

Original Research Article

Prevalence and risk factors associated with obstetric fistula among women of reproductive age in Bungoma, Kilifi and Kiambu Counties, Kenya

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Received: 10 February 2026

Revised: 06 June 2026

Accepted: 09 July 2026

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ABSTRACT

Background: Female genital fistula (FGF) is a debilitating childbirth-related condition affecting an estimated 50,000-100,000 women globally each year. In Kenya, the incidence is estimated at 17.4 cases per 100,000 deliveries, yet only about 8% of new cases receive surgical treatment annually. This study explored the risk factors, psychosocial experiences, healthcare-seeking behaviour, and coping mechanisms among women living with FGF in Bungoma, Kiambu, and Kilifi counties.

Methods: A cross-sectional study was conducted among 113 purposively selected female genital fistula survivors. Quantitative data were collected using structured interviewer-administered questionnaires and analysed using descriptive statistics.

Results: Severe depression was reported by 66.2% of participants, while 51.3% experienced anxiety associated with stigma and social exclusion. Suicidal thoughts were reported by 22.1% of respondents. Regarding childbirth, 59.3% delivered their youngest child in a health facility, whereas 40.7% delivered at home. Among home deliveries, the leading reason was the long distance to a health facility (40.0%). Social isolation was the most common coping strategy, reported by 59.3% of participants.

Conclusions: Female genital fistula continues to have profound psychosocial consequences and remains closely linked to barriers in accessing skilled maternal healthcare. Strengthening maternal health services, promoting community awareness, and providing comprehensive post-repair care that integrates psychosocial and economic support are essential. Increased county investment in fistula prevention, treatment, rehabilitation, and reintegration programmes is recommended.

Keywords: Coping mechanisms, Female genital fistula, Healthcare-seeking behaviour, Kenya, Psychosocial effects

INTRODUCTION

Female Genital Fistula (FGF) is an abnormal connection between the reproductive tract usually the vagina and the urinary tract, most commonly the urinary bladder. It affects between 50,000 and 100,000 women globally each

year.¹ FGF is one of the most debilitating health conditions, as it results in chronic urinary and/or fecal incontinence. This leads to a range of physical comorbidities, psychological distress, and significant social stigmatization.²

Access to surgical care for obstetric fistula remains extremely low, resulting in unmet needs for millions of women in low- and middle-income countries (LMICs).³ The investment gap in this area is substantial. Increased financial resources, training, and infrastructure, particularly in surgery could help avert an estimated 7.2 million disability-adjusted life years (DALYs) annually, including those caused by obstetric fistula.³

Majority of LMICs countries continue to fall short of achieving the recommended access to safe, timely, and effective surgical and obstetric care as these countries are unable to meet the investment targets proposed by the Lancet Commission on Global Surgery and the World Health Organization.^{3,4} In East Africa, approximately 5,400 new fistula cases occur annually. Kenya accounts for an estimated 1,500 of these, with 90% being obstetric in origin.⁵ However, this figure is likely underestimated due to widespread underreporting driven by the social stigma associated with the condition. The prevalence of FGF in Kenya is estimated at 17.4 cases per 100,000 deliveries.⁶ Access to treatment remains low, with only 80 out of 1,000 new cases (8%) receiving surgical care annually.⁷ As a result, many women continue to live with untreated fistula in silence, contributing to a growing backlog of unrepaired cases. The success rate for surgical repair ranges from 80% to 94%. Most of those affected are young, impoverished women and girls.^{8,9} Alarming, incidences of iatrogenic fistula those caused by surgical error are also on the rise across East African countries.

While efforts have been made to increase access to fistula treatment, especially surgical repair, existing policies and programs remain inadequate.¹⁰ Women affected by obstetric fistula face multiple, overlapping barriers including cultural, systemic, and financial constraints. Many live in highly marginalized conditions, desperately poor, socially isolated, and often unreachable via conventional communication channels. Stigma is a powerful deterrent to seeking care, and many women prefer to remain invisible rather than face societal rejection. Limited education among affected women further limits their ability to advocate for themselves or access relevant information and services.¹¹

Despite being entirely preventable, obstetric fistula persists largely due to delayed or absent access to timely, high-quality maternal care, particularly in rural areas.^{12,13} Studies from low-resource settings have reported the psychosocial impacts of fistula, including divorce or separation, loss of social roles, and isolation.^{14,15} Understanding women's journeys from isolation to reintegration following surgery is vital for ensuring holistic recovery.⁵

In their quest for relief, many women turn to traditional healers or unproven remedies before reaching formal treatment centers. A study in Ghana found that most women initially sought care from traditional providers before being referred to fistula treatment hospitals.¹⁶

Contributing factors included misinformation about fistula and its causes, family pressure, lack of decision-making power, and limited awareness about available modern treatment options. Additional delays in seeking care often occur during pregnancy due to long distances to health facilities, unskilled birth attendance, and financial constraints.

Several qualitative and quantitative studies have examined the support needed by women with fistula. Women report feeling extremely vulnerable and often require not only medical care but also psychological counseling, companionship, and family or community support throughout the treatment process.¹⁶ Unfortunately, they are frequently shunned by their partners, families, and communities, reinforcing their isolation.¹⁷

Women with higher educational attainment are more likely to be aware of preventive and treatment options, attend antenatal care, deliver in health facilities, and seek timely intervention. Majority of women failed to recognize the initial symptoms of uterine rupture due to lack of preparedness, a preference for home delivery, refusal by their husbands, and general unawareness. This delay led not only to the development of fistula but also to complications such as neonatal loss and psychological trauma. In many cases, women coped by accepting their condition, withdrawing from society, and relying on traditional healing practice.¹⁸

Surviving obstetric fistula leaves lasting emotional, physical, and social scars. The condition severely disrupts women's socio-economic lives.¹⁹ Post-surgical reintegration into society is a gradual and often challenging process. Studies from Eritrea, Ethiopia and Tanzania all highlight the need for sustained post-operative follow-up and psychosocial support.²⁰⁻²³ Emphasis the importance of structured reintegration programs to improve the quality of life for these women is also critical.²²

Four potential reintegration outcomes have been identified post-surgery: full reintegration into previous communities, partial reintegration, no reintegration, or integration into new social settings.²⁴ Recognizing these outcomes is key to developing tailored support and coping mechanisms for each patient.

The formal health system has often proven unresponsive to the complex needs of women living with fistula. Many navigate a prolonged and fragmented treatment pathway, turning to informal or traditional remedies that are ill-suited for managing this condition.⁵ To address this, health systems must be strengthened with skilled personnel and equipped facilities capable of managing obstetric fistula and reducing treatment delays.

Involvement of husbands, partners, and families in both prevention and treatment programs may lead to better

outcomes when incorporated into support systems to enhance effectiveness, particularly for women who remain incontinent after surgery.²⁵

METHODS

The study was conducted between January and March 2025. A descriptive cross-sectional study design using quantitative approach for data collection among Obstetric Fistula Survivors. The study area covered three counties in Kenya; Bungoma, Kiambu and Kilifi Counties targeting women who had received obstetric fistula screening and treatment through Integrated Fistula Program in three selected counties.

Inclusion criteria

Women were eligible for inclusion if they were: (i) aged 15-49 years (or reproductive age), (ii) diagnosed with obstetric/female genital fistula, (iii) had received fistula screening and/or surgical treatment through the Integrated Fistula Programme in Bungoma, Kiambu, or Kilifi Counties between January and March 2025, (iv) were available during the study period, and (v) provided written informed consent to participate.

Exclusion criteria

Women who declined consent, were critically ill or cognitively unable to participate in an interview, had fistula of non-obstetric origin (if excluded from the programme), or had incomplete programme records were excluded from the study.

Simple random sampling was used to select the respondents using a comprehensive list of all fistula survivors as a sample frame to enroll participants in each selected county. A total of 113 women beneficiaries (fistula survivors) of female genital fistula surgery were selected using purposive sampling method.

Statistical analysis

Quantitative data collection utilized a structured questionnaire administered to the sampled Fistula Survivors. Data was analysed using the STATA Corp. 18.0 into descriptive statistics summarizing distributions. Inferential statistics, specifically the Chi-square (χ^2) test of independence, was used to examine relationships between county of residence and each of the KAP variables. A significance level of $p < 0.05$ was used to determine statistical significance.

RESULTS

Socio-demographic characteristics of respondents

Table 1 shows the characteristics of fistula survivors enrolled in the study. A total of 113 fistula survivors participated in the study, with 79 women from Bungoma, 19 from Kiambu, and 15 from Kilifi. The average age of the respondents was 47 years (SD=16); however, a significant proportion of women (60.18%) had their first delivery between the ages of 15-19 years ($p=0.177$). Early childbearing is a critical driver of obstetric fistula, as younger mothers often experience obstructed labor due to an underdeveloped pelvis, limited access to skilled birth attendance, and socio-economic constraints that reduce their ability to seek timely and appropriate maternal healthcare. The cumulative effects of these factors contribute to an increased risk of prolonged labor, which remains a primary cause of fistula. Most participants have had multiple deliveries with an average of 5 births (SD=16); however, live births/parity was 4 births (SD=3) with Kiambu having the highest number of livebirth/parities per woman at 6 births (SD=3). About 79 (69.91%) respondents were in married. The highest level of education completed by the majority was primary level; accounting for 20.35% of the respondents. Christians were the largest religious group at 98.23%, while Muslims and traditionalist comprised of less than 1 each. On average, respondents had 61 months of recovery times after fistula surgery.

Table 1: Socio-demographic characteristics of respondents.

Characteristics	Project counties***			
	Total, N (%)	Bungoma, N (%)	Kiambu, N (%)	Kilifi, N (%)
Age (Mean/SD)	47 (16)	47 (15)	41 (12)	59 (20)
Age at first delivery in years				
15-19	68 (60.18)	53 (67.09)	7 (36.84)	8 (53.33)
20-24	29 (25.66)	17 (21.52)	9 (47.37)	3 (20.00)
25-29	11 (9.73)	6 (7.59)	2 (10.53)	3 (20.00)
30-34	5 (4.42)	3 (3.80)	1 (5.26)	1 (6.67)
35 and above	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)
Gravida* (Mean/SD)	5 (16)	5 (3)	6 (3)	3 (1)
Parity** (Mean/SD)	4 (3)	5 (3)	3 (2)	3 (1)
Marital status				
Divorced	4 (3.54)	0 (0.00)	2 (10.53)	2 (13.33)
Married	79 (69.91)	62 (78.8)	11 (57.89)	6 (40.00)
Separated	5 (4.42)	3 (3.80)	2 (10.53)	0 (0.00)

Continued.

Characteristics	Project counties***			
	Total, N (%)	Bungoma, N (%)	Kiambu, N (%)	Kilifi, N (%)
Single	10 (8.85)	6 (7.59)	3 (15.79)	1 (6.67)
Widowed	15 (13.27)	8 (10.13)	1(5.26)	6 (40.00)
Education level				
None	12 (10.62)	4 (5.06)	0 (0.00)	8 (53.33)
Primary incomplete	35 (30.97)	28 (35.44)	4 (21.05)	3 (20.00)
Primary complete	23 (20.35)	19 (24.05)	4 (21.05)	0 (0.00)
Secondary incomplete	19 (16.81)	16 (20.25)	2 (10.53)	1 (6.67)
Secondary complete	13 (11.50)	5 (6.33)	6 (31.58)	2 (13.33)
College	5 (4.42)	3 (3.80)	2 (10.53)	0 (0.00)
University	4 (3.54)	3 (3.80)	1 (5.26)	0 (0.00)
Adult education	1 (0.88)	0 (0.00)	0 (0.00)	1 (6.67)
Other	1 (0.88)	1 (1.27)	0 (0.00)	0 (0.00)
Duration after surgery in months (mean/SD)	61 (62)	83 (64)	9 (1)	17 (8)

*Number of pregnancies regardless of the delivery outcome, **Number of live births

Psychosocial effect of genital fistula

The findings from this study highlight the deep psychosocial suffering of affected women, including social rejection, emotional distress, stigma, and financial hardship. Nearly half of all women, accounting for 45.1 percent of the cases, reported experiencing ridicule and abuse because of their condition (Table 2). The stigma was especially severe in Bungoma County, where a

shocking 55.7 percent of affected women were mocked and humiliated by those around them. In Kiambu, the percentage was lower at 31.6 percent, while Kilifi reported the lowest incidence of ridicule at 6.7 percent, suggesting some level of community acceptance. Beyond verbal abuse, some women were physically confined, with 18.6 percent being locked up in their homes and left alone. This practice was particularly widespread in Bungoma, affecting 24.1 percent of women, and in Kiambu, where 10.5 percent of cases were reported.

Table 2: Factors affecting psychosocial status of women living with fistula.

Variables	Total, N (%)	Bungoma, N (%)	Kiambu, N (%)	Kilifi, N (%)
Well treated and accepted	29 (25.66)	17 (21.52)	6 (31.58)	6 (40.00)
Ridiculed and abused	51 (45.13)	44 (55.70)	6 (31.58)	1 (16.67)
Taken to hospital	21 (18.58)	12 (15.19)	5 (26.32)	4 (26.67)
Locked up in the house and left alone	21 (18.58)	19 (24.05)	2 (10.53)	0 (0.00)
Divorced by her husband	13 (11.50)	10 (12.66)	2 (10.53)	1 (16.67)
Other	27 (23.89)	15 (18.99)	6 (31.58)	6 (40.00)

Perhaps the most heartbreaking consequence of fistula-induced stigma is the loss of marital relationships. Affected women often find themselves abandoned by their husbands, left to navigate the trauma alone. Divorce was reported by 11.5 percent of the women, with Bungoma recording the highest percentage at 12.7 percent, followed closely by Kiambu at 10.5 percent, and Kilifi at 6.7 percent. However, not all experiences were negative.

Care seeking behaviour associated with genital fistula

This study found that 59.29% of women delivered in a health facility, while 40.70% gave birth at home. Among the three counties, Kiambu recorded the highest percentage of hospital deliveries at 68.42%, followed by Bungoma at 62.03%. In contrast, Kilifi had the highest proportion of home deliveries at 66.67% (Table 3).

Among those who delivered home, the most frequently cited reason was long distance to a health facility (40.00%), particularly in rural areas where transportation is limited. Abrupt labor (37.78%) was also a major factor, as some women experienced sudden onset of labor, preventing them from reaching a healthcare facility in time. Cultural influences (15.56%) played a role as well, as some families preferred home deliveries due to long-standing traditions. Additionally, financial constraints (13.33%) discouraged women from seeking care at health facilities, despite the availability of free maternity services. A smaller proportion of respondents (6.67%) avoided hospital deliveries due to previous negative experiences with healthcare workers, while 1.11% deliberately chose to be assisted by a Traditional Birth Attendant (TBA).

The study found that 77% of women developed fistula after childbirth, often due to delayed access to emergency

obstetric care., while 8% suffered from the condition unrelated to childbirth. following a stillbirth. However, 15% of cases were

Table 3: Health care seeking behaviors associated with prevalence of genital fistula.

	Project counties***			
	Total, N (%)	Bungoma, N (%)	Kiambu, N (%)	Kilifi, N (%)
Place of delivery				
Health facility	67 (59.29)	49 (62.03)	13 (68.42)	5 (33.33)
Home	46 (40.7)	30 (37.98)	6 (31.58)	10 (66.67)
Reasons for home deliveries				
Long distance to health facility	18 (40.00)	10 (34.48)	1 (16.67)	7 (70.00)
Abrupt labour	17 (37.78)	9 (31.03)	6 (100.00)	2 (20.00)
Cultural influences	7 (15.56)	3 (10.34)	0 (0.00)	4 (40.00)
Financial constraints	6 (13.33)	3 (10.34)	0 (0.00)	3 (30.00)
Friendly traditional birth attendant	5 (11.11)	5 (17.24)	0 (0.00)	0 (0.00)
Negative experiences with HWs	3 (6.67)	3 (10.34)	0 (0.00)	0 (0.00)
Onset of fistula				
After livebirth	87 (76.99)	14 (87.5)	25 (73.53)	10 (90.91)
After stillbirth	9 (7.96)	0 (0.00)	4 (11.76)	0 (0.00)
Don't know	17 (15.04)	2 (12.5)	5 (14.71)	1 (9.09)

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Knowledge, attitude and practice on genital fistula

Table 4 shows distribution of Knowledge, Attitude, and Practice (KAP) levels related to skilled deliveries. About 36.28% of respondents had a high level of knowledge

about obstetric fistula ($X^2=26.22$, $df=4$, $p=0.000$). However, knowledge levels varied across counties. A higher proportion of survivors in Bungoma (48.10%) demonstrated high knowledge, whereas low knowledge levels were more prevalent in Kiambu (68.42%) and Kilifi (60.00%).

Table 4: Knowledge, attitude and practice on obstetric fistula.

KAP levels	Project counties***				X ²	df	P value
	Total, N (%)	Bungoma, N (%)	Kiambu, N (%)	Kilifi, N (%)			
Knowledge							
High	19 (17)	19 (24.05)	0 (0.00)	0 (0.00)	12.94	4	0.012
Moderate	19 (17)	15 (18.99)	3 (15.79)	1 (6.67)			
Low	75 (66)	45 (56.96)	16 (84.21)	14 (93.33)			
Attitude							
Positive	107 (94.69)	78 (98.73)	18 (94.74)	11 (73.33)	16.1775	4	0.000
Negative	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)			
Neutral	6 (5.31)	1 (1.27)	1 (5.26)	4 (26.67)			
Practice							
Sought treatment intervention	41 (36.28)	20 (25.32)	13 (68.42)	8 (53.33)	14.49	2	0.001
Sought non-treatment intervention	72 (63.72)	59 (74.68)	6 (31.58)	7 (46.67)			

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A moderate proportion of survivors (56.64%) exhibited a positive attitude towards skilled delivery, while 43.36% held negative attitudes ($X^2=6.36$, $df=2$, $p=0.042$). Bungoma (60.76%) and Kiambu (63.16%) had the highest proportion of respondents with positive attitudes, suggesting a significant association between attitude and county of residence. In contrast, Kilifi had the lowest proportion of survivors with positive attitudes (26.67%) and the highest proportion of those expressing negative attitudes towards skilled deliveries (73.33%).

The overall proportion of survivors utilizing skilled delivery services was relatively high (59.29%), while 40.7% reported having given birth under unskilled conditions at some point. However, there was no significant statistical association between county of residence and skilled delivery utilization ($X^2=5.73$, $df=2$, $p=0.220$). Skilled delivery rates were highest in Bungoma (62.03%) and Kiambu (68.42%). Conversely, unskilled deliveries were more common in Kilifi (66.67%) compared to Bungoma (37.98%) and Kiambu (31.58%).

Coping mechanisms and approaches adopted by women with genital fistula and co-morbidities

Table 5 shows the most common coping mechanisms reported before repair was social isolation, with 59.3% of

the women withdrawing from their communities to avoid humiliation; stopped attending social events/gathering (50.4%); seeking treatment for fistula services (36.3%); and seeking divine interventions (8%).

Table 5: Coping mechanism and psychosocial support.

	Total, N (%)	Bungoma, N (%)	Kiambu, N (%)	Kilifi, N (%)
Coping mechanism before repair				
Isolated myself from community	67 (59.29)	56 (70.89)	5 (26.32)	6 (40.00)
Stopped attending social events/gathering	57 (50.44)	50 (63.29)	4 (21.05)	3 (20.00)
Sought treatment for fistula services	41 (36.28)	20 (25.32)	13 (68.42)	8 (53.33)
Sought divine interventions	9 (7.96)	4 (5.06)	2 (10.53)	3 (20.00)
Psychosocial support after repair				
Counselling services	43 (66.15)	30 (60)	9 (100)	4 (66.67)
Structured post-surgery follow-up I.e. in groups	24 (36.92)	18 (36.00)	6 (66.675)	0 (0.00)
Being re-united with my family	17 (26.15)	15 (30.00)	1 (11.11)	1 (16.67)
Registration to NHIF/SHIF	9 (13.85)	6 (12.00)	2 (2.22)	1 (16.67)
Livelihood Assistance	6 (9.23)	4 (8.00)	1 (11.11)	1 (16.67)
Startup capital for business	1 (1.54)	1 (2.00)	0 (0.00)	0 (0.00)

The survey further asked the respondents the kind of psychosocial services they have received; among the services provided, counseling emerged as the most utilized intervention, with 66.15% of survivors receiving support to help them cope with the emotional and psychological impact of fistula. Structured post-surgery follow-up, conducted in group settings, was accessed by 36.92%. These sessions provided a supportive environment where survivors could share experiences, receive guidance, and navigate their recovery journey together. Reuniting with family was another significant aspect of psychosocial support, benefiting 26.15% of the survivors across the three counties. This service helped survivors mend relationships and reintegrated into their families and communities after undergoing treatment.

Additionally, efforts to improve financial security and access to healthcare were evident. About 13.85% of the survivors were registered with the National Health Insurance Fund (NHIF) or the Social Health Insurance Fund (SHIF), ensuring continued access to essential health services.

Economic empowerment initiatives, though limited, were also part of the support system benefiting approximately 9.23%, while only 1.54% of the survivors were provided with start-up capital to begin a small business. These efforts were essential for long-term rehabilitation of fistula survivors.

DISCUSSION

We found that psychosocial effects among women with obstetric fistula, with 66.2% reporting depressive symptoms, 51.3% experiencing anxiety, and 22.1% battling suicidal thoughts. These findings corroborate previous research, which documented elevated rates of

mental health dysfunction among fistula survivors, characterized by feeling of despair, hopelessness, and diminished self-worth.^{2,26} Demonstrating high prevalence of psychosocial burden among women affected by Obstetric Fistula.

Our findings also establish risk of social stigmatization among women with obstetric fistula with 45% of participants experiencing ridicule or verbal abuse due to the persistent leakage of urine or stool, which often resulted in an unbearable odor, while 18.5% of women being confined to their homes by family members to avoid public shame, and 11.5% experiencing spousal abandonment. These results align with studies conducted in Nigeria and Zambia, where discrimination, community exclusion, and ostracization by extended family members and peers were more common.^{27,28} Such rejection patterns exacerbate psychological trauma and impede successful reintegration, particularly when complicated by infertility or neonatal loss.^{29,30}

The economic impact of obstetric fistula in this study was profound, with 59.3% of participants unable to maintain income-generating activities due to stigma and hygiene-related challenges. This resulted in employment loss and closure of small enterprises, creating economic dependency and placing additional strain on vulnerable households. Women with fistula frequently become financially dependent on others, perpetuating cycles of poverty and disempowerment. The economic burden extends beyond individual households to affect broader community productivity and development.³¹

Despite Kenya's policy of free maternal health services, our study identifies persistent systemic, cultural, and logistical barriers to care. Many participants developed fistula following home deliveries, delayed hospital

access, or prolonged labor, consistent with findings from Zambia, Ethiopia, and the Democratic Republic of Congo.³²⁻³⁴ Notably, 59% of fistula cases occurred following hospital deliveries, suggesting potential deficiencies in intrapartum care quality.

Our study identified concerning knowledge gaps, with 66% of respondents showing limited awareness of obstetric fistula, while only 17% achieved high knowledge scores. These results highlight critical deficiencies in community health education. Similar knowledge deficits were documented in Nepal, where nearly 99% of women exhibited poor understanding of fistula.³⁵ Limited awareness contributes to delayed care-seeking behaviors and reliance on unsafe delivery practices, particularly in rural and underserved populations. Educational attainment, residential location, antenatal care attendance, and access to health information emerged as key determinants of knowledge levels.^{36,37}

Despite our study indicating low knowledge levels on Obstetric fistula among women with 94.69% of participants expressed positive attitudes toward fistula prevention and management. The finding contrasts with research from Egypt, where attitudes correlated directly with knowledge levels.³⁸ The discrepancy in our context may reflect a strong intrinsic motivation among survivors to seek healing, independent of comprehensive understanding of the condition or its management.

Our findings show that only 36.28% of participants had accessed timely medical treatment, while the majority (63.72%) relied on non-medical coping strategies including traditional remedies, social isolation, use of absorbent materials, or self-imposed hygiene routines. These findings reflect the desperation experienced by many women in the absence of accessible and affordable surgical care.³⁹ The role of Traditional Birth Attendants (TBAs) shows that they are culturally familiar and accessible and are often the first responders despite lacking competency to manage obstetric complications.

Pre-surgical coping mechanisms included social withdrawal (59.3%), excessive hygiene practices, and spiritual interventions.^{40,41} These behaviors highlight emotional burden and the absence of structured psychosocial support systems for survivors. Following surgical intervention, many women experienced reintegration difficulties, partly attributable to inadequate male partner involvement in post-operative care. Some participants experienced fistula recurrence due to premature resumption of sexual activity or non-adherence to post-surgical recommendations. In Addition, psychosocial support systems remained insufficient, with limited access to counseling services or peer support groups. These gaps hinder long-term recovery and successful reintegration. Holistic care approaches, including post-surgical follow-up, community education, and economic empowerment programs are essential for

patient recovery and reintegration back into society.⁴² Successful reintegration cases were facilitated by income-generating initiatives and community awareness campaigns. Trained health workers played crucial roles in monitoring recovery and providing essential psychosocial support, demonstrating the effectiveness of healthcare workers capacity-building initiatives. The findings of this study have important implications for clinical practice and health policy. Healthcare providers should integrate mental health screening and counselling support into fistula care programs. Community health education initiatives should focus on increasing awareness of obstetric fistula, its prevention, and available treatment options. Health systems strengthening efforts should prioritize quality improvement in emergency obstetric care to prevent facility-based fistula occurrence, and holistic post-surgical care models incorporating psychosocial support and economic empowerment should be developed and implemented.

CONCLUSION

This study explores multilayered burden of obstetric fistula, encompassing physical, psychological, social, and economic facets. Beyond clinical complications, survivors face profound stigmatization, social isolation, and financial hardship. While motivation for healing remains strong, most women lack the knowledge, resources, and support necessary to access timely and effective surgical care. The low levels of awareness and high rates of non-medical coping strategies reflect the urgent need for comprehensive community education, health system strengthening, and holistic post-surgical care that incorporates psychosocial and economic support services.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee of National Commission for Science, Technology, and Innovation (NACOSTI)

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Cite this article as: Kilonzo H, Basiye K, Ebole G, Onyango S, Gitimu A, Kutna J, et al. Prevalence and risk factors associated with obstetric fistula among women of reproductive age in Bungoma, Kilifi and Kiambu Counties, Kenya. *Int J Community Med Public Health* 2026;13:xxx-xx.

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