

Obstetric Fistula is a Preventable and Treatable: Bangladesh Perspectives

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Abstract

A study at community level on some VVF patients was conducted to assess and identify the social risk factors related to obstetric fistula. About 54% of the respondents developed VVF as an outcome of their first pregnancy and none of them had a living child, and 39% fell in the age group 15-20 years. The same study revealed that about 68% were illiterate and 22% had received formal education up to 5 years. 52% of respondents had a family income up to Tk. 1000/ only. Almost all respondents were Muslims (94.7%). 64.6% of respondents had a home delivery assisted by TBA and 72% had a history of prolonged labor. Fifty six percent of respondents did not feel comfortable using the health facilities of the nearby health clinic/hospital because of lack of privacy, objection from husband/family, and because of deliveries were carried out by male doctors. Unsympathetic attitudes of husband and in-laws, expressed willingness of husband for taking another wife, disturbed socio-psycho-sexual life and deterioration of general health were the highlights of morbidity at individual, conjugal and community levels of the respondents. Gender imbalances, traditional beliefs and misconceptions all results in additional risk factors for obstetric fistula in Bangladesh. Low literacy levels, especially among women in rural areas, continue to perpetuate misconceptions and superstition. Women in general are not recognized as equal partners in relationships and marriages and there is still an expectation that women will have children because it is their duty rather than their choice or desire. As a result, women affected by obstetric fistula tend to remain invisible and the silence that surrounds their suffering is an additional burden that increases their difficulties at individual level as well as in their relationships with their partners, husbands, families and communities. Since men are often responsible for decision-making and seeking funds for transport to the hospital, promoting the involvement of men (especially potential fathers) as well as religious and community leaders – is a crucial strategy to widening access to emergency obstetric care. The literature reviewed did not address the issue of involving men from adolescence. However, efforts to sensitize men to reproductive health issues should begin long before they get to the age of marriage, and therefore it is very important to strengthen efforts to reach adolescent boys in order to influence their perceptions and behaviors with regard to reproductive health matters. This is particularly important in order to address potential cultural barriers to responsible and supportive behavior. For example, in many areas of Bangladesh there is still a lingering belief that a woman's unfaithfulness to her husband is responsible for a difficult labor. This misconception often continues to negatively influence men's decision to transport their wives to an emergency obstetric care facility. From the literature review a brief overview of fistula can be sketched and it shows the linkage between the low socio-economic status of women and obstetric fistula.

Key words: Obstetric Fistula, Preventable, Treatable, Risk Factors, Morbidity, Mortality

INTRODUCTION

Although it is known that obstetric fistula (both vesicovaginal and rectovaginal) occurs among women in Bangladesh, not much is known about incidence or prevalence of the same in this country. Bangladesh is a country where 40 percent of its inhabitants live below the poverty line, the age of marriage is 15 years and age at first childbirth is 18.7 years. Contraceptive prevalence rate is 53.8. Most women use contraception after completion of family size. Motherhood has a very important cultural connotation in the lives of young women and early childbirth among adolescent girls is very common in Bangladesh. In addition the status of women is low and this severely hinders their families and their access to reproductive health care. Many research findings have portrayed the links between the educational levels of women and their general awareness of reproductive health services and the impact that this situation has on women's access to reproductive health services. It has been established that higher educational levels are associated with increased use of reproductive health services. Bangladesh also has low level of women's literacy which is an additional factor contributing to low use of reproductive health services. In recent years, in spite of the introduction of ESP services at the grass root level, the low utilization rates indicate that much more needs to be done than just setting up one-stop services.

Risk factors in Bangladesh

In Bangladesh, the practice of allowing village attendants to assist with the delivery is widely accepted in the community. Most village attendants are untrained, and when complications ensue, some attempt is made to seek care at the health center. Utilization of antenatal services is also poor. Most mothers in Bangladesh do not receive antenatal care. Nearly 63% of mothers received no antenatal care during pregnancy. Those who received care tended to receive it from doctors (24%) or nurses, midwives and Family Welfare Visitors (10%).

Regarding delivery care two topics are discussed: place of delivery and type of assistance during delivery. Almost all births in Bangladesh (92%) occur at home. People use health facilities for delivery much more in urban areas. Traditional birth attendants (known dais) assist 64% of births in Bangladesh. Among this group of providers, trained dais assist 10% and untrained dais assist the remaining 54% of deliveries. Relatives and friends assist another 22% of births. Medically trained personnel assist only 12% of births - doctors (7%), while nurses, midwives and Family Welfare Visitors assist 5% of deliveries. It is important to note that 2% of babies born in Bangladesh are delivered by caesarean section². The varieties of conditions under which women are receiving unassisted delivery set the stage for the onset of obstetric fistula and rule out the possibility of enabling early diagnosis of prolonged labor or referral to health centers with trained delivery personnel.

In this context, it is highly likely that the number of women living with obstetric fistula will be high in Bangladesh. Moreover, little is known about the social implications that obstetric fistula affects on the lives of women. To date, very few concerted very few concerted efforts have been undertaken to address the fistula issue. This situation analysis is an attempt to know about the conditions of the patients, assess the service delivery situations and formulate possible recommendations for improving the situation in the future.

Morbidity and Mortality

The Bangladesh national estimate reflects that nearly 8.76 million women have been suffering from chronic morbidities like vesicovaginal fistula, recto vaginal fistula, uterine prolapse, dysparunia, hemorrhoids and associated physical and social disabilities. The highest prevalence of chronic morbidities has been reported in the Chittagong Division. The Table-1 below shows the annual number of chronic morbidities in four divisions.

Table-1: Number of Chronic Morbidities

Division	Estimated annual number of chronic morbidities							Total morbidities
	VVF	Urinary incontinence	Passage of stool	Passage of gas	Uterine prolapse	Dysparunia	Haemorrhoids	
Dhaka	89099	131027	-	251572	482180	267296	246331	1467505
Chittagong	108971	405147	5588	354853	1598235	729265	363235	3565294
Rajshahi	17213	146311	4303	361475	426025	443238	236680	1635245
Khulna	191014	542234	6162	224904	671630	308087	147882	2091913
National	406297	1224719	16053	1192804	3178070	1747886	994128	8759957

Source: A cross-sectional study on maternal morbidity in Bangladesh

Based on the prevalence in the maternal morbidity study, national estimate shows that in Bangladesh over 400,000 women are living with vesicovaginal fistula (VVF). The national estimate also shows that over 1.22 million women are suffering from urinary incontinence. Over 16000 women have recto vaginal fistula (RVF). Over 24% reported that urine always dribbles in drop-by-drop manner. This proportion indicates that among the total respondents although 7.7% were experiencing accidental wetness with urine, nearly 2% had complaints of constant dribbling of urine and 2.3% had experiencing erosion or sore on the medial aspects of thighs due to constant dribbling of urine.

Bangladesh shares many of the contributing risk factors for obstetric fistula that are found in other developing countries where illiteracy rates are high and people's socioeconomic status are low, and there is still inadequate availability of and access to perinatal care especially in remote villages. Urinary fistula remains a major gynecological problem in Bangladesh. The condition is not only a problem for the society, but also a great challenge for the surgeons. Cases from African countries have been well documented in the international literature, but the magnitude of obstetric fistula in other underdeveloped countries is still not well defined. Another study namely 'urinary fistula: A continuing menace in the third world' was conducted at the Dhaka Medical College Hospital (DMCH)¹², the most equipped tertiary care hospital accepting referrals from all over the country. To see the etiologic factors, patient characteristics, types of fistula and outcome of surgery, this cohort study was undertaken.

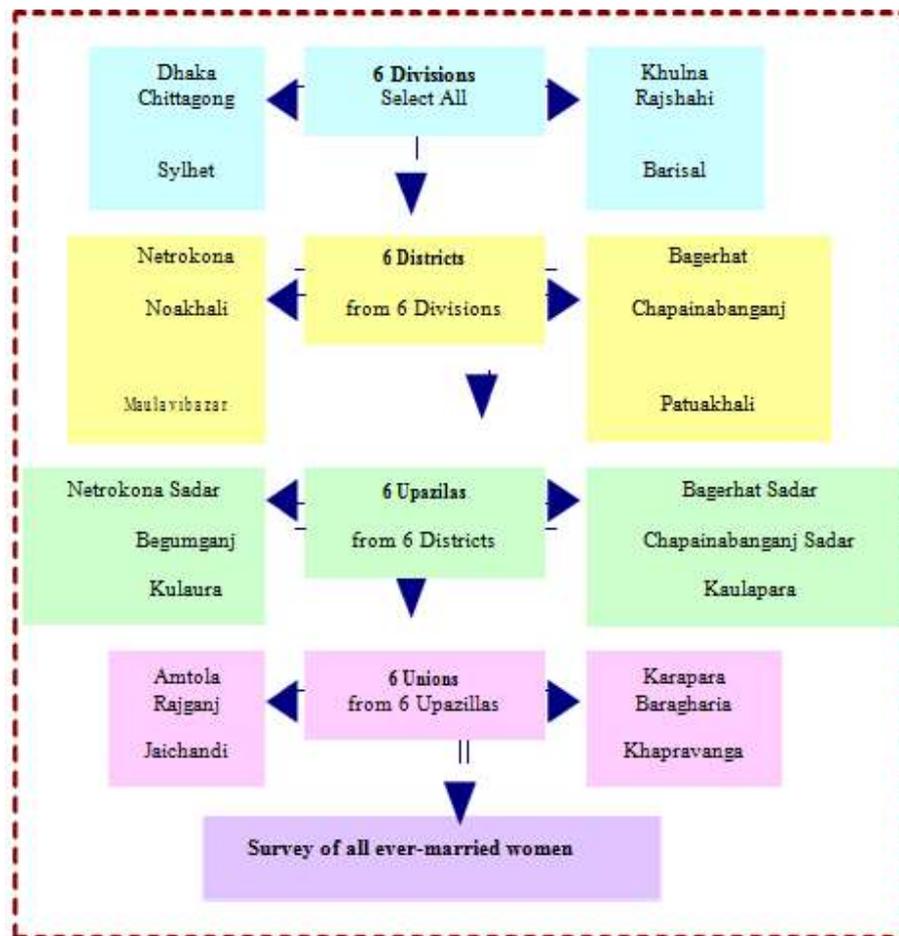
METHODOLOGY OF THE STUDY

Site Sampling

A sample survey was conducted to estimate the number of patients in the community. This activity was carried-out through a multi-stage sampling. One district from each of the six divisions was selected randomly. Then one Upazilla from each of the six districts was selected randomly followed by another random selection of one union from those selected Upazillas. The sampling unit therefore consisted of one union from each Upazilla. Data was collected by interviewing all ever-married women. However, women who never got pregnant and those who were pregnant during data collection were not interviewed. Nonetheless they were counted in the denominator.

Sampling Scheme:

The following diagram is the schematic presentation of the sampling framework:



In-depth interviews

In-depth interviews were conducted with the individual fistula patients (both treated and untreated). In the community, TBAs, RMPs and other community members were also interviewed. The purpose of interviewing the patients, their relatives, TBAs, RMPs and community members was to get information about social, economic and environmental factors that might be responsible for occurrence of fistula and prevent patients from seeking medical care. In-depth interviews with the service providers were conducted at the Medical College Hospitals, district hospitals and Upazilla health complexes. The service providers included the Professors and Heads of the department of Obstetrics and Gynecology of each Medical College Hospital (the professionals responsible for performing the fistula repair surgery) and the Resident Surgeons of the same department. Consultants at the district hospitals and the Resident Medical Officers at the UHCs were also interviewed. Purpose of these interviews was to get their views on service provisions for the fistula patients and validate the social and economic factors responsible for fistula identified at the community level. In-depth interviews were also conducted with the policy makers particularly with the members of the National Fistula Committee, professional bodies like Obstetric and Gynecological Society of Bangladesh, Urological Society and national experts. Purpose of these interviews was to have their suggestions for future directions. A FGD was conducted with the national experts to obtain up to date information about the present fistula situation, existing constraints, areas that need attention for further improvement in fistula management.

Service Delivery Observation

Assessment of the service delivery sites was done using a checklist. The primary purpose of this assessment was to better define the existing capability and gaps for providing fistula repair surgery. The sites included medical college hospitals, district hospitals and Upazilla health complexes. During the facility assessment, records were also reviewed to collect socio-demographic information about fistula patients. In this study, data was collected and systematically recorded from the health centers at all three levels of administrative units for all of the six divisions in Bangladesh.

Data Collection Tools

In total seven tools were used for collecting data. The tools were first developed and then reviewed by the experts. All the tools were then field-tested. Consultants and trained Engender Health staff with medical and social science background collected information through in-depth interviews and FGD. FWAs helped in collecting the survey data and FWVs or MO (MCH-FP/CC) verified the findings. Below is a list of the tools employed:

- In-depth interview questionnaire for the fistula patient: eleven open-ended questions each with some tag questions. There were slight variations between questionnaires for patients who had received treatment and those who had not.
- In-depth interview questionnaire for the relatives/care givers of fistula patient: nine open-ended questions.
- In-depth interview questionnaire for the TBAs/RMPs: five open-ended questions.

- In-depth interview questionnaire for the service providers: 27 open-ended questions divided into different sections.
- Checklist for the facility assessment: A structured checklist with 10 items.
- Checklist for review of records: A separate checklist was used for collection of records of obstetric fistula cases.
- FGD Guideline: A guideline was developed and used for conduction of FGD with the Obstetricians and gynecologists
- The instruments/tools used for this situation analysis are attached as Appendix -1

Steps involved in conducting situation analysis

At the commencement of this study discussions took place with both the Directorate of Health Services and Directorate of Family Planning. Discussions also took place with the policy makers. Interviews of the experts and policy makers were carried out. The selection of experts was based on their involvement in women's health and program management. The protocol and tools were shared with the experts. After getting their comments the protocol and tools were finalized. One FGD was conducted with the members of the Obstetrical and Gynecological Society of Bangladesh. The research team interviewed the professionals, service providers of the Medical College Hospitals and District Hospitals located in the same district. As previously stated, the professionals included the Professor and Head of the departments of Obstetrics and Gynecology, professionals currently performing the obstetric fistula repair and Resident Surgeons (R/S) of Medical College Hospitals. In addition to the interviews of the service providers, the team interviewed the fistula patients admitted to the hospitals. The team also conducted interviews with other members of the clients' family, including husband/partner, mother or mother-in-law, elder sister etc. attending the fistula patient at the Hospital. For providing the repair services of the fistula, facility assessments were conducted at Medical College Hospitals.

At the district level, the research team visited randomly selected six district hospitals for facility assessment, record review and interview of the Consultants working in the Obstetrics and Gynecology Department of the respective District Hospitals. The selected districts were Netokona, Noakhali, Maulavibazar, Chapainabganj, Bagerhat and Potuakhali. At the Upazilla level, the team visited the Upazilla Health Complex and the Maternal and Child Welfare Center (MCWC) for collection of information of fistula patients. The randomly selected six Upazillas were Sadar Upazilla of Netokona, Begumganj Upazilla of Noakhali, Kulaura Upazilla of Maulavibazar, Sadar Upazilla of Chapainabganj, Sadar Upazilla of Bagerhat and Kaulapara Upazilla of Potuakhali. With information about fistula patients, the team went to patients' homes and conducted in-depth interviews of the patients and their relatives. Tools were translated into Bangla for use during home visits. The team also identified and interviewed the Traditional Birth Attendants (TBAs) and Rural Medical Practitioners (RMPs).

Randomly selected unions were Amtola of Netrokona, Rajganj of Noakhali, Jaichandi of Maulavibazar, Baragharia of Chapainabganj, Karapara of Bagerhat and Khapravanga of Potuakhali. The member of the research team visited the Deputy Director (Family planning), Assistant Director (Clinical Contraception) and Medical Officer (Clinical Contraception). After initial briefing the team had an orientation meeting with the FWAs, FWVs and FPIs at the respective Unions. In those occasions representatives from the district administration were present. The purposes of each meeting were to define the condition and how best to identify it, to discuss objectives of the analysis and the process of data collection. All the FWAs of the respective Union were assigned to collect the information of the fistula patients. Identified fistula cases were verified by the FWVs. In some cases, FWVs worked with Medical Officer (MCH-FP or CC) to verify fistula cases.

RESULTS

From the six divisional medical college hospitals data was obtained from records for months of January to December 2002 (see table-2). The table shows that highest number of gynecological admission took place in Chittagong Medical College Hospital (3016) and lowest number of admission took place in Khulna (465) and Barisal (379) Medical College Hospitals in the year 2002. However, the proportion of gynecological surgeries was highest in Chittagong and Khulna followed by Dhaka. The Lowest proportion of surgery took place in Rajshahi and Sylhet Medical Colleges.

Table-2: Number of fistula case admission and surgery in Medical College Hospitals

Name of Medical College Hospitals	Total gyne admission	Major gynecological surgery	VVF cases admitted	% of gyne surgery to admission	% of VVF cases to admission	% of VVF cases to surgery
DMCH	2736	1026	53	37.5	1.93	5.16
CMCH	3016	1220	33	40.45	1.09	2.75
RMCH	2111	480	16	22.73	0.75	3.33
SMCH	2453	507	44	20.66	1.79	8.67
KMCH	1148	465	21	40.5	1.82	4.51
BMCH	1250	379	25	30.32	2.0	6.59

In 2002, the highest number of fistula cases was admitted in Dhaka (53) and the lowest in Rajshahi (16) Medical College. The proportion of fistula cases to total gynecological admission was highest in Barisal followed by Dhaka, Khulna and Sylhet. The lowest proportion of surgery took place in Rajshahi Medical College. Again, the highest proportion of fistula surgery to gynecological surgery took place in Sylhet and the lowest in Chittagong. These figures do not show a consistent pattern and it is difficult to make any generalized conclusions from one-year's worth of data. However, the figures show that medical college hospitals have been providing the services on a quite consistent basis. In the year 2002, a total of 241 fistula cases attended the gynecology outpatient departments of the sample six medical college hospitals. Among them 192 (79.6%) cases were admitted and among the admitted cases 123 (64.1%) were operated (see Figure-1).

Estimation of obstetric fistula cases

In this situation analysis efforts were taken to find out an estimation of obstetric fistula cases in the sample population. The methodology section states, that multistage sampling was done in this survey. The survey was conducted to sample six unions and the respondents were all ever-married women. The following Table-3 shows an estimation of fistula cases within the sampled unions.

Table - 3: Estimated Fistula cases found in the sample Unions

Name of the Union	No. of ever married women	No. of fistula cases	No. of cases 1000 per married women
Rajganj, Noakhali	7017	14	2.00
Bargharia, Chapainababganj	4504	8	1.78
Amtola, Netrokona	3947	9	2.28
Karapara, Bagerhat	6162	9	1.46
Joychandi, Maulavibazar	4364	9	2.06
Kaulapara, Patuakhali	5895	5	0.85
Total	31889	54	10.43

Based on data from Table-3, the total estimated cases of fistula in the sampled union were 1.69 per 1000 ever-married women.

Interviews with the Service Providers

A total of 30 service providers were interviewed using the interview questionnaire. Among them, 15 were from the Medical College Hospitals and 15 were from District Hospitals and Upazilla Health Complexes. Interviews were carried out individually with the service providers. Service providers' perspectives had two dimensions, namely community awareness and responsiveness of the service delivery sites to fistula patients. The service providers noted among other issues, that there was a lack of general awareness among the community members on causes of the problem, its consequences, availability of services, and their costs. Although treatment was available at both district hospitals and medical college hospitals, providers noted that ignorance and poverty were the main reasons for lack of awareness and belief in unsubstantiated information regarding fistula treatment possibilities. Little is known at the community level about the consequences of prolonged labor, early child bearing etc., so there are few who understand how to recognize complications. According to most of the service providers, the poor status of women in Bangladesh society is another major contributing factor to the development of fistula. Lack of cooperation from the husband and in-laws aggravates the situation. One doctor mentioned that in her thirty-five years of practice she had only encountered one husband who had accompanied his wife for treatment of fistula. Others cases she received were either divorced or separated and were brought in by the parental family members.

According to several service providers, "the service delivery system should be more responsive for prevention and management of fistula cases". The doctors at the lowest level (Upazilla and union level) and at the district level should be able to provide early management of fistula cases and know the mechanism of referral and referred the cases to the higher centers. District hospitals should be able to provide treatment for fistula cases; however, several limitations were noted, such as lack of skilled professionals and inadequate and infrequent supplies. Another major constraint was the availability of patient-beds. The postoperative stage of fistula cases is long and average hospital stay of recovering patients is generally more than three weeks. In many referral centers the number of patient-beds is inadequate, so preference is given to the acute cases; the fistula cases get less priority for admission. They are further stigmatized because of the odor of urine that they generally have.

The service providers of two medical college hospitals mentioned that now-a-days there is an increasing number of fistula cases coming to the hospital for the treatment and these fistula cases are non-obstetric in origin. Most of these cases of fistula developed during the operative procedures like abdominal hysterectomy. All the service providers were hopeful that obstetric fistula could be prevented through proper utilization of combined resources. During the interviews the service providers made several recommendations for reducing incidence of obstetric fistula. Those are summarized below:

- There is a need for support from the electronic media to raise awareness on the need for antenatal care, consequences prolonged labor, availability of services for fistula cases.
- Increase access to fistula patients at least down to the district level hospitals. In order to achieve this aim, there is a need to train gynecologists and other doctors at the peripheral levels on fistula management. The essential supplies should be made available adequately and consistently.
- There should be reserve patient-beds for fistula cases at the referral centers.
- In many occasions patients have to pay for medicine and bear other costs. For women with fistula, this can be very expensive. As the fistula patients are mostly poor and socially discriminated, any assistance related to treatment costs in any form would be helpful.
- Fistula patients need rehabilitation; they need psychosocial support and state assistance to go back to their families.
- Incidence of obstetric fistula in Bangladesh could be drastically lowered through interventions that strengthen the capacity of providers in existing services to prevent, detect and provide treatment for fistula. For example, in most cases prolonged/obstructed labor can be detected during ANC. Service providers should be adequately trained to anticipate prolonged/obstructed labor.
- Prolonged labor cases should be referred to higher centers immediately.

Interviews with the Community

A total of 72 persons from the community were interviewed. Among them, 32 were fistula patients. Twenty-seven patients, who were interviewed, had not received treatment and five women had received care. Twenty-five persons, including husbands or relatives of the patients, and 15 TBAs and RMPs were interviewed.

Table- 4: Persons Interviewed in the Community

Persons Interviewed	Number
Patient received treatment	5
Patient not received treatment	27
Husband and relatives	25
TBAs and RMPs	15

Status of fistula patients:

Among the five treated fistula cases two cases received their treatment from India and other three from Bangladesh. The following Table-5 shows the age limit, years living with fistula, number of children and marital status of those fistula cases.

Table-5: Profile of treated fistula cases

ID. No.	Age in year	Years with fistula	No. of children	Marital status
1	40	2	4	With Husband
2	40	1.5	4	With Husband
3	35	16	0	With Husband
4	44	17	0	With Husband
5	37	17	2	Divorced

Among the other 27 fistula cases that did not receive treatment, 13 patients were under the age group 15-30 and 10 were in the age group 31-45 and remaining 4 were more than 45 years old. Monthly income of the families varied from Tk. 1500 to 7000 (US \$26 – \$120). However, for some patients there were no fixed sources of income. In terms of years living with fistula, 12 patients had been living with fistula for more than 10 years, 2 patients for 6-10 years, 8 patients for 2-5 years and 5 patients for less than 1 year. Among those 27 patients, 3 were widows, 5 were divorced, 5 were separated and 14 were staying with their husbands. Among those who were staying with their husbands, one of them was divorced from her first husband because of her fistula. However, she got married to another person before ever receiving treatment. She also had one child with her second husband. Ten fistula patients had no children but the other 17 patients had children ranging from 1 to 6.

Table 5: Age of the respondents

Years	Number
15-30 Years	13
31-45 Years	10
46-60 Years	3
61-75 Years	1

Table 6: Current marital status

Marital Status	Number
With Husband	13
Separated	6
Divorced	5
Widow	3

Interview with the fistula patients:

Table 7: Years of sufferings

Years of sufferings	Number
Less than 1 year	5
2-5 years	8
6-10 years	2
More than 10 years	12

Table 8: Knowledge of the respondents that how fistula can be avoided

Information	Number
Not known	18
Known	6
Not mentioned	3

During the interview process, it was revealed that most women had had prolonged labor during childbirth, and they had not had antenatal care during their pregnancy. Among the slightly educated patients, the knowledge of antenatal care was 100 percent, but service utilization rates were poor due to the dampening effect of mother-in-laws and other relatives. Most women had suffered prolonged labor in the hands of local untrained delivery assistants. Some were even brought to the health centers at the last minute, by which time the damage had already become too severe. One woman had her delivery in the hospital after prolonged labor and developed fistula. She was asked to come back after four months, enough time to allow the tissue to heal before surgery. As her delivery was conducted in the divisional hospital she was put on catheter and extensive damage was avoided. Among those who had already been operated upon, the multiparous women complained of having obstetric fistula symptoms for many years. They were shy of consulting a doctor and only came at this stage when the constant urination was causing them to miss prayers.

Some women did not know that such treatment existed and considered it a curse from God. Another woman, who was awaiting operation, knew of the treatment but did not have money to travel to the Divisional hospital.

In this study it was observed that both young patients and multiparous patients were almost equal in number in the hospitals. One of the reasons could be that for multiparous patients their fistula occurred several years ago, but it took them such long time to overcome barriers to access and treatment. Some of the barriers reported were:

- Shyness to discuss this topic
- Unavailability of funds
- Unavailability of guardian or caregiver
- Distance from the health centers
- Complete ignorance of the illness/treatment possibilities

It was interesting to note that although the health professionals pointed out that there is much neglect and disdain from the husbands and in-laws of the patients, the patients themselves did not admit the same. In most cases, especially among young patients their husbands accompanied them to the health centers and they felt that their husbands were sympathetic to their illness. In some of the cases, the caregivers were the mother or brother of the patient, especially of women who had been suffering for many years. These women complained that they were unable to be useful to their husbands. They felt that they had to accept that their husbands had taken on other women, because as women they had failed in their duties to be sexual partners to them. Even among these patients, none of them mentioned being social outcast or being ill-treated by their husbands. Two possible reasons for this are:

- a) The patients who are seeking treatment in the Division Hospitals are a select group and naturally women's status among them could be higher than other cases.
- b) A possible reason may be that many women are unwilling to mention the social ostracizing they have received because, as shown above, they feel inadequate sexual partners due to their condition and thus do not want to bring additional attention to their situation as this may only increase their feelings of inadequacy and guilt.

Case Study – 1:

Fistula patient: Mrs. S, wife of Mr. H, is about 22 years old, and has been married for 5-6 years. Two years after her marriage she became pregnant. During her pregnancy, she did not receive any antenatal checkups. She was staying at her parent's home. At the time of her delivery, contrary to the doctor's advice to take her to hospital, she was attended by 4-5 TBAs/Dai (in local term they called them 'Dhornee') at home. After three days and three nights, she was transferred to Mohammad Ali Clinic in Baghopara Thana accompanied by one TBA. As there was no opportunity to perform a cesarean section she was taken to one TBA's home and she stayed there for another two days. After that, she was shifted to Bogra Hospital and a dead baby was delivered by cesarean section. After recovery, she found that she had developed incontinence of urine and stool (VVF and RVF, respectively). She was informed about the treatment of her condition from the Mohammad Ali Clinic. Three months after her cesarean section she was operated for her incontinence of stool at Rajshahi Medical College Hospital and she was asked to return after three months. The surgery for RVF was successful. She could not return for her second surgery due to financial constraints. Now after three years she has come to treat the VVF. According to her, 'It's difficult to continue work and do other things. I have to put heavy cloths always. I didn't have any urge of defecation before operation and now I have no urge for micturition. My menstruation has stopped since my pregnancy. White discharge, blisters and itching all are disturbing. I have to continue doing my work and it causes increased dribbling of urine.' 'Nobody wants to stay with me due to the smell of urine. Even my husband sometimes blames me for my condition though we have our good conjugal life. He has feeling for me and so that he is not getting married again even I ask him to do that'. 'We are very poor. Once I had a job, I worked but now nobody is taking me as a maid due to my problems. We have no money. My father has sold his cow for my treatment'. She knows another woman in her village who has been suffering from the condition like her. Mrs. S thought that her urethra had been ruptured somehow by the TBAs during her delivery process. She does not know what measures could prevent her present condition.

Interview with the relatives:

A total of 25 relatives were interviewed in the community. Among them 7 were husbands, 6 were mothers, 4 were mother-in-laws of the patients. Among others there were sisters, sister-in-laws, brother and grandmother. Although the patients mentioned that their husbands had accompanied them to these centers, none was available for the interview at the Medical College Hospitals except in Rajshahi. In fact, very few caregivers were to be spotted. In most cases, a mother or a sister was taking care of the index child, while the patient was awaiting treatment. In one case, the daughter was looking after an elderly mother. Most of the husbands mentioned that their wives have no interest in sexual intercourse. The caregivers spoke about the irresponsible behavior of village unskilled attendants during the delivery of the patient. Even multiparous women, who were in perfect health before, complained of obstetric fistula symptoms during the latest childbirth (their ages being easily over 40). They also spoke of being unaware of the availability of treatment, lack of funds for treatment and lack of caregivers for the patient during this long period of operative and postoperative stages. In the hospitals we encountered no such patients who needed rehabilitation, but the effect of poverty on the lack of access to reproductive health services was quite obvious. So was the effect of poor status of women in the in-laws family.

Case Study – 2:

Husband of a fistula case: Mr. N is a 45 year old school teacher in Barhatta Upazilla, Netrokona. He talked about his wife's fistula. According to him, 'My wife has been suffering from leaking of urine. It has been started since 19 months back during childbirth. Her labor pain persisted for the whole night and she was keeping at home. Time was passing but the baby was not

delivered. Everybody tried his or her best. On the next morning we brought her to Barhatta Upazilla Health Complex. Doctor of the health complex suggested taking her to Mymensingh Medical College Hospital. The baby was delivered in the evening by caesarian section. We first noticed the problems after 14 days when catheter had been removed. She is very much depressed for her problem. Most of relatives and neighbors do not know her problem. But she herself suffers a lot. She wetted her bed every night. It is difficult to wash them in every morning. I feel her unhappiness and misery of life. I don't really know how the problem could be avoided. But now I am trying to arrange money for her treatment. I cannot remember anybody else in the village that has been suffering from such type of problem.

Interview with the TBAs/RMPs:

A total of 15 TBAs/RMPs were interviewed; among them 8 were TBAs and 7 were RMPs. Only one RMP was found at the hospital accompanying the fistula patient. TBAs know of such cases but to no great extent. RMPs were aware of methods to prevent fistula. All of them referred such cases to the nearest hospitals for the treatment.

Case Study – 3:

Traditional Birth Attendants/ Rural Medical Practitioners: Mrs. M N is a 40 year old traditional birth attendant (TBA), and has worked for three years at the village of the Noakhali Sadar Upazilla. She knew that Mrs. S suffered from complications like urine continuously coming through birth canal. She had never before seen someone with this condition. She thought it as a great problem of the patient. Mrs. S cannot do any work. She is separated from her husband. Her Husband and other family members dislike her. She thought that these problems occurred because she met with her husband before 40 days of her childbirth and she did heavy work at that time. If she did not do heavy work or intercourse with her husband she could avoid such type of problems. Mrs. N B is a 36 year old, Rural Medical Practitioner (RMP) and has worked in the Village of Kaulapara Upazilla, Patuakhali. According to her, 'Mothers after complicated delivery may suffer from – perineal tear, uterine prolapses, vaginal bleeding, obstetric fistula etc. I have seen patients who either suffers from dribbling of urine or feces continuously coming out through birth canal. Patients with those problems come to me. I refer them to general Hospital, Patuakhali. No patients come to me after getting treatment of such complicated cases from other places. I know a woman who has been suffering from this problem and her husband has gotten married again. This is a difficult situation for her. I think these complications occur due to obstructed delivery, improper handling during delivery and also during instrumental delivery. To avoid these kinds of problems first thing should be done is to conduct delivery by trained personnel.

Interviews with the National Experts

A focus group discussion (FGD) was held to elicit information on various aspects of obstetric fistula situation in Bangladesh. The participants were prominent members of the Obstetric and Gynecological Society of Bangladesh (OGSB). All the members were of the opinion that obstetric fistula incidence and prevalence was very high in Bangladesh, although exact percentages or figures were not quoted by any. The senior most participant mentioned that the government has been imparting training to the FWAs to become Skilled Birth Attendants (SBA) to assist in delivery. The training has started already and is expected to reach clients at the grass root level. An effective supervisory system is also being launched to monitor the work pattern of the FWAs. One participant was able to correlate with her experience (of fistula) in neighboring Afghanistan where ANC and percentages of deliveries attended by skilled attendants was lower than that in Bangladesh. Her experience was that, compared to Bangladeshi women, the physical build of Afghan women with average height of 5 feet 5 inches contributed greatly to the lower incidence of obstetric fistula in that country. One participant reported one success story of encountering only 5 fistula cases from her area of operation in Manikganj where high utilization of ANC has been carried out by special media awareness, which includes miking. Such local experiences of high success rates of utilization of ANC and screening for prolonged labor as well as low incidence of fistula cases can be replicated all over the country. One participant mentioned that most of the women were from poor socio-economic condition, they were ill treated by their husbands and families' due to this condition. They are even thrown out of the main house to live in the cowshed, and most women have nowhere to go. The main features that were summarized during this session can be mentioned as follows:

- Incidence of fistula is very high in Bangladesh.
- It can be prevented by incorporating the following suggestions:
- Utilize media to sensitize women and her families to use health centers to get ANC during pregnancy, specifically highlighting on the detrimental effects of prolonged labor- "uthan baithak" (courtyard meeting in the villages) can be one form of creating mass awareness.
- Training of gynecological doctors who can perform this operation and seek assistance of urologists in handling certain cases.
- Ensure posting of such doctors in each Medical College Hospitals.
- Have separate and special fistula beds in each medical college hospitals and increase OT rooms in those hospitals.
- Strengthen ANC screening for high-risk pregnancies and implement worthwhile referral system all over Bangladesh.
- Impart training to untrained birth attendants in villages and sensitize them on ill effects of prolonged labor, especially fistula.
- Include curriculum on fistula surgery in the postgraduate training courses in Bangladesh.

Moreover, in the long run, the following aspects should be improved upon:

- Women's literacy rate in the country.
- Scope for women's employment.
- Steps to rehabilitate women with obstetric fistula in the society by giving them vocational training.
- Implementation of minimum legal age for marriage

Interviews with Policy Makers

A discussion session was held with Prof. Dr. Mizanur Rahman, Director General, Directorate General of Health Services regarding the different aspects and issues related to obstetric fistula. He firstly mentioned that the health system MIS do not capture the incidences of fistula cases and as such he does not have a clear picture of the situation with this morbidity. But he knows that all those women having obstetric fistula are kind out casted in the community, their treatment takes a long period of hospitalization and as such do not get proper care in the appropriate places. People are not aware about the reasons of having obstetric fistula and also do not know where to go for getting it treated. Prof. A. B. Bhuiyan, President of OGSB a senior professional in the country and linked with policymaking was interviewed. He stressed on the issue of safe delivery and mentioned that when the country will have trained Safe Birth Attendants everywhere then the incidence of obstetric fistula will definitely go down. Prof. Bhuiyan talked about the training of the Ob/Gyn. and Urologists in sufficient numbers to have the fistula repair services at least available at the District Hospitals.

Private sector activities

The private sector health service delivery system in Bangladesh is quite large and being used by common people. In this situation analysis attempt was made to find out the availability of service delivery facilities for obstetric fistula in the private sector. Accordingly some private facilities in Dhaka were visited. The findings from the private sector are given below as case studies.

Case Study – 4: Private Clinic

A small group of devoted senior health professionals that includes gynecologists, anesthetists, and urologists, along with mid level professionals have been working for quite some time to reduce misery of fistula cases by offering their service free of cost. This group started long time ago. Now, they provide service to fistula cases at the Dr. Muttalib Community Hospital, Bijoyagar, Dhaka. This is a private hospital providing community health services. Professor Anowara Begum has been leading the group. One of the barriers to accessing fistula service is lack of information about availability of services to the patients. The group was pro-active in taking action. They informed the gynecology practitioners at the district level that they offer services free of charge for fistula repair. The group requested the practitioners to refer the fistula patients to them. Several practitioners have sent patients to them. During interviews with the initiators it was revealed that even free medical services are not enough to avail services for many patients. Because there are other costs involved: e.g. the cost for medicine, transportation, food and accommodation, etc. The hospital authority also has come forward to provide assistance to the fistula patients. The hospital charges 50% for patient bed and operation theatre charges. It is known that the majority of fistula patients are the poorest of the poor. In spite of free medical service and 50% hospital charges many patients cannot afford the remaining cost. The group leader has come forward to help those patients from her personal account.

Udayan Clinic at Magbazar, Dhaka is another private sector facility, which provides reconstruction surgery of fistula. There is a group of professionals comprised of gynecologist, urologist, anesthesiologist and other general surgeons working at this clinic. Prof. Sayeba Akhter, Head of the OB/Gyn Department of Dhaka Medical College Hospital is the lead person performing the fistula repairs in this group. The Clinic authority has spared few beds free for the fistula patients and Prof. Akhter provides the reconstruction surgery in most of the cases without any fees. During an interview with the senior members of both the private facilities it was mentioned that addressing obstetric fistula requires both preventive and curative measures. The target people who need the services are unaware of the causes of fistula, and are not informed about the availability of services and cannot afford the direct and other indirect costs of the services. There is a need to expand fistula services both at the central and district levels. They added that even if the patients hear about availability of service centers in Dhaka, often it is difficult for them to come and avail the services. It is necessary to have at least one center of excellence, where professionals can be trained and patients can receive services. They also commented that private sector involvement is essential for increased access to fistula services.

DISCUSSION

The situation analysis for obstetric fistula conducted in Bangladesh is a groundbreaking initiative and has never been attempted before in this country. The findings from the study indicate that fistula affects women on a national scale and the preventive measures are crucial in order to effectively address the issue. Observations made during the study concern patients, service providers and policy makers and should be considered when programming for the prevention and treatment of obstetric fistula. Based on evidence gathered during the study, it is clear that a significant number of women are living with fistula and are not aware of treatment possibilities that could change their life. The study sample indicates that the prevalence of obstetric fistula in Bangladesh is almost 1.69 per 1000 ever-married women. This figure is based on the sample studied and May not represent the actual prevalence, and therefore additional research is needed to accurately assess prevalence. Nevertheless, this assessment has shown that there are many and compounding contributing risk factors for obstetric fistula in Bangladesh.

The service providers, the patients and the community corroborated the basic reasons for high prevalence of fistula in Bangladesh. Of special mention is the fact that utilization of health services for antenatal care is very low in Bangladesh and that currently most ANC providers do not have the necessary awareness and skills to address this issues with their clients. As a result, patients have little awareness of how to prevent fistula and have very limited understanding of potential labor complications and emergencies, leaving them confused about the origins of obstetric fistula and its associated issues. They are generally oblivious to the fact that prolonged obstructed labor is the cause of their condition. Additionally, the untrained birth attendants are unaware of the genesis of the condition, and are unable to identify potential high-risk cases that would require delivery in a facility. This demonstrates a very critical gap in the practice of safe delivery in Bangladesh: obstetric fistula could be avoided by early screening of high-risk cases, when women seek ANC during pregnancy.

The study team observed a shortage of health facilities with the capacity to provide treatment for obstetric fistula. Additionally, most facilities did not have reserved recovery beds/wards for obstetric fistula patients. Because recovery from fistula is substantially longer than for other obstetric surgeries, it could substantially help for women who have lived with the same condition and undergone the same treatment to recover together. Other studies have shown that fistula patients tend to get

psychological support from one another when they can share these experiences; support, which can help in the transition from living with fistula, to being dry.

Many of the women interviewed were alone, having been abandoned by their husbands and ostracized by their families, and unable to maintain a decent standard of living. Some were even forced to live in cowsheds. Many were thought to be afflicted with a curse, their condition misunderstood. However, others knew to look for treatment possibilities. Interviews with these clients revealed harrowing tales of physical and mental torture endured after the onset of the condition. Some patients suffer for most of their adults' life before discovering the opportunity to receive care, due to their inability to locate health facilities that could provide repair services. The cost of the procedure also proved to be a financial burden, however one well worth it in exchange for their dignity re-established.

RECOMMENDATIONS

Service providers noted that poor ANC and non-utilization of existing delivery services are the main reasons for which there is a fairly high incidence of obstetric fistula in Bangladesh. According to them, prevention is the key: increased utilization of ANC; community awareness rising (using a variety of media channels) of the detrimental effects of prolonged obstructed labor; and seeking trained assistance at the onset of labor.

At the facility level, beds and/or wards allocated specifically to fistula patients are essential to recovery, because they generally have longer recuperating periods and for this reasons other gynecological patients take priority. Establishment of separate fistula ward is essential.

Upon receipt of treatment many of the obstetric fistula patients need to be rehabilitated in the society. This may be done through the Ministry of Social Welfare or Women and Children Affairs Ministry and should form an important part of long term planning. Need for rehabilitation services include psychosocial support, if abandoned then livelihood and integration into the society. The issue of rehabilitation is something, which cannot be only dealt by the government; the private sector including the NGOs will have to get involved.

Wide scale awareness on obstetric fistula is needed and for this both the media and health personnel will have to work hand in hand. Awareness-raising activities must also be targeted at reaching men of reproductive age, married and unmarried, as often men can prevent their female partners from accessing health care because of cost issues and/or because of lack of understanding of and misconceptions about the causes of obstetric fistula. Utilization of ANC services to screen high-risk pregnancies shall have to be stressed as the first step to avoid prolonged labor and then developing obstetric fistula. There are examples of private enterprises in Bangladesh where improved ANC awareness and high utilization of health care facilities during childbirth has brought down the obstetric fistula rates to a bare minimum.

Due to a lack of trained personnel capable of performing repair surgery for fistula, service providers expressed the need for technical training to acquire the skills for this specific type of surgery. Because experience in repair is the key to high successful closure of the fistula, it is essential that providers be able to use the skills they have learned in those facilities that have the highest caseloads of fistula clients. Treatment possibilities for simple fistula should also be available in the district hospitals, which would eliminate the need for expensive travel to outstations. The Medical College Hospitals could then focus on the most complicated cases. In such a case, a very effective referral system would be essential.

The government of Bangladesh has already initiated the training of existing FWAs and other female health workers on safe delivery. This training, which is meant to be for assisting childbirth, will be able to cover a higher proportion of the population than what is being currently covered. Early identification of the risk cases, coupled with effective referral and most importantly compliance of patients may be the ways of bringing down the prevalence rates of obstetric fistula in Bangladesh.

This study shows that when appropriate care and support is available women living with fistula can resume a dignified and productive life. However, even when services are available, cost remains a major barrier that most women and their families cannot overcome, as in general the poorest of the poor tend to be affected by this condition. Introduction of schemes for financial support for obstetric fistula patients seeking treatment is therefore recommended.

It is important to stress once again that obstetric fistula is totally preventable even in resource-constrained settings like Bangladesh through cost-effective strategies such as strengthening the capacity of ANC providers to educate clients about the risks of prolonged and obstructed labor. Concurrently, TBAs and other community health workers can be utilized to educate the community about the risk factors contributing to obstetric fistula, with particular emphasis on reaching men and in-laws and sensitize them on their roles and responsibilities in preventing this condition. The prevention-to-care continuum for obstetric fistula also requires urgent action to build treatment capacity in Bangladesh through training of gynecologist and surgeons at peripheral levels to provide surgery and to strengthen referral system. A center for excellence for obstetric fistula repair surgery should also be established by ensuring that this type of training is institutionalized in post-graduate training in Bangladesh. Finally, these strategies will not achieve their desired aims unless concurrent efforts continue to be made to improve the status of women in society and reduce poverty and illiteracy among women.

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