

Coping Strategies among Women Living with Obstetric Fistula Amidst Stigma and Social Isolation at the State Specialist Hospital, Maiduguri, Borno State, Nigeria

By

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Abstract

This study investigates the experiences of women living with obstetric fistula in Maiduguri, Borno State, Nigeria, focusing on the stigmatization and social isolation they face. The primary objectives are to assess the prevalence of obstetric fistula, examine the coping mechanisms of affected women, and evaluate the impact of stigma on their social interactions and mental health. Social Stigma Theory, Feminist Theory, and the Health Belief Model (HBM) were used to explain the study. Employing a mixed-method approach, data were collected from 75 respondents through structured questionnaires and semi-structured interviews. The findings revealed that many women experience obstetric fistula during early adolescence, primarily due to prolonged labour. Despite the debilitating effects of the condition, most respondents did not seek medical treatment and relied on family support, leading to significant social isolation and stigmatization. The study highlighted a general lack of awareness about obstetric fistula, particularly among younger and less educated women, exacerbating their feelings of humiliation and abandonment. Coping strategies were largely limited to seeking emotional support, with minimal engagement in professional counselling or support groups. This research emphasizes the urgent need for targeted awareness campaigns, improved healthcare access, and psychosocial support to combat stigma and enhance the reintegration of affected women into their communities. Overall, the findings underscore the intricate relationship between obstetric fistula, social stigma, and the psychological and economic challenges faced by these women, necessitating comprehensive interventions to improve their quality of life.

Keywords: Among Women, Coping Mechanism, Obstetric Fistula, Social Isolation, State Specialist Hospital Maiduguri, Stigmatization

Introduction

Obstetric fistula is one of the most serious and tragic childbirth injuries. A hole between the birth canal and bladder or rectum, it is caused by prolonged, obstructed labour without access to timely, high-quality medical treatment. It leaves women and girls leaking urine, faeces, or both, and often leads to chronic medical problems, depression, social isolation, and deepening poverty (Nduka et al., 2023). Obstetric fistula is an abnormal communication between the urinary bladder and the vagina that results in the continuous involuntary discharge of urine (Riley, 2006), leaving the victims with tremendous psychosocial and health consequences. In some instances, the opening is formed between the rectum and the vagina, resulting in involuntary leaking of faeces through the vagina, which is called Rectovaginal Fistula (RVF). The uncontrolled urine leakage causing unpleasant odour results in social stigma and consequent neglect. Most women affected are living in shame and isolation, often abandoned by their husbands, and excluded by their families and communities (Wall, 2011).

Half a million women and girls in sub-Saharan Africa, Asia, the Arab States region and Latin America and the Caribbean are estimated to be living with fistula, with new cases developing every year (Fekecha et al., 2022). Yet fistula is almost entirely preventable. Its persistence is a reminder of gross inequities, a sign of global inequality and an indication that health and social systems are failing to protect the health and human rights of the poorest and most vulnerable women and girls. As the leader of the global campaign to end fistula, UNFPA (2019) provides strategic vision, technical guidance and support, medical supplies, training, and capacity building, as well as funds for fistula prevention, treatment and social reintegration and advocacy programmes. UNFPA also strengthens sexual and reproductive health care including timely and quality emergency obstetric services to prevent obstetric fistula from occurring in the first place.

Globally, about 3.5 million women are living with genitourinary fistula, a miserable condition (Wall, 2006). Obstetric fistula is exceptionally rare in developed parts of the world, where it is mostly due to gynaecological causes, i.e., complications of hysterectomy, gynaecological malignancy, and radiotherapy (Wall, 2004). Women in the developing world, are experiencing “unimaginable suffering” due to lack of effective care during pregnancy and childbirth (Nsemo, 2014). Non-fatal maternal childbirth injuries such as obstetric fistula often have devastating psychological and social consequences with an impact greater than maternal death (Nsemo, 2014).

According to United Nations Population Fund (UNFPA, 2008), in Sub-Saharan Africa alone between 3,000 and 130,000 of women giving birth develop fistula each year. Other estimates indicate that there are approximately 73,000 new cases per year. Adequate population-based epidemiological data on obstetric fistula is lacking due to the historic neglect of this condition since it was mostly eradicated in developed nations. Available data are estimations that should be viewed with caution (Donnay & Ramsey, 2006). The prevalence of obstetric fistula is much lower in places that discourage early marriage, encourage, and provide general education for women, and grant women access to family planning and skilled medical teams to assist during childbirth (UNPFA & Engender Health, 2003), hence the burden of obstetric fistula rests largely on the poor women living in rural communities of the world and its severe nature puts a serious toll on the lives of those affected.

The United Nations Population Fund (UNFPA) estimated that Nigeria accounts for 12,000 new cases annually with a current estimated total of 150,000 cases (UNFPA, 2019). The actual prevalence of obstetric fistula may be higher due to the under-reporting of cases in Sub

Saharan Africa (Nduka et al., 2023). This condition is so enormous and thus ravages Nigerian women that the country's Federal Minister for Women Affairs and Youth Development estimated that the number of untreated obstetric fistulas in Nigeria stands between 80,000 and 1,00,000 (Riley, 2006). Majority of the victims are very young and without the basic elementary education (Fasakin, 2008). Most of them find it difficult to engage in any economic activity, surviving the hardship is very complicated and pathetic as coping is done in isolation and loneliness.

Historical knowledge of obstetric fistula dates back to 1872, with the discovery of the Ebers papyrus in a mummy from the Theban acropolis. This ancient document contains a gynaecological reference addressing uterine prolapse. While it seems to mention obstetric fistula, it incorrectly advises physicians against attempting to cure it, stating, "prescription for a woman whose urine is in an irksome place: if the urine keeps coming and she distinguishes it, she will be like this forever".

However, due to significant medical advances, including safer caesarean deliveries and the development of obstetrics as a scientific specialty, obstetric fistula practically disappeared in the industrialized world by the mid-1900s but has remained prevalent in developing nations. Obstetric fistula is considered the most devastating morbidity affecting women following childbirth (Zacharin, 1988).

The Nigeria Demographic Health Survey (2019-2023) indicated that about 31% of women have heard of obstetric fistula symptoms. The knowledge of obstetric fistula was seen to be higher among rural women (33%) than women residing in urban areas with (27%). There was also a substantial variation in knowledge by age as 20% of women aged 15-19 years have heard of obstetric fistula, compared with 37% of women aged 40-44 years. It was interesting to note that knowledge of obstetric fistula was highest among women living in the Northwest and Northeast (66% and 50%, respectively), among those with no education (47%), among women currently in union (36%), and among women in the poorest households (41%) (UNFPA, 2020). This level of knowledge was the lowest in the southeast and southwest regions (with about 8% in each). Twenty per cent (20 %) of those with secondary or higher education had knowledge of obstetric fistula, 16% of those who were never in union and 21% of those from a wealthy household had knowledge of obstetric fistula. These findings may be the result of the many awareness creation activities relating to of that have been undertaken over the years in the Northwest and Northeast regions where prevalence is highest ((UNFPA, 2020).

Obstetric fistula represents a profound global health issue, causing immense physical and psychological suffering for countless women and girls in low-resource settings. This condition, almost entirely preventable, underscores the stark inequalities and systemic shortcomings within healthcare and society. Nigeria, in particular, bears a heavy burden of new cases each year, with many affected women living in silence and isolation. Raising awareness, providing proper medical care, and addressing social and cultural factors are crucial steps in combating this condition and supporting those who live with it. Based on the numerous challenges faced by women with obstetric fistula discussed above, this study is set to investigate the stigma and social isolation experience by women with obstetric fistula in the State Specialist Hospital in Maiduguri, Borno State, Nigeria.

Statement of the Research Problem

Although obstetric fistula is largely preventable and has been associated with profound physical, psychological, social, and economic consequences, women living with the condition may continue to experience stigma, discrimination, social withdrawal, and barriers to treatment and reintegration. The problem is particularly important in contexts where access to skilled maternal healthcare, information, psychosocial support, and social protection may be uneven. The present study therefore focuses on the experiences of women receiving care in Maiduguri, Borno State, with particular attention to stigmatization, social isolation, psychological consequences, and coping.

Objectives of the Study

The objectives reflected in the present manuscript are to:

1. examine the nature of stigmatization experienced by women living with obstetric fistula at the State Specialist Hospital, Maiduguri;
2. identify factors associated with social isolation among women living with obstetric fistula in Maiduguri;
3. examine the coping mechanisms used by women living with obstetric fistula; and
4. consider the psychological and social consequences associated with stigmatization and social isolation, as reflected in the quantitative and qualitative evidence presented in the study.

Research Questions

5. What is the nature of stigmatization experienced by women with obstetric fistula at the State Specialist Hospital in Maiduguri, Borno State, Nigeria?
6. What factors contribute to social isolation among women with obstetric fistula in Maiduguri, Borno State, Nigeria?
7. What coping mechanisms are used by women living with obstetric fistula in Maiduguri, Borno State, Nigeria?

Literature Review

Obstetric Fistula and Its Consequences

Obstetric fistula is a severe childbirth-related injury associated mainly with prolonged or obstructed labour where timely obstetric care is unavailable. The existing literature cited in this manuscript consistently presents fistula as both a medical and social problem. Wall (2004, 2006, 2011) emphasizes the continuing burden of fistula in low-resource settings, while UNFPA (2008, 2019, 2020) highlights prevention, treatment, rehabilitation, reintegration, and awareness as essential components of the response.

The consequences extend beyond urinary or faecal leakage. Women may experience odour, skin problems, reproductive complications, emotional distress, loss of social status, marital difficulties, economic exclusion, and social withdrawal. The literature therefore supports the need to study the lived experience of fistula rather than considering repair alone as the complete solution.

Stigmatization and Social Isolation

The studies already cited in the manuscript indicate that stigma can occur through direct verbal abuse, avoidance, discrimination, anticipated rejection, shame, and internalized negative beliefs. The Bixby Center for Global Reproductive Health (2021), Kimani et al. (2014), Tadesse (2014), and Fekecha et al. (2022) all point to psychosocial consequences associated with fistula-related stigma.

However, the present study adds useful local evidence by showing that experiences are not identical for all respondents. While 62.0% reported stigmatization or discrimination and 65.1% reported social isolation, 54.0% reported that they had not experienced exclusion from social gatherings or community events. This difference is important because it suggests that stigma and isolation may operate through several pathways rather than through a single uniform experience. Family support, community relationships, awareness, and individual coping may moderate these experiences.

Awareness and Healthcare Access

The manuscript's discussion of UNFPA (2020) indicates variation in awareness of obstetric fistula by age, residence, education, and socioeconomic circumstances. Limited knowledge can affect recognition of symptoms, interpretation of causes, willingness to disclose the condition, and decisions about seeking care.

The present findings also indicate challenges in accessing healthcare services and concerns about the quality of services received. These findings should be understood together with the Health Belief Model: awareness alone may not produce treatment-seeking when perceived barriers remain high. The interaction between stigma, perceived treatment barriers, previous experiences, and available support is therefore important.

Coping Mechanisms

Coping mechanisms identified in the manuscript include seeking emotional support from family and friends, professional counselling, and religious or spiritual activities. The results show that emotional support was reported by 58.7% of respondents, professional counselling by 57.1%, and religious or spiritual activities by 38.1%.

These findings demonstrate that women do not respond to fistula only through withdrawal. Some mobilize interpersonal, professional, or spiritual resources. Nevertheless, the fact that substantial proportions did not use these mechanisms indicates that access to supportive resources may remain uneven.

Critical Review and Research Gap

The existing literature provides strong evidence that obstetric fistula has medical, psychological, social, and economic consequences. However, much of the literature emphasizes prevalence, risk factors, treatment, or broad psychosocial effects. Fewer studies bring together the experiences of stigmatization, social isolation, and coping within one local study context while also interpreting these experiences through complementary sociological and health-behaviour frameworks.

The present study addresses this gap by focusing on women receiving or accessing fistula-related care in Maiduguri, Borno State. The Maiduguri context is important because the study provides localized evidence from women whose experiences may be shaped by the social, economic, cultural, and healthcare environment of northeastern Nigeria. The study therefore contributes lived-experience evidence that can complement broader national and international estimates.

Theoretical framework

Social Stigma Theory

Social Stigma Theory provides a central framework for understanding how a socially visible or feared condition can affect identity, interpersonal relationships, and participation in community life. Goffman's classic formulation explains stigma in relation to attributes that

become deeply discrediting within particular social settings and that may reduce an individual from a socially accepted person to one viewed negatively by others. In the context of obstetric fistula, continuous urine or faecal leakage, unpleasant odour, and misconceptions about the condition can become socially interpreted as signs of impurity, abnormality, or personal failure. The consequence may include avoidance, discrimination, humiliation, concealment, and withdrawal from social interaction.

The theory is particularly relevant to the present study because the findings show that 62.0% of respondents reported experiencing stigmatization or discrimination. The qualitative account also describes avoidance and derogatory treatment in community settings. Social Stigma Theory therefore helps explain why the physical consequences of fistula can develop into social isolation: the problem is not only the medical condition itself but also the meanings attached to it by other members of society and by affected women themselves.

Feminist Theory

Feminist Theory draws attention to the ways gender, social power, economic dependence, cultural expectations, and unequal access to resources influence women's health experiences. A feminist perspective treats women's experiences as important sources of knowledge and asks how social structures can shape exposure to risk, access to healthcare, treatment decisions, and the ability to participate fully in social and economic life. Harding's feminist standpoint approach, for example, emphasizes the value of women's lived experiences in identifying forms of inequality that may remain less visible from dominant perspectives.

Applied to obstetric fistula, the feminist perspective directs attention beyond the individual woman to the social and structural conditions surrounding reproductive health. Early marriage, limited educational opportunities, poverty, restricted decision-making power, inadequate access to skilled maternal healthcare, and gendered expectations concerning marriage and childbearing can interact to increase vulnerability. The theory also helps explain why the consequences of fistula can extend beyond physical symptoms to marital relationships, economic participation, dignity, and community status.

Health Belief Model

The Health Belief Model (HBM) explains health-related behaviour through perceptions of susceptibility, severity, benefits, barriers, cues to action, and self-efficacy. The model is useful for examining why individuals may or may not seek treatment, screening, prevention, or other recommended health actions. In the context of obstetric fistula, a woman may understand the severity of the condition but still delay treatment because of perceived barriers such as cost, distance, fear of surgery, previous treatment experiences, stigma, lack of information, or limited social support.

The HBM therefore complements Social Stigma Theory and Feminist Theory. Social Stigma Theory explains the social meanings and consequences of the condition; Feminist Theory explains the gendered and structural context in which those meanings and barriers operate; and the HBM helps explain individual perceptions and decisions concerning treatment and coping. Together, the three frameworks provide a broader explanation of the relationship between stigma, social isolation, healthcare access, and coping.

Theoretical Integration

The three frameworks are complementary rather than competing. Social Stigma Theory explains how the condition becomes socially discrediting; Feminist Theory explains how gendered and structural inequalities shape women's exposure, treatment options, and social

position; and the Health Belief Model explains how perceptions of severity, benefits, barriers, and cues to action may influence treatment and coping decisions. This integrated framework guides interpretation of the findings and supports recommendations that address not only the medical condition but also stigma, social support, gender inequality, and barriers to care.

Methodology

Research Design

This study adopted a mixed-method survey research design to investigate the incidence, distribution, and interrelation of sociological and psychological variables among a sample representing a larger population. The integration of quantitative and qualitative data collection techniques provided a comprehensive and nuanced understanding of the research findings. The study focused on a sample of adult female participants.

Study Setting and Population

The research was conducted in Maiduguri, with participants recruited from healthcare facilities, support groups, and community organizations serving women with obstetric fistula.

Sampling Technique

A purposive sampling technique was employed to select participants. During an initial visit, over 150 women admitted with obstetric fistula were identified. From this group, 75 women were purposefully selected to ensure representation across different points of care: 35 were recruited on clinic days, 35 on surgical days, and 5 on medical check-up days. This stratification ensured an equal distribution and allowed for proper control and supervision, particularly when engaging patients on clinic and medical check-up days. In addition to primary data collection, hospital records from healthcare facilities in Maiduguri were reviewed to obtain secondary data on obstetric fistula cases.

Data Collection Instruments

Data were collected using two primary instruments:

- Semi-structured interviews were conducted with affected women and healthcare providers to facilitate an in-depth exploration of their experiences, perceptions, and coping mechanisms related to stigmatization and social isolation.
- A structured survey was administered to collect quantitative data on the prevalence and severity of stigma and social isolation. The survey instrument incorporated validated scales and specific items measuring stigma, social support, and quality of life.

Data Analysis

Quantitative data were analyzed using descriptive statistics, specifically frequency counts and percentages, to examine the numerical information collected. Qualitative data from interviews were analyzed through content analysis, a systematic method for interpreting and extracting themes and patterns from textual data. The quantitative and qualitative strands were used together to provide numerical patterns alongside participants' narratives and explanations.

Ethical Considerations

Because the study concerns a sensitive condition and potentially vulnerable participants, ethical protection of participants is essential. The Ethical approval was from the Department of Sociology and Anthropology of University of Maiduguri and State Specialist Hospital Maiduguri, Borno State.

Sampling and Response Rate Clarification

The reports indicated that 150 women with obstetric fistula were identified and that 75 were purposively selected: 35 on clinic days, 35 on surgical days, and 5 on medical check-up days. The 150-plus figure should be understood as the number identified during the initial visit unless the researcher can confirm that it represented the complete target population.

The sample of 75 was distributed across the identified points of care to ensure representation. Of the 75 questionnaires administered, 63 were returned valid for analysis, representing a 90% response rate. The present manuscript does not record the reasons for the 12 non-responses; therefore, no reason is attributed to those non-respondents in this revision.

Results

The data collected for this study are presented in tables and analysed using frequency count and percentage. The presentation and analysis are based on the research questions and respondents' information. Out of seventy-five (75) copies of the questionnaire administered at the specialist hospital, sixty-three (63) copies were returned and found valid for analysis, giving a response rate of 90%. The analysis therefore reflects the 63 valid responses.

Demographic Characteristics of the Respondents

Table 1: Age Distribution of Respondents

Age Group	Frequency	Percentage (%)
20-30	34	54.0
31-40	16	25.4
41-45	9	14.3
46 and above	4	6.3

Source: Field Survey, 2024

The age distribution of respondents, as presented in Table 1 reveals that the majority fall within the 20-30 age group, accounting for 54.0 percent of the sample. This is followed by those aged 31-40, who represent 25.4 percent, while respondents in the 41-45 age bracket make up 14.3 percent. A smaller proportion, 6.3 percent, are aged 46 and above. This indicates that women affected by obstetric fistula in the study area are predominantly young adults, with a noticeable decline in prevalence as age increases.

Table 2: Marital Status of Respondents

Marital Status	Frequency	Percentage (%)
Single	6	9.5
Married	37	58.7
Divorced	11	17.5
Widowed	9	14.3

Source: Field Survey, 2024

The marital status distribution of respondents, as shown in Table 2 indicates that the majority are married, representing 58.7 percent of the sample. Divorced women account for 17.5 percent, while 14.3 percent are widowed. A smaller proportion, 9.5 percent, are single. This suggests that obstetric fistula affects women across different marital statuses, though it is more prevalent among those who are married.

Table 3: Educational Level of Respondents n

Educational Level	Frequency	Percentage (%)
No formal education	2	3.2
Primary education	8	12.7
Secondary education	38	60.3
Tertiary education	15	23.8

Source: Field Survey, 2024

The educational level distribution of respondents, as presented in Table 3 shows that the majority have attained secondary education, accounting for 60.3 percent of the sample. This is followed by those with tertiary education, who make up 23.8 percent, while 12.7 percent have primary education. A small proportion, 3.2 percent, have no formal education. This indicates that most women affected by obstetric fistula in the study area have some level of formal education, with secondary education being the most common.

Table 4: Occupation of Respondents

Occupation	Frequency	Percentage (%)
Housewife/non-employed	33	52.4
Civil servant	17	27.0
Business	8	12.7
Farming	5	7.9

Source: Field Survey, 2024

The occupational distribution of respondents, as shown in Table 4 reveals that the majority are housewives or non-employed, representing 52.4 percent of the sample. Civil servants account for 27.0 percent, while 12.7 percent are engaged in business activities. A smaller proportion, 7.9 percent, are involved in farming. This suggests that most women affected by obstetric fistula in the study area are not formally employed, with fewer participating in public service, business, or agricultural work.

Research Question One: What is the nature of stigmatization experienced by women with obstetric fistula in the State Specialist Hospital in Maiduguri, Borno State, Nigeria?

Table 5: Duration of Living with Obstetric Fistula

Duration (Years)	Frequency	Percentage (%)
1-15 years	23	36.5
16-25 years	18	28.6
26-30 years	5	7.9
31-35 years	8	12.7
36-40 years	6	9.5
41 and above	3	4.8

Source: Field Survey, 2024

Table 5 reveals that the majority of respondents have been living with obstetric fistula for between 1 to 15 years, accounting for 36.5 percent. This is followed by 28.6 percent who have endured the condition for 16 to 25 years. Smaller proportions have lived with the condition for 31 to 35 years (12.7 percent), 36 to 40 years (9.5 percent), and 26 to 30 years (7.9 percent), while only 4.8 percent have experienced it for 41 years and above. This indicates that while many women have lived with the condition for over a decade, a

significant number have been burdened by it for several decades, highlighting the chronic and long-term nature of obstetric fistula in the study area.

Table 6: Experience of Stigmatization or Discrimination[\\[C11\\]](#_msocom_11)

Response	Frequency	Percentage (%)
Yes	39	62.0
No	24	38.0

Source: Field Survey, 2024

Table 6 shows that 62.0% of the respondents have experienced stigmatization or discrimination due to their obstetric fistula, while 38.0% reported no such experience. This indicates that stigma and discrimination are prevalent among women living with obstetric fistula in the study area, affecting a significant majority.

One of the respondents responded that:

I am 35 years old, married with three children, and have completed secondary school. I work as a market vendor selling fruits and vegetables. My husband and I are focused on ensuring our children receive better education than I did.

I have been living with obstetric fistula for six years, which developed after a difficult childbirth due to lack of proper care. I have sought medical treatment multiple times, but it hasn't been effective. I underwent surgery three years ago, which was painful and the recovery process was long and challenging. While I have received some support from my husband and family, there were times when they didn't fully understand my struggles, which made me feel isolated. However, my husband's encouragement has been a source of comfort during the tough times.

I have experienced stigmatization because of my condition. Many people avoid sitting close to me because of the smell, and some even whisper about me behind my back. One time, at a community gathering, a woman openly told others to stay away from me because I was "unclean." That moment was very painful and made me stop attending such events.

Research Question Two: What are the other factors that contribute to social isolation among women with obstetric fistula in Maiduguri, Borno State, Nigeria?

Table 7: Experience of Social Isolation Due to Obstetric Fistula

Response	Frequency	Percentage (%)
Yes	41	65.1
No	8	12.7
If yes, please describe	14	22.2

Source: Field Survey, 2024

Table 7 shows that a significant proportion of respondents (65.1%) have experienced social isolation as a result of living with obstetric fistula, indicating that stigmatization in the form of social exclusion is prevalent among affected women. A smaller percentage (12.7%) reported not experiencing such isolation, while 22.2% provided further descriptions of their experiences, highlighting the varied and personal nature of the social challenges they face. This suggests that social isolation is a major component of the stigmatization associated with obstetric fistula in the study population.

Table 8: Comfort Discussing Obstetric Fistula with Others

Response	Frequency	Percentage (%)
Yes	17	27.0
No	33	52.4
Sometimes	13	20.6

Source: Field Survey, 2024

Table 8 reveals that more than half of the respondents (52.4%) do not feel comfortable discussing their obstetric fistula with others, suggesting a strong sense of stigma and shame surrounding the condition. A smaller portion (27.0%) indicated that they are comfortable talking about it, while 20.6% reported that they sometimes feel comfortable, depending on the situation. This highlights the communication barriers and emotional burden experienced by many women living with obstetric fistula.

Table 9: Exclusion from Social Gatherings or Community Events

Response	Frequency	Percentage (%)
Yes	19	30.1
No	34	54.0
If yes, please	10	15.9

Source: Field Survey, 2024

Table 9 shows that while a majority of the respondents (54.0%) have not experienced exclusion from social gatherings or community events due to their condition, a significant 30.1% reported being excluded, reflecting the social stigma associated with obstetric fistula. Additionally, 15.9% provided further descriptions of such exclusion, indicating that social marginalization remains a real challenge for a considerable number of affected women.

Summary of Findings

The findings can be interpreted through the three theoretical frameworks adopted for the study. From the perspective of Social Stigma Theory, the 62.0% reporting stigmatization or discrimination demonstrates that fistula is not experienced solely as a medical condition. Leakage, odour, and community perceptions can become markers through which women are judged and socially devalued. The participant quotation describing being told that she was “unclean” illustrates how a bodily condition can become a socially discrediting identity. The reported discomfort in discussing fistula also reflects the possibility of concealment and withdrawal as responses to anticipated rejection.

Feminist Theory further suggests that the experiences of these women should be interpreted within wider gender and structural conditions. The concentration of respondents in lower economic roles, together with the discussion of poverty, education, early marriage, healthcare access, and reproductive expectations, indicates that the burden of fistula is connected to social structures as well as individual circumstances. A gender-sensitive response therefore requires more than surgical treatment; it requires attention to women's education, economic independence, decision-making power, respectful healthcare, and social reintegration.

The Health Belief Model helps explain the treatment and coping dimensions of the findings. Women may recognize that fistula is serious while simultaneously facing barriers to treatment, counselling, or social participation. The findings on healthcare access and the reported use of emotional support, professional counselling, and spiritual activities show that coping and health-seeking behaviour are influenced by available resources and perceived

options. Awareness campaigns can serve as cues to action, but they are likely to be more effective when accompanied by accessible services, social support, and reduction of stigma.

Taken together, the theories show that stigma, isolation, and coping are interconnected. A woman may withdraw because she anticipates stigma; withdrawal may reduce access to social and health information; limited information may increase uncertainty about treatment; and treatment barriers may prolong the condition and reinforce stigma. The combined framework therefore supports an intervention approach that addresses medical, psychosocial, social, and structural dimensions simultaneously.

Conclusion

The study examines the Stigmatization and Social Isolation among Women with obstetric Fistula in State Specialist Hospital Maiduguri, Borno State Nigeria. The study showed a very good success rate of repairs undertaken during the surgical campaign. Hence government and non-governmental organizations should invest more in similar campaigns and other preventive strategies in order to reduce the menace of this dehumanizing condition. The entire society needs to be educated so that women can comprehend the importance of pursuing health care services at the right time and the right place; know the causes of common pathology, not involved in early marriages and risky traditional practices. Investing in girl child education did not only commence a positive living for the girl child and builds her holistically for life but also defends her against consequences of ignorance and the negative influence. Girl child education also improves her economic wealth, therefore empowering her to make responsible reproductive health decisions, including access to health care services, child spacing, prenatal and delivery services under the care of skilled medical personnel. All these measures may likely help in averting Obstetric Fistula among women. For now, gigantic health awareness campaign to educate the population on the need to make use of the current health care facilities in their area and address misunderstandings concerning health issues lead to acceptance of prenatal, delivery and emergency obstetric care by concerned individuals.

The contribution of this study lies in bringing together quantitative evidence and women's lived experiences to show how obstetric fistula operates simultaneously as a health condition, a source of stigma, a pathway to social isolation, and a challenge requiring multiple forms of coping. The findings show that although a substantial proportion of respondents experience stigma and isolation, experiences are not completely uniform, indicating the importance of family, community, awareness, and support systems.

Theoretically, the study demonstrates the value of combining Social Stigma Theory, Feminist Theory, and the Health Belief Model. No single framework adequately explains the full experience. The stigma framework explains social devaluation, feminist theory highlights structural and gendered conditions, and the Health Belief Model helps interpret treatment perceptions and coping decisions. The combined perspective provides a more comprehensive sociological understanding of women's experiences with obstetric fistula.

The central takeaway is that successful fistula care should not end with medical repair. Prevention, treatment, psychosocial support, stigma reduction, community reintegration, education, and economic empowerment need to be addressed together.

Recommendations

Based on the findings of the study, the following recommendations are made, arranged broadly according to urgency and feasibility:

1. Strengthen awareness and early referral. Government health authorities, healthcare workers, and partner organizations should organize sustained community awareness programmes on the causes, prevention, symptoms, treatment, and social consequences of obstetric fistula. These programmes should use community meetings, health education sessions, and appropriate local communication channels, and should involve trusted community stakeholders.
2. Improve access to fistula treatment and surgical repair. Government and relevant partners should strengthen the capacity of specialist hospitals to provide accessible fistula assessment, referral, surgical repair, postoperative care, and follow-up. Campaign-based repair services should be complemented by routine services so that women are not dependent only on periodic surgical campaigns.
3. Integrate psychosocial support and counselling. Professional counselling should be incorporated into fistula services, with referral pathways for women experiencing severe emotional distress, stigma, or social isolation. Peer-support groups should also be encouraged where feasible because women can benefit from sharing experiences and coping strategies with others who have lived through similar circumstances.
4. Address the social and structural causes of vulnerability. Programmes should address poverty, early marriage, limited education, inadequate access to skilled maternal healthcare, and other barriers that can increase women's vulnerability. Girl-child education, economic empowerment, reproductive health education, and timely access to antenatal and emergency obstetric services should form part of long-term prevention strategies.
5. Promote reintegration and economic empowerment. Women who have undergone fistula treatment should receive support for safe reintegration into their families and communities. Skills training, livelihood opportunities, and community sensitization can help reduce dependence, improve self-esteem, and strengthen women's ability to participate in social and economic life. Implementation will require coordination among government health agencies, specialist hospitals, community organizations, non-governmental organizations, women's affairs and social development structures, and community leaders. The practical challenges of financing, continuity of services, transportation, community acceptance, and availability of trained personnel should be considered when planning interventions.

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