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Treat (the whole of) *me*: a systematic review and qualitative meta-ethnographic synthesis of the experiences of women with POP, SUI or mesh complications in the context of surgical treatment

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Abstract

Background Stress Urinary Incontinence (SUI) and Pelvic Organ Prolapse (POP) are common pelvic floor disorders that may significantly impact women's quality of life. Surgical interventions are available to treat these conditions, some using synthetic mesh. Whilst most women experience good surgical outcomes, some experience complications; in some cases, this has led to further corrective surgery. As part of the NIHR-funded APPRAISE project which aims to develop surgery-specific PROM and PREM measures for women undergoing treatment for POP, SUI, or mesh complications, we conducted a systematic review of qualitative evidence. The review synthesised findings from existing studies to ensure these measures accurately reflect surgical outcomes and experiences of care.

Methods We conducted a systematic review of qualitative research with women eligible for surgery for POP, SUI and mesh complications, using meta-ethnography to synthesise study results. Key concepts were synthesised into third-order constructs and a line of argument to reveal insights beyond individual studies.

Results A total of 2,613 titles and abstracts and 254 full-text articles were screened, with 18 publications included in the final synthesis. We developed 14 third-order constructs, which were abstracted into six higher order themes, reflecting the trajectory of women's experiences from living with the conditions through to life after surgery. These themes formed the basis of our line of argument synthesis, which demonstrated that that surgical outcomes cannot be understood solely through clinical symptom assessment, and that women's perceptions of their condition are closely tied to their experiences of care and their social roles. To illustrate the implications for clinical practice, we also developed a visual representation of the synthesis.

Conclusions The findings speak to the importance of determining what matters to women in defining good outcomes following surgery for POP, SUI or mesh complications and of creating the conditions within which women are able to communicate their needs. This highlights the value of a validated PROM and PREM to capture key

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functional and quality of life outcomes for women pre- and post-surgery, and to support them in having meaningful conversations with their healthcare providers.
Trial registration PROSPERO CRD42023412750.

Keywords Pelvic organ prolapse · Stress urinary incontinence · Pelvic mesh · Mesh complications · Patient-reported outcome measure · PROM · Patient-reported experience measure · PREM · Systematic review · Qualitative evidence synthesis

Background

Stress urinary incontinence (SUI) and pelvic organ prolapse (POP) are common pelvic floor disorders [1, 2] which may significantly impact women's quality of life [3, 4]. A range of surgical interventions are available to treat these conditions, some of which have used synthetic mesh. Whilst the majority of women experience good surgical outcomes, a proportion of women have experienced complications, and in some cases have needed further corrective surgery [5]. The UK Government and National Health Service (NHS) have restricted the use of vaginal mesh to treat SUI and POP until a set of conditions to reduce risk of injury are met [6].

At the time of conducting this meta-ethnography, no comprehensive surgery-specific patient-reported outcome measure (PROM) was available to capture the full range of outcomes relevant to women undergoing surgery for POP, SUI or mesh complications, including the potentially harmful effects of pelvic mesh surgery [5, 7]. Similarly, no surgery-specific patient-reported experience measure (PREM) was available to assess women's experiences of care. As a result, important outcomes and experiences may not be consistently measured, limiting evidence to compare the benefits and risks of different treatments and to support treatment decision-making [8]. The National Institute for Health and Care Excellence (NICE) highlighted a need for the development and validation of a single surgery-specific PROM, that also captured patient experiences of care, to address this evidence gap [8]. Funded by the National Institute for Health and Care Research (NIHR), the APPRAISE team was tasked with developing these new tools for use with women undergoing surgery for SUI, POP or mesh complications [9]. Although surgery for POP, SUI and mesh complications represent distinct clinical groups, assessment of urinary, bowel, vaginal and sexual symptoms, and their impact on quality of life can be assessed by an appropriately designed comprehensive pelvic floor patient reported outcome measure. The development of such a measure, designed specifically to assess outcomes of surgical treatment was called for by the Cumberlege Review [5], which investigated how the healthcare system in England should respond to patient reports of harm in relation to vaginally placed mesh to treat pelvic organ prolapse and stress urinary incontinence. Synthesis of existing qualitative research is necessary to inform the content validity of these new measures and to ensure they comprehensively capture patient-reported outcomes and experiences [10]. Existing qualitative evidence syntheses (QES) have described women's experiences of living with POP and SUI [11–14], but no review to date has explored experiences specific to surgery for these conditions or for mesh complications.

Meta-ethnography was chosen as the method of synthesis for this review for its ability to generate novel, higher-order interpretations through a line of argument synthesis that goes beyond simply summarising findings [15] Examination of the included studies revealed that all were either primary qualitative studies or mixed-methods studies with substantial qualitative components and whilst some of the studies were admittedly 'thinner' in terms of analysis, many provided rich, in-depth insights, rendering them suitable for meta-ethnography [16].

Study aims

The aim of this review and meta-ethnography is to synthesise qualitative evidence on women's experiences and perceptions of surgery for POP, SUI, or mesh complications to inform the development of surgery-specific PROM and PREM measures.

Objectives:

- To explore how women experience and perceive surgery for POP, SUI, or mesh complications.
- To identify aspects of surgical outcomes and care experiences that are important to women and should be reflected in the new PROM and PREM.

Methods

A systematic review of qualitative studies was undertaken, with findings from the included studies synthesised using a meta-ethnographic approach. The protocol for this study was registered on PROSPERO in March 2023 and updated in November 2023 (CRD42023412750) [17]. The review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines [18]. A completed PRISMA checklist [19] is included in Additional file 1. The meta-ethnography was guided by the seven methodological phases described by Sattar et al. [20]; reporting of the study followed the eMERGe reporting guidelines [21].

Search strategy and data sources

Three electronic databases, Medline, PsycINFO and CINAHL, were searched by GF from inception to September 2023 using search terms derived from existing key systematic reviews [11, 14, 22–29]. The search strategy was reviewed by clinical members of the team (TG, SD), piloted, and refined before the searches were carried out (Additional file 2 contains the final search strategy).

Eligibility criteria

In line with the APPRAISE project aims, papers were included if they related to the experiences of women aged 16 and over who were eligible for, or had undergone, surgery for POP, SUI, or mesh complications. We included primary qualitative studies of any design, as well as qualitative components of mixed-method studies.

Study selection

References from the electronic database search were downloaded and deduplicated in Zotero reference management software, before being uploaded into Covidence review management software. A dual review approach was undertaken whereby four reviewers (AMB, KB, VF, GF) independently screened all titles and abstracts. To ensure reliability, 20% of full-text articles were screened by two reviewers against the inclusion criteria, with the remaining full texts screened by a single reviewer. Disagreements were resolved by consensus with reference to a third reviewer or the wider study team as needed. Reference lists of included studies were hand-searched throughout the review process for further relevant papers. A PRISMA flow diagram is provided in the results to illustrate the study selection process.

Critical appraisal

To assess the methodological quality of the included studies, the Critical Appraisal Skills Programme (CASP) checklist for qualitative research [30] as applied by AMB, KB, VF, and GF. The CASP checklist evaluates key domains of qualitative research quality, including clarity of study aims, appropriateness of methodology, research design, recruitment strategy, data collection and analysis, consideration of researcher-participant relationships, ethical considerations, and the overall rigor of findings. Using a quality assessment form (Additional file 3), each

study was appraised independently, and any uncertainties or discrepancies in scoring were discussed collectively until consensus was reached. The results of this appraisal informed the interpretation of study findings, helping to identify potential limitations and strengthen the robustness of the qualitative evidence synthesis.

Data extraction

In-depth data extraction of included studies was undertaken by AMB, KB, VF, GF, DM and GJ, following close reading and familiarisation of the papers. Two pre-piloted data extraction forms were used, following established meta-ethnographic methods [20]. The first included descriptive data of the study characteristics and participants (e.g. demographic, clinical and surgical data) (Additional file 4). The second was used to record first- and second-order constructs, which were extracted verbatim from the papers. First-order constructs are direct participant quotes reported in the papers, and second-order constructs are the interpretations (e.g. descriptions of themes) made by the authors of the included studies. Only findings from the qualitative components of mixed-methods studies were included in the synthesis. Initial data extraction for each paper was undertaken by one reviewer, with completed extraction forms subsequently reviewed by multiple members of the review team and discussed to ensure consistency.

Data synthesis

A meta-ethnographic approach was used to synthesise the findings, enabling the development of analytical rather than purely descriptive insights. As described by Sattar et al. [20] this method involves translating key concepts ('second-order' constructs) from one study into the context of others to generate new interpretations ('third-order' constructs), thereby producing a deeper understanding of the phenomenon. When concepts from across studies are sufficiently similar, they can be brought together through 'reciprocal translation', which involves comparing and integrating them to develop a coherent set of shared meanings. In contrast, 'refutational translation' is used when studies offer divergent or contradictory findings, with the aim of examining and explaining these differences [20]. In this review, the similarity of second-order constructs from the included publications meant that reciprocal translation was most appropriate, though we have also taken care to point out differences or contradictions between the studies.

Following repeated readings of the studies and the two data extraction forms, AMB, KB, VF and GF clustered second-order constructs with similar meanings into categories according to common concepts and ideas. These were developed with reference to the table of study and participant characteristics to maintain the contextual accuracy of the categories. Nine categories were created and were assigned descriptive labels, such as 'body image' and 'mental and emotional health'.

Translation tables were created for each category (KB), which included the first- and second-order constructs and a summary of the primary authors' interpretations (Additional files 5–13). This process was iterative: following further familiarisation with the data through the process of translation, KB refined the categories and the inclusion of data within them. KB also noted connections between categories, recognising that key concepts and issues often overlap. The tables were then further refined (KB and GF) to enable comparison of constructs across the studies and make the development of third-order constructs transparent.

The translation tables were used to aid the development of third order constructs, which represent our interpretations of the data in light of the study's objectives and key concepts relating to the impact of POP, SUI and mesh complications surgery on women's lives. On-going team discussions refined the third-order constructs, which were included in the translation tables to ensure that the interpretations were consistent with the original data (Additional file 5–13).

Finally, by identifying links and relationships between the third-order constructs, we abstracted them into higher-order themes, which in turn informed the development of our line-of-argument synthesis. This synthesis offers a higher-level interpretation that moves beyond the individual studies to generate new insights and reveal

overarching concepts that may otherwise remain hidden [15, 20]. To illustrate the key implications for clinical practice, we also produced a visual representation of the synthesis that depicts both the impacts of surgery and recommendations for care.

As an interpretive qualitative synthesis, the review did not aim for statistical generalisability. Instead, detailed study and participant characteristics are reported to enable judgments about the transferability of findings to other populations and settings [31].

Results

From 2,613 titles and abstracts identified through database searches, 2,362 were excluded at screening and 236 at full-text review, yielding 15 studies that met the inclusion criteria (Additional file 14). Hand-searching identified three additional relevant publications, including a PhD thesis [32] containing more comprehensive findings than its corresponding journal article [33]; the thesis was included. The final dataset comprised 18 publications reporting on 17 distinct studies (Fig. 1; Table 1).

Study characteristics

Table 1 summarises key details of the 17 included studies (18 publications), including study aims, population characteristics (including sample size, age, and ethnicity where reported), condition(s) and surgery status, study design, location, type of surgery (where applicable), sampling and recruitment strategies, and methods of data collection and analysis.

In total, from across the studies we were able to explore the experiences of 894 women. This includes 146 women from prolapse studies, 29 women from SUI studies, 101 women from studies including both POP and SUI, and 618 women from mesh complication studies. The studies reported the experiences of women from a range of countries, although most of these were Western settings: USA (6); UK (5); Australia (2); New Zealand (1); Yemen (1); Ethiopia (1); Canada (1). The included studies varied in terms of participants' conditions and timing relative to surgery. Three studies focused on women seeking or awaiting surgery for POP or SUI, with data collected pre-surgery [39–41]. Four studies included women who had undergone surgery for POP and/or SUI [34, 36–38], and two focused exclusively on women experiencing surgical mesh complications [47, 48]. Two further studies included only women who had undergone mesh revision or removal surgery [45, 49], while another two included mixed samples of women who had surgery for the original condition and either developed mesh complications or required additional revision surgery [32, 44]. One study included both women eligible for surgery and women who had already undergone surgery for POP [35]. Finally, two studies collected data from women with bothersome urinary incontinence or POP both pre- and post-surgery, either longitudinally [42] or by comparing separate pre- and post-operative groups [43]. In one study [46], all participants had received transvaginal mesh implants, but details regarding the original condition, incidence of mesh complications, or further corrective surgery were not reported.

Methodological quality of included studies

Overall, the methodological quality of included studies was good (Additional file 3). Most papers clearly articulated their research aims, used appropriate qualitative designs, and demonstrated suitable data collection and analysis methods. All studies were rated as making a contribution to knowledge.

However, some limitations were identified. Thirteen studies provided insufficient detail on ethical considerations to fully meet the CASP criteria, and the same number did not sufficiently explore the relationship between researchers and participants. Four studies provided insufficient detail on data analysis, whilst the appropriateness of the recruitment strategy in two was uncertain. Although the evidence base is broadly robust, gaps in reflexivity

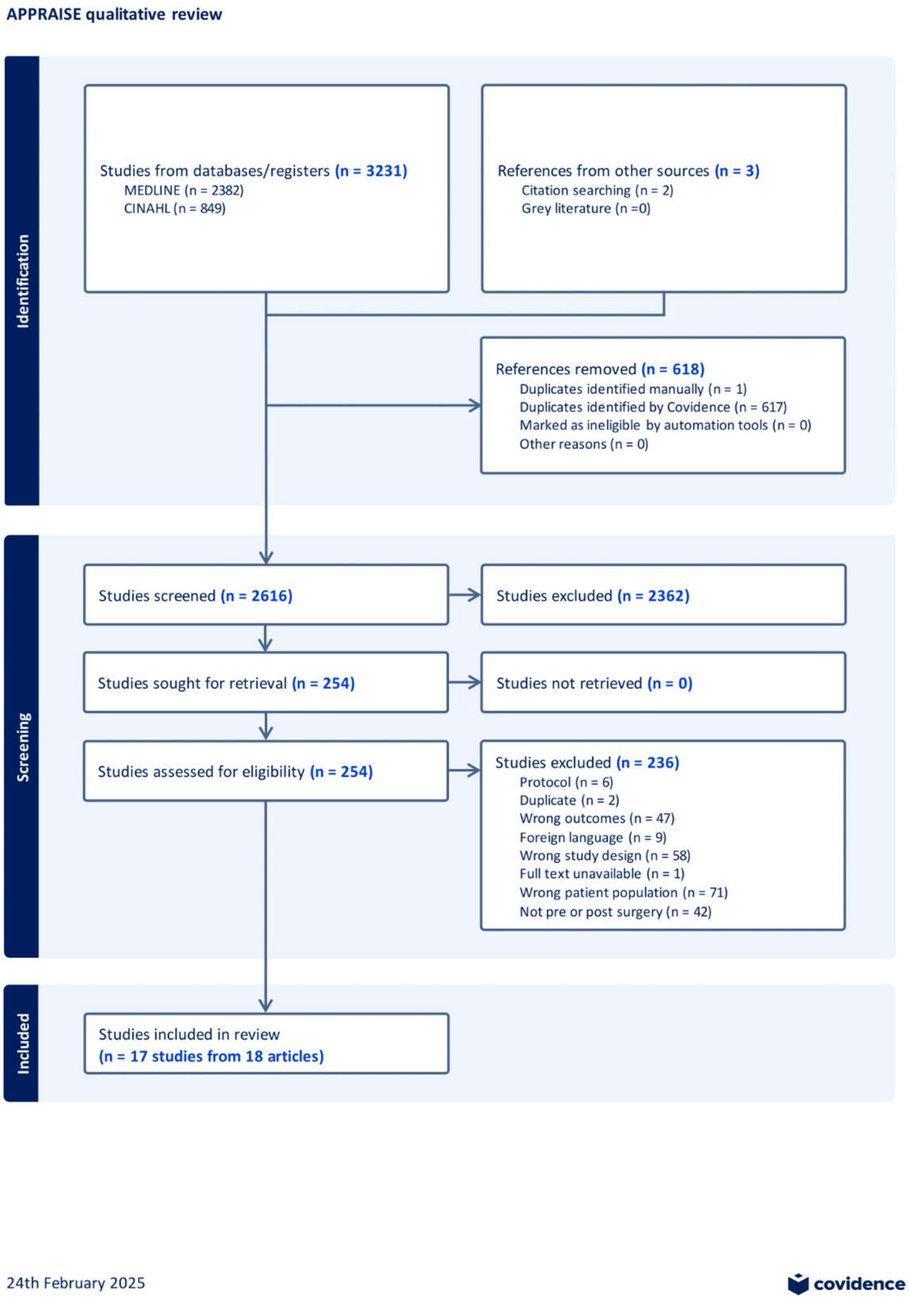


Fig. 1 PRISMA Flow Diagram

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Table 1 Summary of Studies Included Within the Synthesis

Study author(s)	Study objective	Sample size	Participant age	Participant ethnicity	Condition and surgery status	Study design	Study location	Type of surgery	Follow up time
Pelvic Organ Prolapse Studies									
Baskayne et al. (2014) [34]	To explore pre-surgical expectations of prolapse surgery and examine reasons why these expectations were met or unmet.	32 women (4 pilot; 28 involved in main study whose data is included in this review)	Range 32–86 (median 58).	Of 28 women in main study: 19 Caucasian; 9 South Indian Asian.	Post-surgery (primary or repeat surgery).	Qualitative	UK	Vaginal hysterectomy Pelvic floor repair TVT Vaginal prolapse repair without mesh Vaginal mesh repair Abdominal sacrocolpopexy	<6 months since surgery
Dejong et al. (2012) [35]	To explore constraints to seeking healthcare and women's perceptions of the implications and determinants of PID, infertility, POP.	35 women total. Only findings relating to women with POP included within the synthesis ($n=13$).	Full sample ($n=35$): 18 women under 30; 17 women over 30	Race and ethnicity not reported.	Pre- or post-surgery.	Mixed methods	Yemen	Prolapse surgery – Type of surgical procedures not reported.	Not reported.
Evans et al. (2021) [36]	To describe patients experience of an enhanced recovery protocol following minimally-invasive sacrocolpopexy (SCP) for POP.	14 women	Median age 65.5.	93% White; 7% Black.	Post-surgery.	Qualitative	USA	Sacrocolpopexy for POP.	2–6 weeks after surgery.
Gjerde et al. (2018) [37]	To explore patient perspectives of recovery and reintegration following free surgical treatment for POP in a resource-constrained setting.	12 women	Mean age 43.3 (range 32–60).	100% Amharic.	Post-surgery.	Qualitative	Ethiopia	Vaginal hysterectomy Sacrospinous fixation and/or anterior/posterior colporrhaphy.	Not reported.
O'Dell & Jacelon (2005) [38]	To understand women's experiences following vaginal closure surgery for severe prolapse.	6 women	Range 61–85 years.	100% White Caucasian.	Post-surgery.	Qualitative	USA	Vaginal closure surgery	Time since surgery 6 months – 3 years.
Ramage et al. (2022) [39]	To explore how women's gendered responsibilities and identities impact their experience of prolapse and their decision-making around surgical treatment.	26 women	Mean age 53 years.	92% White, 4% Mixed Race, 4% Black.	Pre-surgery.	Qualitative	Canada	Hysterectomy or uterine-preserving surgery.	Not reported.

Table 1 (continued)

Study author(s)	Study objective	Sample size	Participant age	Participant ethnicity	Condition and surgery status	Study design	Study location	Type of surgery	Follow up time
Srikrishna et al. (2008) [40]	To explore the expectations and goals of women undergoing surgery for urogenital prolapse.	43 women	Mean age 56 years.	Race or ethnicity not reported.	Pre-surgery	Mixed methods	UK	Pelvic floor reconstructive surgery. Surgical approach not reported.	Not reported.
Stress Urinary Incontinence Studies									
Srikrishna et al. (2009) [41]	The expectations and goals of women undergoing continence surgery.	29 women	Mean age 61, range 39–83.	59% White Caucasian; 34% Afro-Caribbean; 7% Asian.	Pre-surgery.	Mixed methods	UK	Women eligible for SUI surgery, but surgical approach not reported.	Not reported.
Combined Prolapse & Stress Urinary Incontinence Studies									
Dunivan et al. (2019) [42]	To describe patient perceptions of adverse events related to pelvic floor disorder surgery and how they change over time.	20 women	Mean age 55.3 (SD 12.7).	50% Non-Hispanic White; 25% Hispanic; 25% American Indian.	Pre- or post-surgery.	Mixed methods	USA	Mid-urethral sling Sacral neuromodulation Vaginal native tissue repairs Laparoscopic hysterectomy	6–8 weeks and 6 months post-surgery
Dunivan et al. (2019) [43]	To describe patient perceptions of adverse events following surgery for pelvic floor disorders.	81 women	Mean age: pre-op group 58.4 years, short term post-op group 60.4 years, long term post-op group 60.2 years.	Only % of White participants was reported: 84%, 96% and 82% in immediate, short- and long-term post op groups respectively.	Pre- or post-surgery.	Qualitative	USA	Surgery for POP & SUI - Type of surgical procedures not reported.	3 groups: 1. Pre-op assessment 2. short-term follow up (up to 12 weeks) 3. Long term follow up (1–5 years post-surgery).
Mesh Complication Studies									
Brown (2019; 2020) [32, 33]	To shed light on lived experiences of transvaginal mesh complications.	7 women	Range 43–69 years.	Race and ethnicity not reported.	Post-surgery (primary or corrective surgery).	Mixed methods	New Zealand	Mesh implantation: transvaginal mesh, TOT, TVT, sacrohysteropexy, burch colposuspension. Removal surgery: Partial/full removal, open approach, transvaginal, laparoscopic, or hysterectomy	Removal occurred 1–12 years following implantation
Dibb et al. (2023) [44]	To understand the experiences of women who have mesh complications.	18 women	Range 40–67 years (mean 52).	Race and ethnicity not reported.	Post-surgery (primary or corrective surgery).	Qualitative	UK	Mesh implantation: TOT, TVT, TVT-O. Removal surgery: partial/full removal	Mean time since mesh fitted 8 years, range 4–15 years.

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Table 1 (continued)

Study author(s)	Study objective	Sample size	Participant age	Participant ethnicity	Condition and surgery status	Study design	Study location	Type of surgery	Follow up time
Dunn et al. (2014) [45]	To describe women's experiences of vaginal mesh complications after optimized tertiary care level treatment.	84 women	Mean age at presentation to clinic: 54.1 years, range 30–81 years.	Race and ethnicity not reported.	Post-surgery (corrective surgery only).	Mixed methods	USA	Midurethral sling Vaginal mesh for POP Abdominal sacrocolpopexy Vaginal mesh plus midurethral sling.	Mean time years from initial surgery to interview 4.5 years; mean time from mesh complications to interview 2.3 years.
McKinlay & Oxlad (2024) [46]	To explore how transvaginal mesh implants impact women's lives through a biopsychosocial lens.	399 women	Age not reported.	Race and ethnicity not reported.	Post-surgery (corrective surgery only).	Qualitative	Australia	Trans-vaginal mesh surgery.	Not reported.
Ralphsmith et al. (2023) [47]	To develop a conceptual framework defining the important elements of pain as identified by women with pelvic floor disorders.	17 women	Mean age 57 years.	Race and ethnicity not reported.	Post-surgery (corrective surgery only).	Qualitative	Australia	TVT Mini-sling TFS TVT-O Mesh laparoscopic hysteropexy TO sling TVT and mesh rectopexy Sacrocolpopexy mesh Burch colposuspension.	Not reported.
Toye et al. (2023) [48]	To explore and understand the experience of living with complications attributed to vaginal mesh surgery.	74 women total.	Range 48–78 years.	100% White.	Post-surgery (primary or corrective surgery).	Qualitative	UK	Mesh surgery: TVT for UI, TVTO for UI and mixed, including TVT and hysterectomy. Revision/removal surgery: partial/full removal of mesh.	Not reported.
Uberoi et al. (2021) [49]	To gain a detailed understanding of women's experiences after undergoing revision surgery for mesh midurethral sling (MUS) complications.	19 women.	Mean age 58, range 39–76.	79% Non Hispanic; 5% Hispanic; 5% American Indian; 11% not provided.	Post-surgery (corrective surgery only).	Qualitative	USA	Removal or revision surgery for MUS complications (MUS for SUI).	Time between revision surgery and study participation ranged from 10 to 70 months (median 39).

Pre-surgery before surgery for the original condition, *Post-initial surgery* after surgery for the initial condition, *Post-mesh revision/removal* after revision/removal of surgical mesh

and ethical reporting may reduce confidence in some findings. However, these limitations were not considered to have substantially affected the overall conclusions of the synthesis.

Qualitative evidence synthesis

Reciprocal translation of key concepts from across the 17 studies (18 publications) produced 14 third-order constructs, which were further synthesised into six high-order themes (Table 2). These themes were organised to reflect the potential trajectory of women's experiences from living with the conditions (*Priorities for surgery - Performing womanhood)* to life after surgery (*Adjusting to a new normal following surgery* and *Living with uncertainty*). This structure was intended to map qualitative evidence from different stages of the treatment pathway, rather than suggest that all women followed the same journey. Whilst the synthesis draws on studies of women with POP, SUI and mesh complications, the post-operative themes are informed primarily by mesh complication studies, alongside more limited evidence from post-operative studies involving women with POP and SUI. These themes formed the basis of our line-of-argument synthesis.

The synthesis addresses our review objectives to understand how women experience surgery for POP, SUI, and mesh complications, and by identifying the health outcomes and aspects of care they value most. In particular, the line of argument demonstrates that surgical outcomes cannot be understood solely through clinical symptom assessment, and that women's perceptions of their condition are closely tied to their experiences of care, their social roles and their overall quality of life. These insights are essential for informing the development of surgery-specific PROMs and PREMs to support holistic, patient-centred care. The six themes, line of argument, and the visual representation of the synthesis are described in detail below.

Priorities for surgery – fulfilling roles and performing womanhood

The first theme captures the initial stage of women's treatment trajectories and their experiences of living with POP, SUI, or mesh complications. Women's decisions about surgery were influenced not only by physical symptoms, but also by their ability to fulfil roles and responsibilities and meet sociocultural expectations of womanhood and femininity. These concerns informed whether and when women chose to pursue surgery and their goals for treatment, as well as how they approached recovery and post-operative self-care.

Whilst relief from physical symptoms was importantn [34], women with POP, SUI and mesh complications were also concerned about the distal impacts of their symptoms on body image, sexuality, confidence and overall quality of life, including their ability to engage in daily activities, maintain personal relationships, and fulfil social

Table 2 Table of Third-Order Constructs & Higher Order Themes

Higher Order Themes	3rd Order Constructs	POP	SUI	MC
Priorities for surgery – fulfilling roles and performing womanhood	The distal impacts of symptoms and surgery affect activities of daily living, quality of life, body image, sexual function and intimacy	X	X	X
	Women's role expectations shape condition management and treatment decisions	X	X	X
Stigma and shame	Stigma and shame are barriers and facilitators to disclosure and treatment seeking	X	X	X
Misaligned priorities	Differing treatment goals between women and clinicians impact perception of success and recovery	X	X	X
Agency and trust in healthcare encounters	Feeling powerless	X	X	X
	(Mis)trust in clinicians	X	X	X
	The role of peer support in regaining agency	X		X
Adjusting to a new normal following surgery	For better or worse? Adjusting to a changed quality of life	X	X	X
	Living with new or unresolved symptoms	X	X	X
	The psychological toll of unmet surgical expectations	X		X
Living with uncertainty	Uncertainty regarding the ongoing impact of mesh and value of further surgery			X

and professional roles. Restoring these functional outcomes was often fundamental to their sense of recovery after surgery; not achieving these goals could be perceived as a severe adverse event [42].

Frequently, women's concerns related to activities or expectations aligned with gender norms and the performance of femininity and womanhood (e.g. housework, caring for others). Difficulties meeting these expectations led to feelings of loss, guilt, sadness and frustration when valued activities became difficult or impossible, either because of pre-surgical symptoms or during post-surgical recovery period [32, 33, 35, 39–41, 43, 46, 49]. Affected activities included work outside the home, physical activity, social, family, or religious activities, and shopping or domestic chores. For women pre-surgery, these impacts influenced decisions to undergo surgery [43].

> *'Before this, my house was always spotless, now I really don't feel up to it. Before all this happened I really enjoyed my job you know? I looked forward to it and it defined me. Now, it's so uncomfortable and annoying, I can hardly wait to go home at the end of the day.'* (*Woman with POP* [50]).

Women with mesh complications also described the impact of their symptoms on their relationships and on the lives of partners or children, reporting feelings of being a burden [32, 33, 43, 46, 48] and, in some cases, avoiding future relationships to prevent others from taking on a caring role [32]. A small number of women in Gjerde et al.'s study [37] opted to divorce their husbands since they felt unable to fulfil their expected role as wives, owing to prolapse. Further consequences included financial difficulties [32, 33] (sometimes owing to relationship breakdown), social isolation [32, 33, 40, 41], and concerns about physical health, such as becoming overweight or unfit. [40, 41].

Women with POP reported pushing through pain or discomfort to meet role expectations [37, 39]. In Ramage et al.'s study [39], women reported that mothering duties exacerbated their prolapse symptoms and described balancing keeping up with their children with making adjustments to manage symptoms. However, such adjustments often led to shame and guilt about not meeting expectations of being a 'good mother'. For women with POP and mesh complications, concerns about fulfilling these roles could both facilitate and preclude surgery or other treatment. For example, some women wanted to regain role function and be a 'good mother' which motivated them to pursue surgery for POP [39]. Others prioritised their obligations to care for children or elderly relatives over their own treatment needs. This included delaying consultations or surgery for POP or mesh complications [32, 39] or seeing prolapse surgery as a final resort due to concerns about recovery time and childcare [39].

> *'I struggled with taking this risk at all because my kids are young and there's always risk of complications. It was hard to [say] it's OK to go for this to improve quality of life and to take this risk. It felt selfish, I guess, for me. And so, it took a while to get more comfortable with that feeling of it's OK to prioritize the surgery.'* (*Woman with POP* [39]).

Concern about the needs of others and their ability to fulfil social role obligations also influenced women's decisions about surgical recovery, including opting for early discharge after POP surgery [36], and affected their ability to adhere to post-surgery recommendations, such as avoiding heavy chores, particularly where social support was limited [37]. This highlighted the importance of social support during surgical recovery. One study also found that embodied notions of womanhood directly influenced surgical decision-making. Women described their attachment to the uterus, and its symbolic connections to womanhood, motherhood, and femininity, as an important factor in deciding whether to undergo hysterectomy [39].

In the pre-treatment studies, women also described the impact of POP or SUI symptoms on their body image, including concerns about incontinence-related odour [33] and the visibility of a bulge from POP [39]. These symptoms, which deviated from cultural ideals of embodied femininity, left women feeling less confident, attractive and womanly [39, 41]. Shame and embarrassment about their symptoms, as well as the accommodations needed manage them, sometimes led women to hide the extent of their condition from partners, impacting intimacy and sexual function [39, 41].

Overall, sexual function was an important issue for women both pre- and post-surgery. Women living with POP, SUI and mesh complications reported dissatisfaction with their sex lives: their conditions could cause

pain or physical discomfort during sex and, for women with mesh complications, discharge from infections and injury to male partners during intercourse, leading some women to avoid sex [32, 33, 39–41, 44–46, 49]. Body image and sexuality appeared to have a two-way relationship. Difficulties with body image added to problems with sexual function, whilst disruptions to sexual relationships further damaged body image and left women feeling unattractive [44]. Sexual issues also affected women's psychological wellbeing [46] and often led to loss of intimacy; close relationships were sometimes described as becoming more like friendships [44]. Problems with sexual function put strain on relationships, contributed to relationship breakdown of or, for some women, led them to rule out future relationships altogether [41, 44–46, 49].

> *'I think, the inability to have a sexual relationship you know, sort of is another sort of very, difficult journey you know, to deal with I think, because you feel unattractive you know, you feel.that there is a strain on the relationship because of it.' (Woman with mesh complications* [44]).

Restoring sexual function was described as a goal of surgery for some women [39, 42, 43], and failure to meet this goal could be perceived as an adverse surgical event [42, 43]. Women also described feeling 'guilty' or like a 'failure' for not meeting what they perceived as their partner's sexual needs and living up to relational role expectations [39, 46]. By contrast, older women who had vaginal closure surgery for POP did not report problems with sexual function and felt that, at their age, restoring sexual function was not a concern for themselves or their partners. One woman remarked that she had 'done her duties', suggesting this may have been a concern if she was younger [38].

Stigma and shame

The second theme highlights how stigma, embarrassment, and social taboo influenced women's experiences of POP, SUI, and mesh complications. These concerns often inhibited discussion and disclosure of symptoms, limiting women's ability to seek support and make informed decisions about surgery. Conversely, symptom-related shame sometimes prompted women to undergo treatment.

Women highlighted a sense of stigma and shame surrounding prolapse, SUI, and mesh complications, often linked to the perceived social unacceptability of discussing women's genital areas and to fears of judgment or discrimination [32, 33, 39]. For some, this made their condition difficult to discuss or disclose, even to partners, friends, relatives [32, 33, 35, 38], or health professionals [38, 39, 48]. Others felt able to confide only in a few close friends or family members and often endured their symptoms in silence [32, 33, 37, 38]. In some cases, women concealed or downplayed the impact of their condition to avoid 'bothering' or 'burdening' others, or because of their own discomfort or embarrassment [32, 33, 38].

Stigma and shame could therefore silence women and limit their ability to seek support from social networks and health professionals, potentially restricting discussions about treatment options, including surgery.

> *'Participants described the humiliation of urine leakage that was the context for surgery, and which could also become a barrier to discussions about surgical complications. They described the impact on their sense of dignity or worth. The shame, taboo, and stigma around incontinence played a part in the decision to have mesh surgery, and the decision to remove it. Participants felt "ashamed", "dirty", "humiliated", and "mortified", because of lost bladder control.' (Author interpretation* [48]*).*

In the context of incontinence, shame could also sometimes motivate women to pursue surgery, both for the original condition and for mesh complications, when embarrassment about ongoing symptoms drove them to seek help [48]. The impact of taboo, shame and stigma is therefore complex, both prompting women to consider surgery and limiting their ability to disclose their condition and seek support. This finding highlights the potential value of incorporating a PROM into clinical consultations for women with these conditions, as it may facilitate disclosure by enabling them to express concerns without embarrassment.

Social and peer support could help break down taboo around POP and encouraged women to seek surgical treatment [37]. Another study found that disclosing POP to others within support networks facilitated help-seeking [38].

Misaligned priorities

This theme reflects the stage in women's treatment journeys where they moved from deciding to seek help toward engaging with healthcare professionals and planning surgery. At this point, women's personal goals and expectations for treatment often differed from clinicians' priorities. This sometimes led to frustration and feelings of being misunderstood, highlighting the need for more patient-centred and collaborative approaches to surgical decision-making.

Women's surgical priorities and expectations often extended beyond physical symptoms [34] to broader 'distal' outcomes such as body image, sexuality, social participation, and fulfilling social roles [39]. However, pre-surgery POP and mesh complication studies, in particular, reported that women felt clinicians focused primarily on symptom resolution, with this seen as determining a good clinical outcome. By contrast, women stressed the importance of being treated holistically, with their condition, symptoms and surgical outcomes considered within the context of their lives [39], or being seen as a whole person [48]. Women valued this approach as part of enhanced recovery programs for POP [36]. Conversely, some women reported feeling dehumanized and treated as a 'body part' during mesh surgery [48].

Misaligned priorities extended to the recovery period, where women's concerns related to ongoing or new symptoms or complications following surgery [32, 33, 44, 48] and their ability to meet social roles and expectations upon discharge [37, 39]. These concerns were reflected in Dunivan et al.'s research [43] where women's perceptions of adverse events following surgery shifted over time towards functional outcomes (e.g. sexual function, ability to manage everyday activities), rather than clinical outcomes. For some women with mesh complications, there was a perception that once surgery had addressed the original problem, surgeons considered their job complete. As a result, women felt that ongoing symptoms, complications, or impacts on quality of life were dismissed, leaving them to 'fend for themselves' after discharge [32, 33, 44, 48]

> *'Women present to medical practitioners because of the impact of mesh complications on their lived bodies but find the focus is on their pelvis, the personhood of the woman to whom that pelvis belongs is neglected.He (gynecologist) believed the surgery was a great success but the impact it had on my life was devastating and still continues to have far reaching effects. I knew something was wrong, but the surgeon said the surgery was not the cause (Beth).' (Author interpretation and woman with mesh complications* [32]*).*

In summary, this theme illustrates that women's goals for surgery include not only symptom relief but also a range of psychosocial factors often closely linked to their role expectations.

Agency and trust in medical encounters

This theme explores how women's sense of agency and trust evolved during medical encounters relating to surgery for POP, SUI, or mesh complications. Many studies reported that women experienced feelings of powerlessness within medical settings, both during pre-surgery consultations and after surgery, including when managing complications. Closely linked to agency, trust emerged as a central concept: women's trust in both clinicians and themselves shifted throughout the process of seeking surgery, undergoing treatment, and raising subsequent concerns.

Prior to surgery many women reported taking a 'doctor knows best' approach; trusting their health provider's recommendations for surgery and believing that they had their best interests at heart [32, 33, 38, 44, 48, 49]

'When she was offered the simpler vaginal closure instead, she recalls saying, "Please just do for me what you think is best"' (Woman with POP [38]*).*

At this stage, some women reported that when they raised questions or concerns about surgical mesh, they were reassured of its benefits but received little discussion of alternative options [32, 49].

Following surgery, many women found it difficult to ask questions, raise concerns, or challenge health professionals, especially when outcomes did not meet expectations [32, 33, 38, 44]. Women with mesh complications, in particular, reported that their concerns were minimised, normalised, or dismissed, with symptoms sometimes attributed to psychological rather than physical causes [32, 33, 44, 48, 49].

'...every time I'd go back into hospital, I'd say things like, do you not think it could be this mesh, I'd be told oh no, don't worry it can't possibly be your mesh.' (Woman with mesh complications [44]*).*

As in 'Misaligned priorities' above, women's surgical complications were often dismissed where the procedure addressed their original complaint.

'When I had the check up after he said oh, you'll get used to the pain...are you still incontinent? And I said no, so he said Well I won't be reporting it then because the operation's worked as far as I'm concerned' (Woman with mesh complications [44]*).*

Brown [32, 33] suggests that the power imbalance in the practitioner–patient relationship can invalidate women's experiences and foster self-doubt. This pattern was evident in several studies, with women reporting diminished trust in their own bodily experiences. When healthcare providers dismissed or failed to trust women's experiences [32, 33], this could have serious consequences for women's agency in seeking or obtaining further treatment for mesh complications [44, 48], including delays in referral, investigation or treatment [49], or post-surgical discharge despite pain, discomfort or not feeling ready [32, 33, 38, 48]. Further, women with mesh complications reported that clinicians appeared unprepared to value or learn from their perspectives [48]; thus, whilst women placed their trust in health professionals, this was not always reciprocated.

Whilst being dismissed by clinicians often led women to doubt their own perception that something was wrong following surgery, it also eroded their trust in health professionals. Some women questioned how their treatment options had been communicated, reporting feeling misled, underinformed, or that alternatives had not been discussed, raising doubts about whether they had provided fully informed consent [32, 45, 48, 49]. Similarly, others reported that pre-surgery information was confusing or inadequate [51], difficulty asking questions [38], or wanting more information about surgery and potential adverse events [42, 43]. Women emphasized the importance of managing expectations around surgery and wanted more information about post-surgery outcomes, both short-term, such as recovery time and resumption of usual activities, and long-term, including the potential need for further surgery and restoration of sexual function [38, 42, 43].

Being fully informed about risks, alternatives and post-surgical recovery was important to women's agency in surgical decision-making. Some women with POP were unsure about important details of their procedure [34], whilst those with mesh complications questioned whether original treatment recommendations were appropriate [32, 33].

'Why did I ever go with that? but he was kind of so plausible and "I've had lots of experience, and I can fix this, it's easy," so I went with it and that was the start of all the problems really. I didn't need all of that surgery, I didn't probably need the mesh put in, there were other alternatives that he never even offered me. So that is irritating, you know you put your trust in these surgeons and yeah.' ('Donna' - woman with mesh complications [32]*).*

It is apparent that, particularly following mesh complications, the trust women placed in health professionals at the beginning of their treatment broke down; some women began to see them as fallible, untrustworthy and felt betrayed. For example, women questioned whether clinicians had their best interests at heart, whether they were

knowingly putting women at risk, or disregarding women's reports of mesh complications to protect colleagues [32, 48]. Women reported regretting their trust in healthcare professionals and their decision to undergo surgery [32, 45, 48, 49].

Trust in practitioners is central to healthcare, and for women with mesh complications who felt this trust had been broken, it became a barrier to seeking further support, due to the need to (re)place trust in a system that had previously let them down. In some cases, this led women to seek multiple opinions or pursue private treatment [48].

Women sought support from peers, particularly through online mesh complication support groups [44, 48, 49]. Over time, they were able to regain trust in themselves, as these spaces validated their experiences and helped them feel less isolated. Similarly, women who subsequently obtained a diagnosis for mesh complications felt vindicated as this validated their experiences [32]. Being part of a community of other women with POP or mesh complications also provided knowledge about their condition [37, 38]. This gave them the strength to assert their needs and advocate for themselves during healthcare encounters and, in some cases, to campaign on behalf of other women experiencing similar difficulties [44, 48]. Overall, this speaks to the importance of peer support in accessing healthcare for these conditions.

More positive experiences were also reported in the dataset. Some women with POP or mesh complications felt well-informed and appreciated surgeons taking time to fully explain procedures (for example, using diagrams) or being honest about risks associated with further surgery [34, 49]. Moreover, in Evan's study, women offered an enhanced recovery protocol following POP surgery felt confident approaching health professionals with concerns and adequately prepared for what to expect before and after surgery, though some expressed distress around being discharged with a catheter [36]. However, positive experiences were less frequently discussed, possibly owing to the focus of many studies on mesh complications. Where women with mesh complications had more positive experiences, these related to feeling listened to and believed, and being supported by healthcare professionals who were caring, kind, and proactive in addressing their concerns, even when further treatment was not possible [48, 49]. They also valued honesty and apologies from clinicians when things went wrong [32].

Adjusting to a new normal following surgery

This theme reflects the process of adjustment that women underwent following surgery, especially those who experienced mesh complications. Women reported wide-ranging impacts of surgery on physical and mental health and quality of life, and described needing to adapt to a 'new normal', a concept borrowed from Dunn [48]. For some women, this 'new normal' encompassed improvements in health and functioning, as well as manageable adjustments to their lives [34, 37, 45, 46]. However, for others, adjusting to a new normal meant poorer physical functioning, coping with new or unresolved symptoms, or living with uncertainty about their physical health status. This theme is largely relevant to women with mesh complications but also draws on post-surgical studies of women with POP and SUI.

A minority of the data described women who experienced improved symptoms following surgery for POP, SUI, or mesh complications and, consequently, better physical and social functioning, mental health, and quality of life, or who felt, at least, that the benefits of surgery outweighed any remaining complications [34, 37, 45, 46].

> *'I used to have to walk by holding the prolapse; I couldn't walk like I wanted to. I had a lot of problems. But I'm thankful after the surgery; it was a big change. I had suffered for six years.' (Woman following surgery for POP* [37]*).*

> *'Absolutely brilliant no to me it's the best thing I think I can go on holiday and not have to worry about stopping and no it's changed my life you know.' (Woman following surgery for POP* [39]*).*

However, other women following surgery for POP or SUI, including those with mesh complications, reported new or unresolved symptoms following surgery [32–34, 38, 43–45, 48]. These included persistent symptoms and

difficulties returning to previous levels of functioning [43]. For those with mesh complications this was in sharp contrast to the 'quick fix' or 'gold standard' treatment they felt they were promised.

> *'I wish I never had the mesh surgery on my bladder. I don't think it helped the problem and just created a new problem.' (Woman with mesh complications* [45]*).*

As a result, women reconfigured their daily lives to accommodate these challenges, managing them according to the severity of their symptoms. Women described various stages of accepting this 'new normal' (including non-acceptance) [32, 33, 38, 48, 49], a process that, for those with mesh complications, could be iterative as new limitations emerged over time [32]. For some women, new symptoms led to surgical regret; in certain cases, they perceived their original condition as easier to manage [38, 44].

New or persistent symptoms included pain, recurrent urinary tract infections, urinary or faecal incontinence, infections and unpleasant discharge, exhaustion or difficulty sleeping, problematic immune responses, sexual function and mobility problems. Pain was a key symptom following surgery and, for women with mesh complications, its onset and nature could vary. Whilst some women experienced pain immediately after surgery and could therefore attribute it directly to the procedure, for others it occurred days, weeks, months, or even years later [32, 46, 47]. Pain could be associated with the original implant, a revision procedure, or full or partial removal surgery; it could be constant or intermittent and manifest in different sensations and areas of thebody [47]. Pain could be debilitating and impacted women's daily functioning [32, 33, 47]. Some women reported hypervigilance in identifying and avoiding pain triggers [32]. A distinct feature for some women with mesh complications was pain arising from mesh erosion. Described as having 'barbed wire' within, mesh erosion had significant implications for some women's physical functioning and quality of life [32, 46]

> *'To say this filthy mesh has changed my life is an understatement. Before it was implanted, I was walking 5kms a day. This is now not possible. I have chronic leg pain that renders me crippled after sitting or laying down. Swollen feet, abdomen and hands, and a horrendous lethargy, makes most mundane jobs difficult.' (Woman with mesh complications* [46]*).*

As this quote demonstrates, new or persistent symptoms could profoundly affect women's physical health, social functioning, psychological wellbeing, and overall quality of life. Women described the contrast between their lives before surgery and afterwards, particularly in the wake of mesh complications [32, 33, 44, 45, 48], highlighting that, for some, surgery had worsened rather than improved their wellbeing. Women expressed a deep sense of loss for their 'former selves,' often describing mesh complications as life changing. Some felt 'robbed' of their previous lives [44], with formerly routine activities now 'off the table' [32, 33] . Brown considers how managing pain and other symptoms forced women to focus on the present and live day-to-day, making it difficult to envisage the future and illustrating how mesh complications could shrink their lives [32, 33].

> *'Prior to having mesh implanted into my body I was a hardworking, strong woman that loved life and especially the outdoors. I am now a tired, in constant pain, disabled women who cannot enjoy things I used to love.' (Woman with mesh complications* [32]*).*

In one study, some women described their pre-mesh selves as 'healthy' compared to their post-mesh selves as 'unhealthy' [45] despite having lived with a health condition before surgery, suggesting that the original condition was preferable to life after mesh. Overall, women reported that ongoing or new symptoms had a significant impact on their mental health, including depression and anxiety, and, in some cases, suicidal ideation [32, 33, 44–46, 49]. This was in stark contrast to women's pre-surgery hopes that alleviating physical symptoms by having surgery would improve their overall wellbeing [39, 40].

For women who underwent further surgery, including multiple revision or removal procedures, these challenges could be compounded. Dunn et al. [45] identified three trajectories of women's experiences following mesh surgery. Women with 'cascading health problems' faced the greatest difficulties: they often felt their health was beyond their control, felt powerless to improve their situation, and experienced desperation and hopelessness.

For women undergoing multiple mesh surgeries, each procedure could present new or worsening complications, further damaging their wellbeing and quality of life [32, 33, 46].

Living with uncertainty

Concluding the treatment journey, this theme illustrates how life after surgery was often marked by enduring uncertainty, particularly for women with mesh complications. For example, mesh was characterised by women in some studies as 'other' - a 'foreign body' damaging them from the inside [45, 48]. Since it could not be seen, women experienced fear and uncertainty about what damage it might do next [45, 46], which was exacerbated by feeling powerless to intervene. Women described being hypervigilant as they closely monitored their bodies for changes to existing complications or new symptoms; they worried whether mesh was the cause and how they would cope [45, 46].

> *'Every time something unusual happens to me, I wonder if it is the mesh.' (Woman with mesh complications* [45]*).*

Some women who had already had removal surgery expressed uncertainty about the continued presence of mesh within the body [45].

> *'I was thinking she'd be able to take all the mesh out, but I wonder if the remaining piece is where the pain is.' (Woman with mesh complications* [45]).

Other women were uncertain about whether to undergo further surgery and, related to Theme Two, whether to (re)place trust in a healthcare system and professionals who, albeit unintentionally, had caused them harm [48]. This decision was particularly difficult for women diagnosed with PTSD following mesh surgery or who felt re-traumatised when (re)entering medical spaces [32, 33, 46]. Women expressed uncertainty about whether surgery would successfully remove the mesh or improve quality of life [35] and the possibility of further complications, weighing whether potential benefits outweighed the risks [32, 48]. Owing to these difficulties, some women ruled out additional surgery altogether, whilst others wanted to remove the mesh to prevent further damage [48]. Women therefore faced difficult decisions about the risks and benefits of further surgery. This uncertainty, alongside feelings of powerlessness to improve their situation [45], could further compound the psychological distress associated with ongoing symptoms and functional impacts. Harder still for some women was the resolution of uncertainty, when health professionals declared that nothing more could be done to improve their symptoms [45, 49]

> *'He [clinician] just looked at me and pointed to the door and says, "I can't help you anymore."' (Woman with mesh complications* [49]*).*

Line of argument synthesis

Through our thematic framework, we have outlined the trajectory of women's surgical experiences, demonstrating how these can impact multiple aspects of their daily lives. The six themes demonstrate that women's experiences of surgery for POP, SUI, and mesh complications cannot be understood solely through clinical outcomes or symptom resolution. Rather, these experiences are situated within broader personal, social, and cultural contexts that inform how women make decisions, experience care, and live with the consequences of treatment. Women's priorities for surgery often included their ability to fulfil roles, preserve dignity, maintain relationships, and uphold a sense of femininity and self. Stigma and shame further complicated disclosure and treatment-seeking, while misalignment between women's goals and clinical priorities sometimes left them feeling dismissed or unsupported. Women's perceptions of their condition were intricately connected to their experiences of care.

Across the pathway from decision-making to post-operative recovery, trust, agency, and access to support was fundamental to how women adjusted to a new normal and navigated ongoing uncertainty.

This line-of-argument synthesis shows that, for women, surgical success is defined not only by clinical indicators but by whether surgery enables them to reclaim valued aspects of their lives and identities. This emphasises the importance of centring women's voices in surgical care and developing PROMs and PREMs that reflect these experiences to support patient-centred practice.

Visual representation of synthesis

Figure 2 presents a visual synthesis of the findings, illustrating the experiences and quality of life of women with POP, SUI, or mesh complications, and highlighting implications for consultation, decision-making, clinical encounters, and follow-up care. The model places the woman at its centre, reflecting the priorities of the Women's Health Strategy for England to ensure that women's voices are at the heart of healthcare [52] and our findings that women's priorities and agency in decision-making were not always considered. Surrounding the woman are concerns identified as important in the review, emphasising the need for a holistic approach to understanding women's priorities and surgical goals [48, 49]. Beyond this, the model includes key practice recommendations developed from women's experiences of seeking and undergoing surgical treatment. These recommendations highlight the importance of fostering relationships between women and clinicians in which women are fully informed, consulted, respected, and trusted, and of aligning clinical priorities with the broad range of women's needs and concerns.

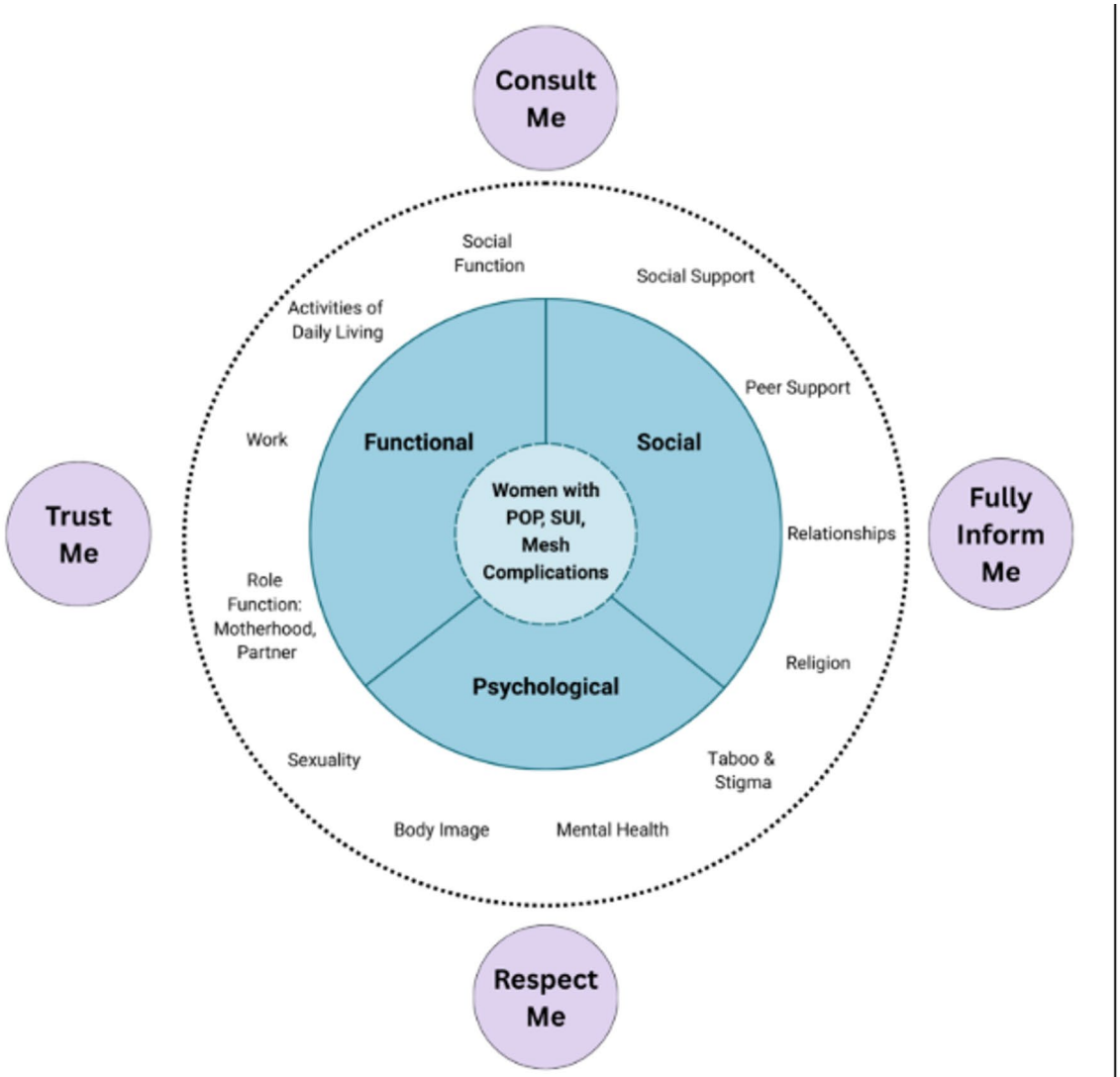
Discussion

Summary of the results

This meta-ethnography highlights the wide-ranging functional and quality-of-life impacts of surgery for POP, SUI and mesh complications, and the importance of women's experiences of care. For many, restoring function was both a goal and an expectation of surgery, informing their perceptions of surgical success. These goals were often influenced by women's role expectations, particularly their perceived obligations to others, reflecting broader gender norms that emphasise selflessness and 'putting others first.' Women frequently feel pressured to meet such expectations, even while managing a chronic illness [53]. Women's priorities were sometimes misaligned with those of clinicians, who tended to focus on symptom resolution. Women's perceptions of surgical success were not always captured by conventional clinical outcome measures. Experiences of shame, stigma, agency, and (reciprocated) trust were also central to women's accounts. Overall, surgical outcomes cannot be separated from the broader relational, social, and identity-based contexts in which women live.

Our findings support and extend existing qualitative syntheses on POP and SUI. Rada et al. [12, 54] highlight the impact of symptoms on women's quality of life and psychological wellbeing, as well as factors influencing treatment decision-making, including time constraints and lack of clear guidance [54]. They also note women's reliance on healthcare professionals, even when recommendations were not always responsive to their individual concerns [12]. Toye et al. [14] demonstrate how stigma and taboo can leave women feeling isolated, powerless, and unable to disclose their condition, alongside effects on body image, sexual desire, identity, and ability to fulfil roles and responsibilities associated with womanhood.

The present synthesis extends this evidence by examining surgery-specific experiences, including how poor outcomes and complications can destabilise women's trust in healthcare. Women frequently placed initial trust in clinicians when making surgical decisions, but this trust was not always reciprocated when they raised concerns or experienced complications. Their concerns were sometimes normalised, attributed to emotional or psychological factors, or dismissed, affecting their ability to access further treatment and support. These findings echo



Treat the whole of me

Consult me: Create a safe space to allow me to disclose my experiences of a potentially stigmatised condition and be heard. Take into consideration my treatment goals and understandings of treatment failure. Move towards aligning patient and clinician goals and understandings of what constitutes a good outcome from surgery or other treatment.

Fully inform me: Appraise me of all the risks and benefits of the full range of treatments and their potential quality of life and functional impacts. Be open about and manage my expectations around post-surgical recovery, so that I can make the right decision for me, and those around me.

Respect me: Listen to and validate my concerns; treat me with kindness, dignity, and compassion; be honest when things don't go to plan.

Trust me: Believe me, learn from my experiences.

Treat the whole of me: The wide ranging functional and quality of life impacts of these conditions require a holistic approach to treatment.

Fig. 2 Visual Synthesis – 'Treat the whole of me'

broader literature on gender bias in healthcare, where women's pain is more likely than men's to be minimised or taken less seriously [50]. Women with chronic conditions such as endometriosis report similar experiences [55], sometimes described as medical gaslighting [56]. Similar concerns informed the Women's Health Strategy for England, which identified dismissal of women's concerns as a persistent problem across health services [52].

Strengths and limitations

This synthesis provides novel insights into surgery-specific experiences of women with POP, SUI, and mesh complications, but several limitations must be acknowledged. The included studies varied in their clinical populations, timing relative to surgery, and qualitative methods. Whilst this diversity enabled the synthesis to capture a broad range of experiences, this variation should be considered when interpreting findings relating to particular clinical groups or stages of the surgical pathway. As outlined in the Methods, detailed study and participant characteristics are provided to support readers in judging the transferability of findings to other populations and settings.

Furthermore, the NIHR brief to inform development of a surgery-specific PROM and PREM led us to synthesise an evidence base with an overrepresentation of mesh complication studies, with many focused on problematic surgical experiences. There is also potential for self-selection bias within the primary studies, as women with particularly difficult or negative experiences may have been more motivated to participate. Consequently, this synthesis may give greater prominence to difficulties associated with surgical treatment. The findings should therefore not be interpreted as representative of all women undergoing POP or SUI surgery, particularly those with uncomplicated or positive surgical outcomes. Whilst women often have good outcomes, and we do not wish to deter them from potentially vital surgery; there is an additional responsibility to give voice to the women who have challenging experiences and learn from those.

The overrepresentation of mesh complication studies also points to a dearth of qualitative research on women's experiences of surgery for POP and SUI, despite quantitative findings reporting positive quality of life outcomes for many women. Further research could provide clearer understanding of what works for women and inform clinical practice.

Another limitation is that most studies were conducted in Western, high-resource settings ($n=15$), meaning that other healthcare and sociocultural contexts are underrepresented. This should be considered when interpreting findings which may be influenced by context, including those related to healthcare access, relationships with clinicians, stigma, and expectations of women.

Finally, the review was limited to three databases and English-language publications, and no systematic grey literature search was undertaken; therefore, some relevant studies may have been missed. In addition, although all titles and abstracts were independently screened by multiple reviewers, only 20% of full texts were double-screened, which may have increased the risk of eligible studies being missed. One further eligible paper [57] was identified post-synthesis and was therefore not included in the review. However, on appraisal, its findings supported our synthesis.

Implications for clinicians, policy makers and researchers

This review found that although surgery for POP and SUI often improves women's health and quality of life, some experience poor outcomes, with new or ongoing symptoms having profound physical, psychological, and social consequences. These findings are particularly salient for women with mesh complications, but are not limited to them, and underline the need for a more holistic and patient-centred approach to surgical care. Drawing on this synthesis, we propose the following recommendations for clinicians, policy makers, and researchers.

Trust was central to women's experiences. Where surgical outcomes were poor, women often described feeling misled, insufficiently informed, let down or regretful about surgery, destabilising their trust in healthcare professionals. This highlights the need to address power imbalances and support women's agency in shared

decision-making. Women must be able to trust clinicians to provide transparent information, realistic expectations of outcomes and recovery, and recommendations made in their best interests. Where uncertainties about treatment efficacy exist, women valued being informed rather than receiving confident recommendations that later prove inaccurate. Equally, clinicians must trust women, validating their accounts and being willing to learn from their experiences. This is particularly important for women with mesh complications, who may live with ongoing fear and anxiety about whether complications will progress, and may also fear re-engagement with healthcare or further revision surgery.

Establishing reciprocity of trust requires an open and approachable manner, sufficient consultation time, and access to clinical nurse specialists who can offer continuity and follow-up support. Clinicians should also ensure informed consent by fully informing women of the range of treatment options, their risks and benefits, and the broad spectrum of potential outcomes.

Women's concerns related not only to the surgery itself but also to its impact on quality of life during recovery. Clinicians should therefore provide clear information about what to expect during recovery in relation to women's treatment goals and consider the availability of social support given its importance to women's ability to follow healthcare advice and optimise recovery. Peer support may also facilitate access to surgery and post-surgical recovery particularly for women experiencing complications. Establishing peer networks could reduce isolation and provide reassurance for women who feel unable to disclose or discuss their condition due to stigma or taboo.

Clinicians should adopt a collaborative model of care that explicitly incorporates women's priorities, surgical goals, and concerns about recovery, recognising how gendered social expectations may shape decision-making. Treatment priorities should be negotiated collaboratively, with a focus on the full spectrum of outcomes that matter to women, including social, relational, and functional domains as well as symptoms.

Finally, at a system level, emphasis should be placed on long-term post-surgical follow-up, integrating PROMs and PREMs into routine care, and fostering open, respectful dialogue. Researchers, meanwhile, should expand qualitative enquiry into surgery for POP and SUI beyond high-income contexts and adverse outcomes to generate a more balanced evidence base.

Implications for a new PROM and PREM

The findings of this review demonstrate the need to rethink what constitutes a 'good' surgical outcome and to foreground the patient's perspective in determining treatment success. This highlights the importance of a user-led health service in which patient-reported outcomes and experiences are central to evaluations of care. PROMs and PREMs are particularly valuable for capturing women's subjective definitions of surgical success, extending beyond symptom relief to include relational, social, and functional domains.

Our synthesis has directly informed the development of the APPRAISE PROM, ensuring that it reflects the wider quality-of-life outcomes prioritised by women before and after surgery. These include social and relational functioning, as represented in the inner rings of our visual synthesis. Stigma and shame emerged as essential constructs. Feelings of embarrassment and shame could both inhibit and facilitate help-seeking, depending on women's circumstances, and were therefore incorporated into a PROM designed for this population.

The APPRAISE PREM was likewise informed by this review, addressing trust, communication, and respectful care in clinical encounters. It captures women's concerns about the transparency of information, realistic treatment expectations, being listened to, and having sufficient time for open dialogue. Together, the PROM and PREM align surgical evaluation and service delivery with women's priorities for both outcomes and experiences of care.

Finally, the review highlights the importance of longer-term post-surgical follow-up, as women described complications that arose or evolved over time. PROMs and PREMs validated for this population, administered pre- and post-surgery, offer a structured way to monitor outcomes and experiences across the care pathway. These measures should be complemented by clear, transparent information and decision-making guides that set

out the full range of benefits, risks and potential quality-of-life impacts. Such resources would support informed decision-making and help prepare women for both the benefits and potential challenges of surgery.

Statement on reflexivity

In line with the eMERGe reporting guidelines for meta-ethnography [21], we reflected on how the review team's experiences and perspectives may have influenced the research process, synthesis, and review outcomes.

The review was undertaken by a multidisciplinary team. The analysis was led by health psychology and public health researchers who are all women (KB, GF, AMB, VF, DM, GJ), some of whom had personal experiences of seeking medical support and not always feeling heard or believed, or having symptoms attributed to psychological factors. Some team members have also experienced medicalised interventions and motherhood, bringing perspectives relevant to findings around healthcare, caring responsibilities and pressures to prioritise others. However, we are younger than the average age of women in the included studies and all based in the UK, limiting our alignment with the experiences of women in low resource settings [35, 37].

We found many women's accounts challenging to read; we could, therefore, barely begin to appreciate how difficult they were to experience. We held in mind that their experiences are potentially on the horizon for any of us, given the prevalence of POP and SUI for older women [51, 58, 59]. All authors place importance on women's choice, autonomy and wellbeing in healthcare, which may have drawn our analytical attention towards challenging experiences. In recognition of this, we actively looked for more positive experiences of healthcare interactions within the analysis.

The team also included four urogynaecologists whose clinical and research expertise informed the review design, search strategy and interpretation of findings. Bringing together our different professional backgrounds and experiences strengthened the review but also required us to reflect on how our assumptions influenced the analysis and presentation of findings.

Conclusions

This review demonstrates that the outcomes of surgery for POP, SUI, and mesh complications can extend well beyond symptom relief: successful outcomes can substantially improve women's quality of life and functioning, whereas poor outcomes and complications can have profound consequences for wellbeing, relationships, and sense of self. It highlights the centrality of trust, communication, and the recognition of women's priorities in surgical decision-making. PROMs and PREMs developed through the APPRAISE project offer a means of embedding these insights into clinical care. To optimise surgical outcomes and experiences, clinicians and policymakers must ensure that women are fully informed, supported, and trusted throughout their surgical journeys.

Abbreviations

APPRAISE	A Patient-reported outcome measure for PRolApse, Incontinence and meSh complication surgery
CASP	Critical Appraisal Skills Programme
eMERGe	Meta-ethnography Reporting Guidance
NHS	UK National Health Service
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health and Care Research
POP	Pelvic organ prolapse
PREM	Patient-reported experience measure
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PROM	Patient-reported outcome measure

QES Qualitative evidence synthesis
SUI Stress Urinary Incontinence

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Authors' contributions CRediT: Conceptualization: GLJ, AMB, KB, GF, SJ, TGG, SKD, SCR; Data curation: KB, GF, VF, AMB, GLJ, DM, TGG, SKD; Formal Analysis: KB, GF, VF, AMB, GLJ; Funding acquisition: GLJ, AMB, TGG, SKD, SJ, SCR; Investigation: KB, GF, VF, AMB, GLJ, DM; Methodology: KB, GF, VF, AMB, GLJ; Project administration: KB, AMB, GLJ, GF; Resources: KB, AMB, GLJ; Software: AMB; Supervision: AMB, GLJ; Validation: AMB, GLJ, TGG, SKD, SCR, SJ; Visualization: GF, KB, GLJ; Writing – original draft: KB, GF, GLJ; Writing – review & editing: GF, GLJ, AMB, KB, VF, DM, TGG, SKD, SCR, SJ. All authors reviewed and approved the final manuscript and agree to be accountable for all aspects of the work.

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Data availability All data generated or analysed during this study are included in this published article and its supplementary information files.

Declarations

Ethics approval and consent to participate Not applicable. This study is a systematic review of qualitative research based exclusively on previously published data. No new human or animal participants were involved; therefore, ethical approval and informed consent were not required. All included studies reported adherence to recognised ethical standards, such as the Declaration of Helsinki, and had obtained informed consent from their participants as stated in their original publications. Data privacy and confidentiality were maintained throughout the process, as no individual-level data were accessed or disclosed. The review protocol was registered in PROSPERO under registration number CRD42023412750, in accordance with best practices for systematic reviews and to ensure transparency and reproducibility.

Consent for publication Not applicable. This study synthesised data from previously published research and did not include any identifiable individual participant data; therefore, consent for publication was not required.

Competing interests The authors declare no competing interests.

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