and skills training significantly improved mental health outcomes. Countries like Uganda and Ethiopia routinely integrate psychosocial support into post-repair care, highlighting a gap between Zambia's policy aspirations and actual practice. The National Strategic Plan (2022–2026) recommends integrating mental health services into fistula care, but implementation remains limited. This is why this study's focus on women's perspectives offers a timely opportunity to assess how these services are or are not being delivered.

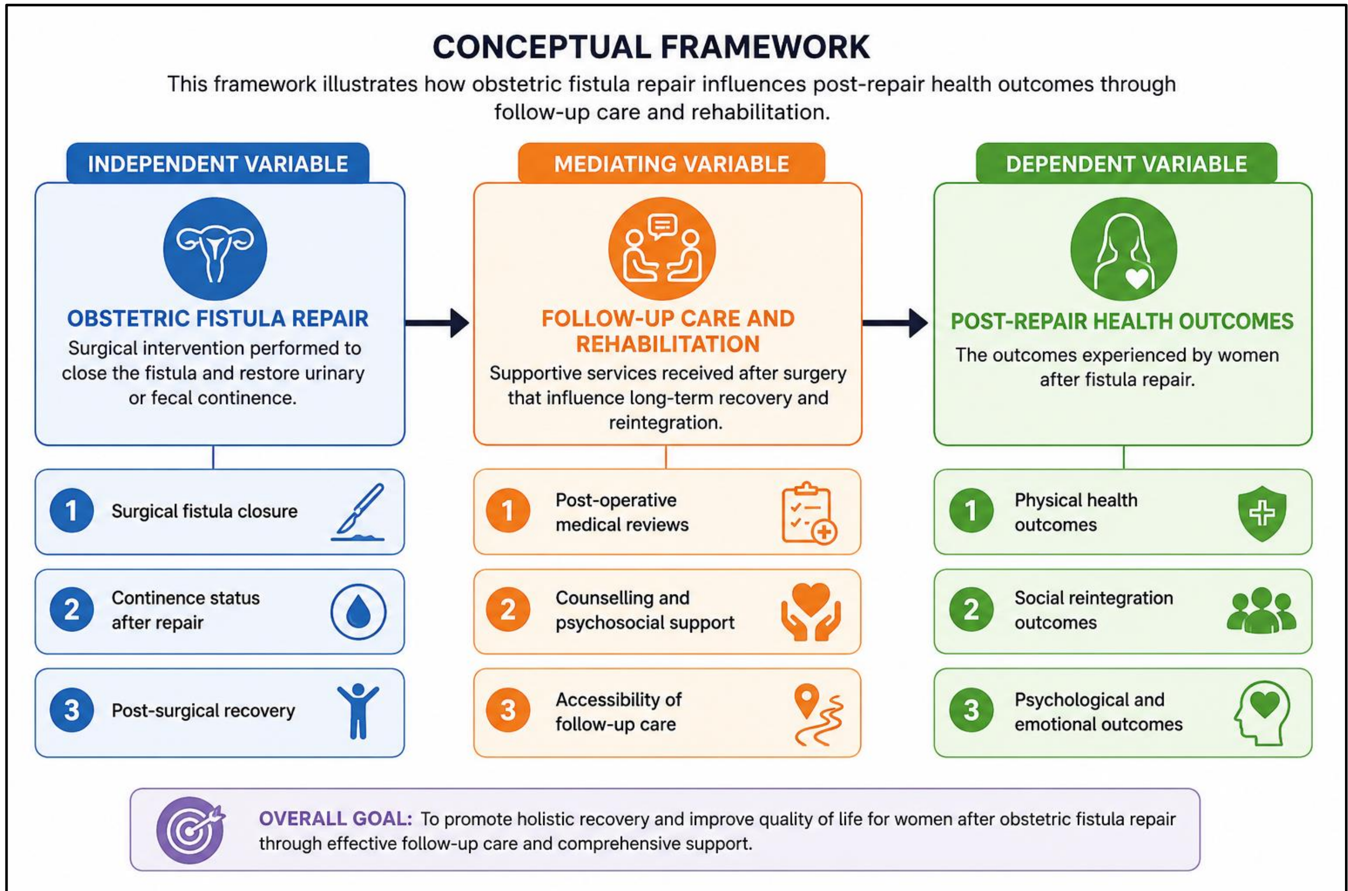
4. Conceptual Framework

A conceptual framework is a way to show how different factors in a study are connected. It helps explain what the research is looking at and how the different parts relate to each other. This conceptual framework illustrates the pathway through which obstetric fistula repair influences post-repair health outcomes, with

a particular emphasis on the role of follow-up care and rehabilitation. The framework is structured around three categories of variables: independent, mediating, and dependent.

- The independent variable is obstetric fistula repair, which marks the beginning of the recovery process. While surgical intervention is essential for closing the fistula and restoring physical function, it does not guarantee full recovery on its own.
- The mediating variable is follow-up care and rehabilitation. This includes post-operative medical reviews, physical therapy, psychosocial counselling, and reintegration support. These services are critical in bridging the gap between surgical repair and long-term recovery, ensuring that patients receive continued care and guidance during the healing process.
- The dependent variables are physical complications and social reintegration. Physical complications may include residual incontinence, infections, or other health issues that arise after surgery. Social reintegration refers to the patient's ability to resume normal social roles, rebuild relationships, and participate in community life.
- The framework expresses that successful obstetric fistula repair combined with receiving adequate follow-up care and rehabilitation, in turn reduces physical complications and promotes social reintegration. This model underscores the importance of continuity of care and highlights follow-up services as a key determinant of holistic recovery.

Figure1: Diagrammatic representation of the Conceptual Framework



5. Methodology

This study employed a qualitative research approach using a phenomenological design. Phenomenology is an appropriate research design for exploring and understanding individuals' lived experiences and how they interpret those experiences. This design enabled the researcher to capture detailed narratives from women who had undergone obstetric fistula repair, focusing on their physical, social, and psychological experiences after treatment. The phenomenological design allowed participants to describe their personal journeys in their own words, thereby providing rich, contextualized data that could not be obtained through quantitative methods. This design was particularly suitable for addressing the study objectives, which required an exploration of subjective experiences rather than measurement of variables.

6. Study Sample

The study utilized purposive sampling to recruit participants who could provide rich and relevant information. This sampling technique is commonly used in qualitative research to identify individuals with specific experiences related to the phenomenon under investigation. The sample size was determined by the principle of data saturation, which occurs when no new themes or insights emerge from additional data collection. In this study, saturation was achieved after interviewing approximately 12-15 participants, which is consistent with phenomenological research standards.

7. Study Findings

Findings of the study exploring the post-repair health experiences of women treated for obstetric fistula at the Women and Newborn Hospital, University Teaching Hospital (UTH), Lusaka. The findings are based on in-depth interviews with fifteen women who underwent fistula repair between January and December 2025. The data were analysed thematically and the results are presented as lived-experience themes that emerged from the interviews. The chapter begins with a brief description of the participants, followed by the major themes and sub-themes that reflect the women's physical, social, emotional, and care-related experiences after repair.

7.1 Participant Profile

The study involved fifteen women aged between 18 and 43 years. The participants came from several residential areas in Lusaka and represented varied marital and occupational backgrounds. The profile below presents the participants as they were captured in the study materials

Table 1: Profile of Participants Included in the Study (N = 15)

Participant ID	Age	Marital Status	Occupation	Residence (Lusaka)	Time Since Repair	Self-Reported Recovery Status
P1	38	Divorced	Small-scale trader	Kanyama	7 months	Failed/leaking
P2	25	Separated	Subsistence farmer	Chawama	4 months	Closed but wet
P3	39	Married	Tailor	Kanyama	12 months	Closed and dry

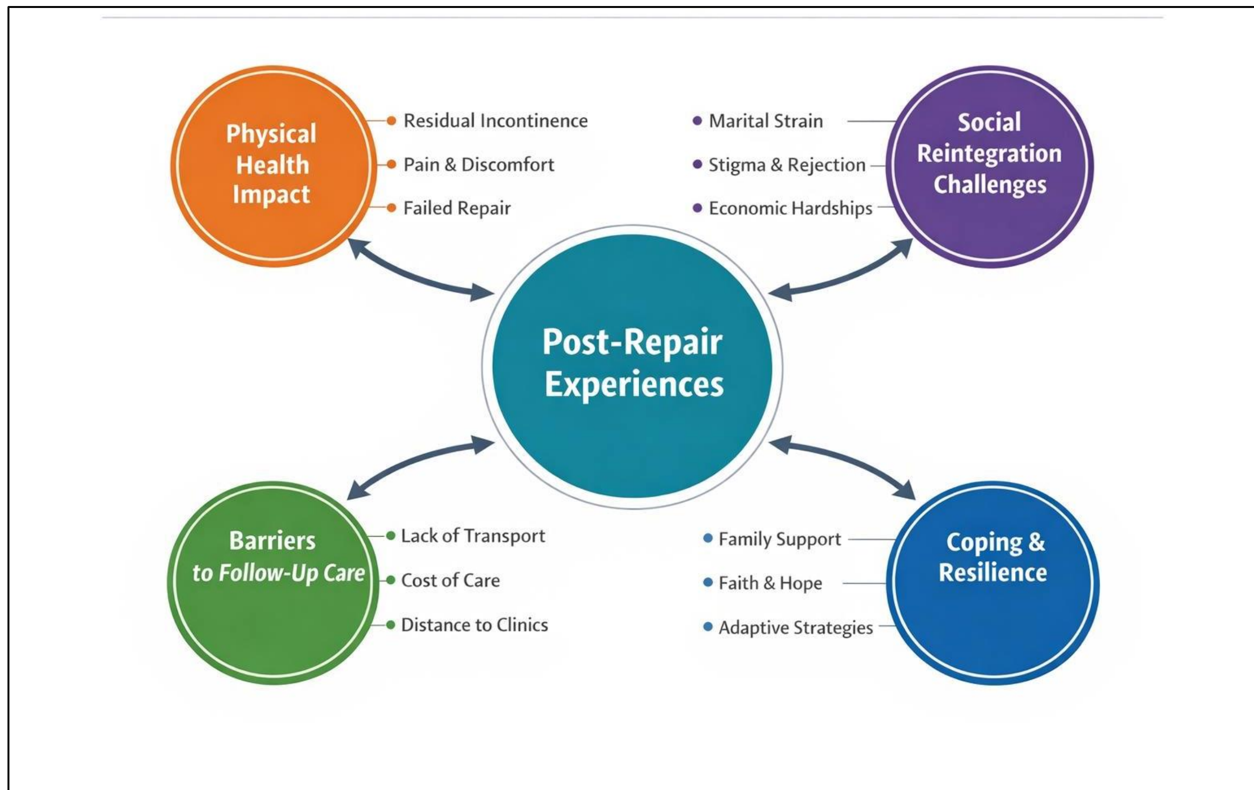
P4	31	Separated	Small-scale trader	Kanyama	4 months	Closed but wet
P5	24	Single	Subsistence farmer	Bauleni	12 months	Closed and dry
P6	18	Married	Tailor	Chawama	11 months	Closed and dry
P7	31	Divorced	Subsistence farmer	Garden	12 months	Closed and dry
P8	26	Separated	Small-scale trader	Chipata Compound	5 months	Closed and dry
P9	40	Divorced	Housewife	Matero	7 months	Closed and dry
P10	22	Married	Subsistence farmer	Chipata Compound	8 months	Closed and dry
P11	21	Married	Small-scale trader	Garden	4 months	Closed and dry
P12	29	Married	Unemployed	Bauleni	7 months	Failed/leaking
P13	43	Single	Small-scale trader	Mtendere	10 months	Closed and dry
P14	35	Married	Small-scale trader	Garden	4 months	Closed and dry
P15	35	Married	Unemployed	Chipata Compound	12 months	Closed but wet

The participant profile shows that the women were mainly within the reproductive age group and lived in high-density urban settings. Their narratives reflected not only the physical consequences of fistula repair, but also the wider social and emotional effects of recovery.

7.2 Thematic Presentation of Findings

The interview data produced seven major themes. These themes were closely aligned to the study objectives and reflected the women's experiences of physical health challenges, social reintegration, and follow-up care after fistula repair.

Figure 2: Thematic Map of Post-Repair Experiences



This figure summarizes the central meaning units that emerged from the interviews and shows how the women's accounts clustered around physical recovery, social rebuilding, continuity of care, and coping.

7.2.1 Theme One: Residual Incontinence Despite Anatomical Closure

The first theme described the experience of women who were told that the fistula had closed, but who continued to experience urinary leakage during daily activities. The women described this as frustrating because the surgery was technically successful, yet their bodies still did not feel fully restored. One participant explained, "The doctors told me the hole is closed, but I still wet my clothes when I sneeze or walk fast. It feels like I am only half-healed." (P15, 35 years old). Another participant noted, "I was told that the operation worked, but I still leak when I move around too much." (P4, 31 years old). The women's descriptions showed that anatomical closure did not always translate into a sense of complete recovery. Even when the fistula was closed, persistent wetness remained a major concern in their everyday lives. This theme was particularly evident among participants whose recovery was described as "closed but wet."

7.2.2 Theme Two: Persistent Leakage Following Failed Repair

The second theme captured the experiences of participants whose surgery did not lead to complete closure. These women reported that leakage resumed after catheter removal and that the operation had not produced the recovery they had hoped for. One participant stated, "I was so hopeful, but after the catheter was removed, the water started coming again. It is heartbreaking to go through the pain of surgery and still be leaking." (P1, 38 years old). Another participant said, "I stayed hopeful for some weeks, but I still leak, and it makes me feel like nothing has changed." (P12, 29 years old). The emotional content of these

accounts showed deep disappointment, frustration, and distress. The women described their surgery as painful and emotionally demanding, and the return of leakage intensified their sense of loss.

7.2.3 Theme Three: Marital Instability and Abandonment

The third theme described the disruption of intimate relationships and family life. Many women reported that their marriages or partnerships had been damaged during the period of active fistula, and in some cases the relationship did not recover even after repair. One participant shared, "My husband left me three years ago when the leaking started. Now that I am dry, I heard he is married to someone else. The surgery fixed my body, but it cannot bring back my family." (P7, 31 years old). Another participant explained, "After the fistula started, my marriage changed completely. Even though I am better now, things are not the same." (P9, 40 years old). These accounts showed that the social consequences of fistula often continued long after the physical repair. For some women, the operation restored their health but not their relationships. The loss of a partner, emotional rejection, and the breakdown of family stability were strongly present in their narratives.

7.2.4 Theme Four: Difficulties Resuming Work and Economic Roles

The fourth theme focused on the women's efforts to return to work and rebuild their livelihoods. Participants who had previously worked as traders, farmers, tailors, or informal workers described uncertainty, weakness, and fear about returning to their usual roles. One participant explained, "I wanted to go back to selling, but I was afraid of lifting heavy things because I thought the problem would come back." (P11, 21 years old). Another participant said, "I am trying to work, but sometimes my body still feels weak, and I cannot do much." (P2, 25 years old). These experiences showed that economic recovery was uneven. Some women were physically able to resume work, while others remained dependent on family members or were unsure whether they could safely return to demanding tasks. The fear of reopening the fistula shaped how they approached movement, work, and income generation.

7.2.5 Theme Five: Geographic and Financial Barriers to Follow-Up Care

The fifth theme concerned the participants' difficulties in accessing follow-up care after repair. Many women reported that the cost of transport and the distance to the hospital made it hard to attend review appointments. Some also had to balance hospital visits with household responsibilities and limited finances. One participant explained, "It is not easy to go back for review because transport is costly, and sometimes I do not even have the money." (P8, 26 years old). Another participant stated, "I wanted to return, but I stayed away because I could not manage the transport fare." (P10, 22 years old). The participants' accounts revealed that follow-up care was not simply a matter of appointment scheduling. Practical barriers shaped whether women could return for review, and these barriers affected continuity of care after discharge.

7.2.6 Theme Six: Lack of Structured Psychosocial Support

The sixth theme reflected the women's perception that the care they received focused mainly on surgery, with limited emotional or psychosocial follow-up after discharge. Participants explained that they needed counselling, reassurance, and support for reintegration, but that these services were not consistently available. One participant noted,"They treated me, but after the operation there was no proper counselling. I still needed someone to talk to." (P13, 43 years old). Another participant said, "I think the hospital should

help women more after surgery, not only during the operation." (P6, 18 years old). These statements showed that the women did not experience repair as a complete package of care. They wanted more than wound healing or discharge; they wanted guidance for emotional recovery, social reintegration, and long-term adjustment.

7.2.7 Theme Seven: Coping, Resilience, and Hope

Although the women described many difficulties, the interviews also revealed persistence and resilience. Some participants drew strength from family support, prayer, gradual return to work, and the hope that recovery would improve with time. The study materials also noted that some women demonstrated resilience through family support and engagement in income-generating activities, which reflected an important part of their lived experience. Participants did not present themselves only as victims of illness. Several described continuing to try, adapt, and rebuild their lives, even when recovery was incomplete. Their coping strategies included accepting help from relatives, reducing physically demanding tasks, and maintaining hope that they would eventually regain full confidence.

8. Discussion

The discussion explores the lived experiences of women following obstetric fistula repair, focusing on physical health outcomes, social reintegration, and access to follow-up care. The findings are examined within the broader context of maternal health in low-resource settings, particularly Sub-Saharan Africa. In addition to examining the clinical and social outcomes of fistula repair, this study also revealed important socio-demographic patterns among participants. Most women in the study came from high-density, low-income communities within Lusaka and were engaged in informal or unstable forms of employment such as small-scale trading and subsistence farming. In my view, these socio-economic realities shaped not only women's experiences of fistula, but also their ability to avoid heavy labor during pregnancy and recover fully after surgery. The findings suggest that recovery cannot be separated from broader issues of poverty, education, and social inequality, which continue to influence access to healthcare, follow-up attendance, emotional wellbeing, and reintegration into society.

8.1 Physical Health Outcomes Following Fistula Repair

The findings of this study revealed that while many participants experienced successful anatomical closure of the fistula, a number continued to report residual urinary incontinence. This aligns with the concept of the "continence gap," where surgical closure does not necessarily result in complete continence. Studies have shown that although closure rates may be high, a subset of women continue to experience stress incontinence due to urethral damage or reduced bladder capacity (Wall & Arrowsmith, 2007; Arrowsmith et al., 2013). Similarly, a cohort study conducted in Malawi demonstrated that continence outcomes significantly influence quality of life after repair, with women experiencing persistent leakage reporting poorer physical and psychological outcomes (Kopp et al., 2019) . This is consistent with the narratives in this study, where participants described ongoing leakage as a source of distress and functional limitation. Furthermore, the persistence of leakage among some participants following repair reflects findings from a Tanzanian study, which showed that women with residual incontinence had significantly higher levels of psychological distress compared to those who were fully continent (Wilson et al., 2016) . The current study reinforces this association, as participants linked ongoing physical symptoms with emotional discomfort and reduced confidence. The socio-demographic profile of participants may also help explain

some of the differences in recovery experiences observed in this study. Many of the women had low-income occupations and lived in densely populated areas where access to healthcare resources may be limited. In my opinion, social class may have indirectly influenced post-repair outcomes because women with fewer economic resources appeared more likely to face barriers such as delayed follow-up attendance, transport difficulties, and reduced access to supportive care. This observation is supported by Tembo (2022), who found that poverty and limited healthcare accessibility significantly affected women's ability to sustain recovery after fistula treatment in Zambia. Education may also be an important factor influencing recovery outcomes. Although educational level was not directly measured in this study, participants with limited economic opportunities may also have experienced lower health literacy regarding post-operative care instructions, continence management, and the importance of follow-up visits. Literature suggests that women with greater health awareness and stronger social support networks are more likely to engage consistently with rehabilitation services and achieve improved long-term outcomes (El Ayadi et al., 2020). This may partly explain why some women in this study demonstrated more confidence and gradual reintegration than others. It is also highlighted that cases of failed repair, where women continued to leak despite undergoing surgery is in line with evidence from Zambia indicating that although overall surgical success rates can be as high as 88%, outcomes are influenced by factors such as fistula complexity, previous repairs, and access to skilled surgeons . This suggests that variations in clinical outcomes observed in this study are consistent with broader regional patterns.

8.2 Social Reintegration After Repair

Social reintegration emerged as a major challenge for many participants. The study found that marital instability, separation, and abandonment were common experiences, particularly among women who had lived with fistula for extended periods. These findings are strongly supported by Ahmed and Holtz (2007), who reported high rates of divorce and social isolation among women with obstetric fistula. Even after surgical repair, social reintegration was not always complete. Some participants reported that relationships did not recover, and stigma persisted despite improved physical health. This reflects broader evidence indicating that while surgery can improve health and self-esteem, social acceptance often lags behind clinical recovery (Ahmed & Holtz, 2007). An important observation from this study is that social reintegration appeared to be strongly connected to socio-economic stability. Women who had access to supportive family structures or some form of income-generating activity seemed better able to rebuild confidence and re-engage socially. Conversely, women who were unemployed, financially dependent, or socially isolated appeared more vulnerable to prolonged stigma and emotional distress. In my view, this highlights how obstetric fistula is not only a medical condition but also a condition deeply shaped by social inequality. The burden of fistula disproportionately affects women from disadvantaged backgrounds, particularly those with limited education, unstable income, and restricted access to maternal healthcare services. This aligns with UNFPA (2023), which emphasizes that obstetric fistula is closely associated with poverty, limited access to emergency obstetric care, and gender inequality. The findings also suggest that educational empowerment may influence reintegration experiences. Women with greater exposure to social networks, economic opportunities, or health information may feel more capable of navigating recovery and community re-entry. Chanda and Mweemba (2021) similarly argue that reintegration should be understood as a gradual social process influenced by personal resilience, support systems, and social positioning within the community. In addition, the findings of this study are consistent with research showing that women with obstetric fistula often experience long-term social exclusion, including rejection

by spouses and communities (Wall, 2006). These social consequences are deeply rooted in cultural perceptions of the condition and are not easily reversed by medical intervention alone. Economic reintegration also presented challenges. Participants described difficulty returning to work due to fear of re-injury, persistent symptoms, or reduced physical strength. A longitudinal study in Uganda found that ongoing physical symptoms were significantly associated with poorer reintegration outcomes, including reduced participation in economic and social activities . This supports the findings of the present study, where women's ability to resume productive roles was closely linked to their physical recovery.

8.3 Access to Follow-Up Care and Rehabilitation

The study revealed significant barriers to accessing follow-up care, particularly related to transportation costs and distance to healthcare facilities. These structural challenges are widely documented in low-resource settings, where access to post-operative care is often limited by financial and geographic constraints. The findings further suggest that structural inequalities may have influenced access to follow-up care among participants. Most women in the study depended on informal employment or family support, which may have reduced their ability to prioritize transport costs and repeated hospital visits. In my opinion, this introduces an important social-class dimension to post-repair recovery, where women with fewer economic resources may be systematically disadvantaged in accessing continued care. This potential bias is important because women from lower socio-economic backgrounds may experience poorer long-term outcomes not necessarily because of unsuccessful surgery, but because they face greater barriers to continuity of care. Similar concerns were raised by Bashah et al. (2018), who found that women in resource-limited settings often struggle to access rehabilitation and psychosocial services after repair. Education may also influence healthcare utilization after discharge. Women with limited understanding of post-operative care recommendations may underestimate the importance of review appointments or fail to recognize early complications requiring medical attention. This reinforces the need for patient-centered education strategies that use clear communication and culturally appropriate counselling approaches. Evidence from Zambia and other Sub-Saharan African countries indicates that healthcare access inequalities remain a major barrier to effective fistula management, particularly for women in rural or low-income settings. The findings of this study align with this evidence, as participants described missing follow-up appointments due to lack of transport and competing financial priorities. Another important finding was the lack of structured psychosocial support after surgery. Participants expressed a need for counselling and emotional support, which was often not available. This is consistent with findings from Browning et al. (2007), who demonstrated that although mental health improves after surgery, a significant proportion of women continue to experience psychological distress, particularly those with ongoing symptoms. Further evidence suggests that psychosocial recovery is closely linked to physical outcomes. Women who remain incontinent are more likely to experience depression, stigma, and reduced quality of life (Wilson et al., 2016). The current study supports this relationship, highlighting the need for integrated care that addresses both physical and emotional recovery.

8.4 Coping Mechanisms and Resilience

Despite the challenges identified, the study also revealed important aspects of resilience among participants. Women described relying on family support, faith, and gradual reintegration into daily activities as coping strategies. These findings align with broader literature on maternal health, which emphasizes the role of social support systems in facilitating recovery. Research has shown that even in

the presence of ongoing symptoms, women can experience improvements in psychological well-being over time, particularly when supported by family and community networks (Wilson et al., 2016). Similarly, longitudinal studies have demonstrated that psychosocial outcomes improve significantly after repair, although these improvements are moderated by physical health status. The presence of resilience in this study highlights the importance of considering not only the challenges faced by fistula survivors but also their capacity for adaptation and recovery. This perspective is essential for developing patient-centered care models that build on existing strengths.

9. Conclusion

This study set out to explore the lived experiences of women following obstetric fistula repair using a phenomenological approach. The findings demonstrate that recovery from obstetric fistula extends beyond surgical intervention and encompasses complex physical, social, and psychological dimensions. In relation to physical health outcomes, the study found that although many women achieved successful fistula closure, a proportion continued to experience residual urinary incontinence. This highlights the distinction between anatomical closure and functional recovery, emphasizing that surgical success does not always translate into complete continence. Persistent symptoms were found to significantly affect daily functioning, self-esteem, and overall quality of life. Regarding social reintegration, the study revealed that many women faced ongoing challenges even after repair. Marital instability, stigma, and social isolation were common experiences, particularly among those who had lived with fistula for extended periods or continued to experience symptoms. While some participants reported gradual reintegration into their families and communities, this process was often slow and influenced by cultural perceptions and levels of social support. In terms of access to follow-up care, the findings indicate that many women encountered significant barriers, including financial constraints, long distances to health facilities, and limited awareness of the importance of post-operative care. The lack of structured psychosocial support further compounded these challenges, leaving many women without the necessary resources to fully recover. Despite these difficulties, the study also highlighted the resilience of participants. Many women demonstrated adaptive coping strategies, including reliance on family support, faith, and gradual re-engagement with daily activities. These findings underscore the importance of considering both the challenges and strengths of fistula survivors in designing care interventions. Overall, the study concludes that obstetric fistula repair, while essential, is only one component of recovery. A holistic, patient-centered approach that integrates physical, social, and psychological support is necessary to achieve meaningful and sustained recovery outcomes.

10. Recommendations

- At the clinical level, there is a need to strengthen post-operative care services to address residual incontinence and other long-term complications experienced after repair. This includes incorporating pelvic floor rehabilitation, continence management strategies, and routine follow-up assessments into standard fistula care protocols. Healthcare providers should also receive additional training in holistic and patient-centered care to ensure that women's physical, emotional, and psychosocial needs are adequately addressed throughout recovery.
- Structured counselling services should be integrated into post-repair care to support women experiencing emotional distress, fear of recurrence, stigma, or difficulty reintegrating into family and community life. Hospitals providing fistula repair services should also consider establishing

peer-support systems where survivors can share experiences and encourage one another during recovery.

- At the health system level, efforts should be made to improve access to follow-up care, particularly for women from low-income and socially vulnerable backgrounds. Many participants described transport costs, distance to healthcare facilities, and financial difficulties as major barriers to attending review appointments. To address this, community-based follow-up programs, outreach services, and decentralized rehabilitation services should be strengthened to bring care closer to affected women.
- In addition, healthcare facilities should improve patient education before discharge by providing clear and culturally appropriate information on post-operative recovery, continence management, danger signs, and the importance of follow-up care. Improving health literacy may enhance women's confidence in managing recovery and increase utilization of rehabilitation services.
- Psychosocial support should be recognized as a core component of fistula care rather than an optional service. Counselling, family engagement initiatives, and community reintegration programs should be strengthened to help reduce stigma and improve women's emotional wellbeing after repair.
- Economic empowerment initiatives should also be considered as part of long-term rehabilitation. Skills training, income-generating activities, and social support programs may help women regain independence and improve reintegration outcomes, particularly among women who remain financially vulnerable after surgery.
- Community awareness campaigns involving healthcare workers, local leaders, and women's groups could further help challenge stigma surrounding obstetric fistula and promote acceptance of survivors within families and communities.
- The findings of this study also highlight the importance of strengthening maternal healthcare services to prevent obstetric fistula from occurring in the first place. Improving access to quality antenatal care, skilled birth attendance, and emergency obstetric services is essential, particularly for women in low-resource and rural settings.
- Health education programs should emphasize the importance of antenatal care attendance, early recognition of pregnancy-related complications, and timely healthcare seeking during labour. Particular attention should be given to women with limited educational opportunities, as low health literacy may contribute to delayed access to obstetric care and increased risk of prolonged obstructed labour.
- In addition, maternal health interventions should address broader social determinants such as poverty, education, and gender inequality, which continue to place disadvantaged women at greater risk of obstetric fistula and poor recovery outcomes.
- From a policy perspective, there is a need for greater investment in comprehensive fistula care programs that extend beyond surgical repair. National maternal health policies should prioritize long-term rehabilitation, psychosocial support, and reintegration services as essential components of fistula management.
- The Ministry of Health and collaborating partners should strengthen monitoring and follow-up systems to ensure continuity of care after discharge. Increased funding for community outreach

programs, rehabilitation services, and patient support initiatives may improve long-term outcomes among fistula survivors.
- Collaboration between government institutions, non-governmental organizations, and international partners should also be strengthened to support integrated and sustainable approaches to fistula prevention, treatment, and recovery.

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