

**SITUATION ANALYSIS OF OBSTETRIC FISTULA
IN BANGLADESH**

REPORT

September 2003

**EngenderHealth
Bangladesh Country Office**

SITUATION ANALYSIS OF OBSTETRIC FISTULA IN BANGLADESH

REPORT

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TABLE OF CONTENTS

| | |
|---|-----|
| Foreword | iv |
| Acknowledgment | v |
| List of Acronyms | vi |
| Executive Summary | vii |
| Introduction | 1 |
| Literature Review | 2 |
| Objectives | 8 |
| Methodology | 8 |
| Steps Involved in Conducting of the Situation Analysis | 10 |
| Findings | 11 |
| Discussion | 22 |
| Recommendations | 23 |
| References | 25 |
| Appendix | |
| Data Collection Tools | |
| Flow Chart on Action Steps | |
| List of the People Interviewed for the Analysis | |

FOREWORD

Every year a large number of women in our country are experiencing life threatening, high risk, chronic or other serious health problems due to pregnancy and childbirth. Obstetric fistula is one of the most devastating morbidity of pregnancy. Poor and young women are mostly affected and there is an immense lack of information on access to surgical repair. The demand of reconstruction surgery is far greater than the capacity of existing facilities specifically in terms of skilled manpower.

In Western countries, the obstetric fistula are nowadays rarely seen as a maternal morbidity rather as a complication of pelvic surgery or radiotherapy. Fistula is a preventable condition and for this reason many developed and developing countries have been successful in fighting against fistula even in low resource setting situations.

Very few studies have been conducted addressing the maternal morbidity in detail. Reliable source of data are totally not available particularly on obstetric fistula in Bangladesh. To address the need for information, UNFPA, supported EngenderHealth to conduct ‘The Situation Analysis of Obstetric Fistula in Bangladesh’. It was conducted during July – September 2003. The findings show us the overall picture of the obstetric fistula. I am thankful to UNFPA and EngenderHealth for conducting this situation analysis.

Every fistula patient has the right to live with dignity. It is my hope that UNFPA will continue its collaborative support to our country and day will come when there will be no fistula patients in our country.

Prof. Dr. Md. Mizanur Rahman
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ACKNOWLEDGMENTS

This exercise of carrying out the ‘Situation Analysis of Obstetric Fistula in Bangladesh’ is the result of collaboration between UNFPA Bangladesh, EngenderHealth and a number of health professionals who are expert in their respective fields. This situation analysis was carried out with financial contributions from UNFPA. In carrying out the analysis EngenderHealth has taken assistance and guidance from different government senior officials, service providers and policy makers. We would like to extend our gratitude to Prof. Dr. Md. Mizanur Rahman, Director General, Directorate General of Health Services, Prof. A. B. Bhuiyan, President of OGSB, Mrs. Tahera Ahmed, Assistant Representative, UNFPA Bangladesh, Prof. A. Z. M. Zahid Hossain, Urologist, and Prof. Sayeba Akhter, Head of Ob./Gyn Deptt., Dhaka Medical College.

We would like to acknowledge the contributions of the organizations involved in this situation analysis namely the Obstetric and Gynecology departments of the six Medical College Hospitals located in the divisional headquarters, district hospitals of Netrokona, Noakhali, Chapainwabganj, Maulavibazar, Bagerhat and Patuakhali, different Upazilla Health Complexes and two private clinics namely Dr. Muttalib Community Hospital and Udayan Clinic. Staff members of the Directorate of Family Planning at the different levels starting from the national headquarter down to the field workers needs special mention here that directly helped in identifying patients and undertakes the fieldwork. Our heartfelt gratitude and thanks to all of them.

We would like to extend our appreciation to the adviser and consultants who worked directly in developing this report. EngenderHealth is also indebted to the many individuals who contributed to this report. In addition, we are deeply grateful to EngenderHealth’s Regional Office and Headquarters who gave time and effort to the project particularly in designing and then reviewing the report.

Finally, we would like to express our deep gratitude to the many women with fistula, their relatives and TBAs/RMPs who shared their experiences with us. We dedicate this report to the fistula patients of Bangladesh.

LIST OF ACRONYMS

| | |
|-------------|---|
| AMDD | Averting Maternal Death and Disability |
| ANC | Antenatal Care |
| CMCH | Chittagong Medical College Hospital |
| BBC | British Broadcasting Corporation |
| BDHS | Bangladesh Demographic and Health Survey |
| CPR | Contraceptive Prevalence Rate |
| DMCH | Dhaka Medical College Hospital |
| DFID | Department for International Development |
| DGHS | Directorate General of Health Services |
| DHS | Demographic and Health Survey |
| ELCO | Eligible Couple |
| ESP | Essential Services Package |
| FIGO | International Federation of Obstetric and Gynecology |
| FGD | Focus Group Discussion |
| FWA | Family Welfare Assistant |
| FWV | Family Welfare Visitor |
| FPI | Family Planning Inspector |
| HIV | Human Immunodeficiency Virus |
| KMCH | Khulna Medical College Hospital |
| MCH | Maternal and Child Health |
| MCWC | Maternal and Child Welfare Center |
| MMR | Maternal Mortality Ratio |
| MOH | Ministry of Health |
| MO (MCH-FP) | Medical Officer (Maternal Child Health-Family Planning) |
| MO (CC) | Medical Officer (Clinical Contraceptive) |
| MTCT | Mother To Child Transmission |
| NGO | Non-Government Organization |
| OB/GYN | Obstetric/Gynecology |
| OGSB | Obstetric and Gynecological Society of Bangladesh |
| OPD | Out Patient Department |
| OT | Operation Theatre |
| RVF | Rectovaginal Fistula |
| RMP | Rural Medical Practitioner |
| RMCH | Rajshahi Medical College Hospital |
| BMCH | Barisal Medical College Hospital |
| SMCH | Sylhet Medical College Hospital |
| STI | Sexually Transmitted Infection |
| TBA | Traditional Birth Attendant |
| UNAIDS | Joint United Nations Program on HIV/AIDS |
| UNDP | United Nations Development Program |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| VVF | Vesicovaginal Fistula |
| VCT | Voluntary Counseling and Testing |
| WHO | World Health Organization |

EXECUTIVE SUMMARY

Each and every pregnancy is a risk and life threatening condition for a woman. In the under developed countries like ours obstetric fistula is one of the devastating pregnancy-related morbidity. While the proximate causes of fistulas are physical injuries, the larger causes are social i.e poverty, lack of education, childbearing at too early age and lack of medical care. In many rural areas, girls are married off just after they experience their first menstrual flow-between 10 and 15 years of age. These girls become pregnant which leads to many unwanted conditions including mortality and long term morbidity like obstetric fistula. Medical facilities are not trusted, or may be used only as a desperate last resort when damage is already far advanced.

Fistula usually occurs when a woman is in obstructed labor for days on end without medical help and cannot get a Caesarean section. The blood supply to the soft tissues surrounding mother's bladder, rectum and vagina is cuts off due to the prolonged pressure of the baby's head against the mother's pelvis. The injured tissue soon rots away, leaving a hole, or fistula. If the hole is between the woman's vagina and bladder, she loses control over her urination, and if it is between her vagina and rectum, she loses control of her bowels. Reconstructive surgery can mend this injury.

This report on "Situation Analysis of Obstetric Fistula in Bangladesh" is the first attempt to find out the obstetric fistula situation in Bangladesh was undertaken by UNFPA (United Nations Population Fund) and EngenderHealth. This report finds that the number of women living with fistula is estimated to be 1.69 per 1000 ever married women. This number is not a meager figure. However there is a need of a comprehensive study to find out the actual prevalence of obstetric fistula in Bangladesh.

The report shows that many fistula sufferers are abandoned by their husbands, forced out of their homes, ostracized by family and friends and even disdained by health workers, who consider them 'unclean'. Without skills to earn a living, some have no choice but to beg to survive. They are so ashamed that they even do not like to share their experiences with others. However, they could not hide the smell. Women living with fistula in Bangladesh are usually in the age group of 15-30 years, illiterate, poor and unaware that treatment is available, or cannot access or afford it according to the findings of this report.

The report assessed the capacity to treat the fistula patients of 12 hospitals i.e six Medical College Hospitals and six District Hospitals and outlines their needs for equipment, surgical supplies and skilled professionals. All of the six Medical College Hospitals have one or two trained professionals but all the six District Hospitals have no trained professionals. The District Hospitals refer the fistula cases to Medical College Hospitals. The report highlights the need to train more local doctors in fistula reconstruction surgery and recommends a specialized training center in the country.

Fistula is a preventable and treatable condition. Awareness raising program through media and other means would much help in prevention. Moreover treated fistula cases need to be rehabilitated. Rehabilitation could be done through psychological counseling to repair emotional damage, vocational training to develop skills to maintain living wage and social support. Through a concerted effort which includes prevention and treatment the issue obstetric fistula in Bangladesh can easily be addressed.

1. INTRODUCTION

In Europe and North America, obstetric fistula existed 100 years ago, and has virtually disappeared, and it is usually a side effect of surgical treatment with radium and deep x-ray for malignancy in the pelvic region. Sadly, obstetric fistula remains a devastating pregnancy related disability in many resource-constrained settings and affects estimated 50,000-100,000 women each year globally¹. Obstetric fistula is a preventable and treatable condition, so no woman should suffer from this misery. Direct causes of fistula include premature child bearing, limited access to obstetric care and malnutrition. Some of the indirect causes, such as poverty, women's status in the society, and lack of education, prevent women from accessing services that could prevent the onset of such conditions. Prevalence is highest in impoverished communities in Africa and Asia.

2. OBSTETRIC FISTULA IN BANGLADESH

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 53.8². 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 services³. 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.

3. 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%)².

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.

4. LITERATURE REVIEW

4.1 Morbidity and Mortality

Reliable data on obstetric fistula are scarce⁴. The full extent of the problem has never been mapped. To address this need for information, UNFPA, the United Nations Population Fund, partnered with EngenderHealth to conduct a groundbreaking study on the incidence of fistula in sub-Saharan Africa and the capacity of hospitals to treat patients. A team of researchers traveled to nine countries over a period of six months to visit public and private sector hospitals that provide fistula surgery and to interview doctors, nurses, midwives and patients. Over 35 facilities in Benin, Chad, Malawi, Mali, Mozambique, Niger, Nigeria, Uganda and Zambia were visited during this rapid assessment process. The team also met with government officials and U.N. representatives. Results from this nine-country study will lay the groundwork for future action to prevent and treat fistula in the region.

In the countries in which facility-based assessments were conducted, it was learned that many of those who suffer from fistula are under 20 (some as young as 13); they are also often illiterate and poor. Many have been abandoned by their husbands or partners, forced out of their homes, ostracized by family and friends and even disdained by health workers. Rarely do they have the skills to earn a living and some may turn to commercial sex work to procure an income for themselves, further heightening their social and physical vulnerability. Despite these hardships, the women interviewed showed another common trait: tremendous courage and resilience.

The World Health Organization estimates that over two million women are currently living with obstetric fistula. Estimates are based on the number of people who seek treatment in hospitals and clinics and therefore it is reasonable to assume that they provide a very incomplete picture of the real situation, as many women never seek care⁵.

Farhang Tahzib⁶ conducted a study on epidemiological determinants of vesicovaginal fistula on a series of 1443 cases between 1969 and 1980 in Northern Nigeria. Until now this is the largest series of such cases which uncovers a vivid picture of social morbidity of women in Northern Nigeria, pertaining to socio-economic conditions and values of traditional mores of the community concerned.

Thornton⁷ in 1986 published a series of 14 fistula cases of obstetric origin. He mainly reported on the possibility of undertaking repair of VVF cases at district and sub-district hospitals by relatively inexperienced doctors in a small hospital. A hospital-based survey at Mymensingh Medical College Hospital shows that a total of 108 cases of genito-uro-rectal fistula were admitted during the period 1985 – 1987.

Professor Edwin M Robertson⁸ of Queen’s University of Ontario said ‘Urinary incontinence in women is one of the most frightful afflictions of human kind. Hour by hour and night by day a leakage wets, excoriates and hurts the victim of this misfortune; clothes are ruined; the bed becomes a nightmare; social intercourse is stopped; a pariah is made; the family houses an outcast’. Genital fistula is a dreadful obstetric complication of labor. Women, who contract the condition, lose her self esteem and become a social outcast. High incidence of the condition has been reported from Nigeria in early eighties. Most of those cases were of obstetric origin. Although similar high prevalence has also been reported from United States, but pelvic surgery was the principal causative lesion in such developed situation.

The extent of maternal morbidity as a health problem is often expressed in terms of numbers of morbid events to every death. Until recently, the number of 16.5 morbidities for every death was the accepted figure to quantify maternal morbidity. This estimate was based on a small study in India⁹. More recent estimates suggest that this figure is far too low and that there may be as many as 100 morbidities for every pregnancy related death¹⁰. This would mean that more than 61.8 million women suffer significant ill health annually as a result of childbearing.

Annual Estimation of Chronic Morbidity among Women in the Country¹¹: 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 urine¹¹.

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.

However, these difficulties should not further delay addressing this serious health problem, especially in consideration of the fact that most fistulas can be repaired surgically, even if they are several years old. Although the cost ranges from \$100–\$400 USD, and this amount is far beyond what most patients can afford, it must be stressed that, if done properly, the success rate for surgical repair is as high as 90 per cent and women can usually continue to bear children. Attentive post-operative care, for a minimum of 10-14 days, is critical to prevent infection, catheter blockage and breakdown of the repair site while the surgery heals. Education and counseling are also needed to help restore the woman's self-esteem and allow her to reintegrate into her community once she is healed.

4.2 Preventing Obstetric Fistula

Prevention of fistula has two main foci - the prevention of early pregnancy and improving access to essential obstetric and basic health care services¹³. Both issues are directly linked to poverty. Although large-scale poverty reduction activities are clearly outside the scope of this initiative, it is important to recognize that health interventions, whenever possible, should be supported and complemented through poverty reduction activities as well as policy action to address the problem of early marriage and childbearing. A primary health intervention should address the lack of access to timely obstetric care. This will require addressing each of the classic delays: the delay in the decision to seek medical care, the delay in reaching a health care facility and delay in receiving care at the health care facility.

The delay in seeking medical care often arises from the lack of trained birth attendants who can recognize impending complications. In many unattended births, women and their families do not recognize life-threatening complications early enough to access treatment. Another cause of this initial delay may be the fear of high costs associated with seeking medical treatment.

The delay in reaching a health facility involves transport: treacherous roads, long journeys and/or the expense or unavailability of transportation.

The delay in getting care at the facility is the most critical one and should be addressed as a matter of priority. It requires ready access to surgical supplies, adequately trained personnel and operating theatres. In many cases, it may mean expediting or waiving the hospitals' fee requirements.

Strategies to address fistula must aim to address the prevention to care continuum, thus including preventative methods (postponing marriage and pregnancy for young girls and increasing access to education and family planning services for women and men, and providing access to quality medical care for all pregnant women to avoid complications), and curative methods (repairing physical damage through surgical intervention); and rehabilitative methods (repairing emotional damage through counseling, social rehabilitation and vocational training).

Fistula prevention requires good management of labor with a partograph, early diagnosis of prolonged and obstructed labor and timely referral to an obstetric care facility. At facilities, prompt surgery should be available. The waiver of hospital user fees for maternity care can facilitate this.

4.3 Gender, culture and poverty

A study at community level on 132 VVF patients was conducted to assess and identify the social risk factors related to obstetric fistula¹⁴. 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.

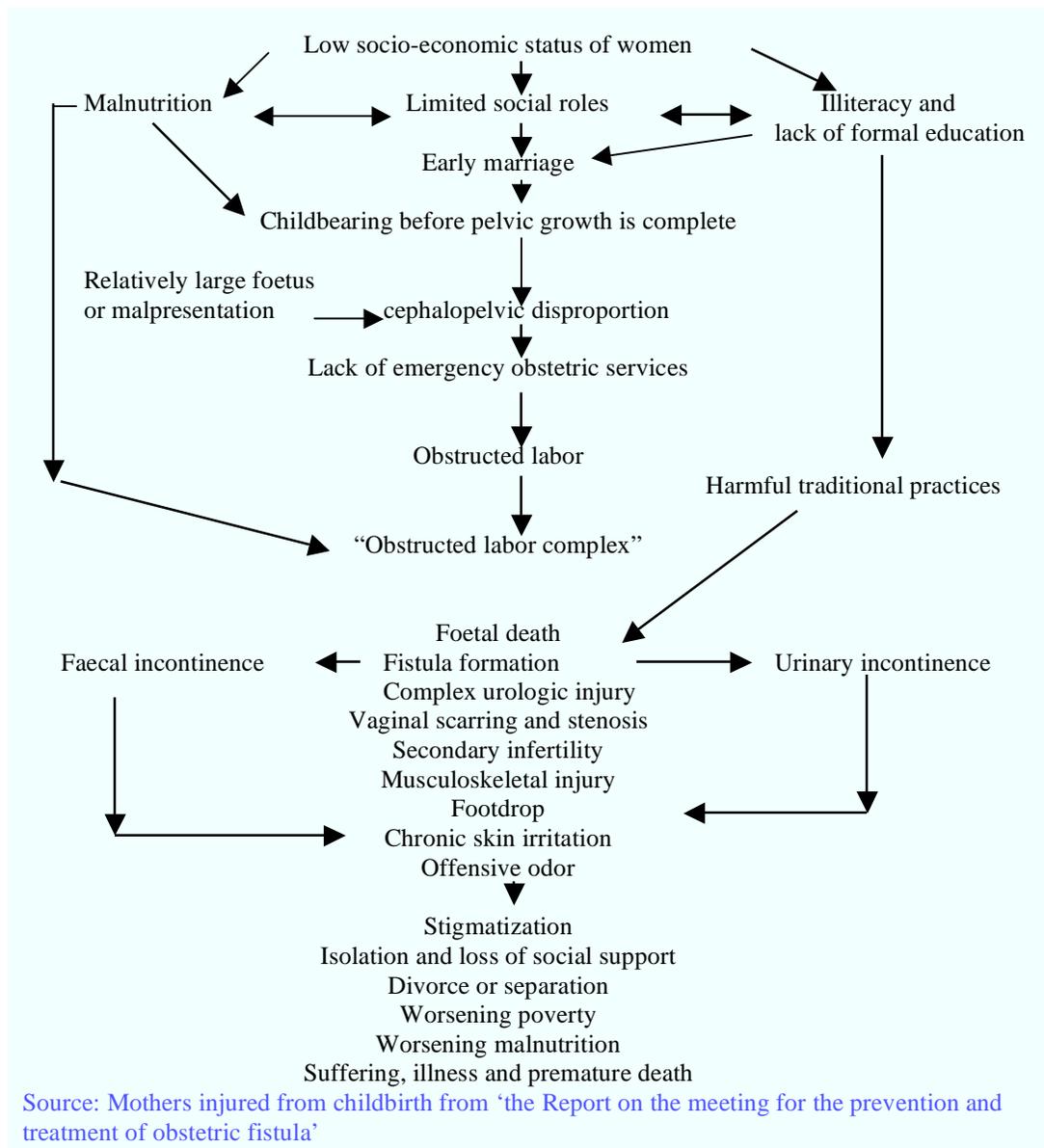
Gender imbalances, traditional beliefs and misconceptions all results in additional risk factors for obstetric fistula in Bangladesh. Low literacy levels, especially among women in rural areas, continue to perpetuate misconceptions and superstition. Women in general are not recognized as equal partners 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:

A Brief Overview of Fistula



4.4 The need for multi-level advocacy

Advocacy is a core component in addressing fistula. On a global scale, advocacy should aim to raise general public awareness on the issue and target the medical community in particular. UNFPA, FIGO and AMDD are uniquely positioned to promote the training of surgeons and nurses to work in this area and for mobilizing funding for fistula surgery. They can also build awareness of the problem and work in close collaboration with other relevant reproductive health organizations.

Although media coverage has succeeded in bringing attention and funding to the issue of fistula in the past, the goal now should be to produce concrete programs and activities, not simply media events. Through judicious and appropriate use of the media, this initiative can effectively advocate for fistula funds and programs with the ultimate goal of improving access to services.

Audio-visual materials that help understand the human and social costs of fistula will help attract donors from outside the medical community. Though this is a very sensitive topic, care must be taken not to portray women with fistula as victims but as human being whose dignity should be respected.

UNFPA has already created a Video News Release and will produce an advocacy video for journalists that will be available in several formats. There are also two useful videos about fistula available through the BBC. Media advocacy will include bringing reporters and donor country journalists to the field. This will help to bring attention to the issue in the print media and radio as well¹³.

At the government level, advocacy should focus on influencing policies that address the issue of minimum legal age at marriage and access to maternity care, as well as direct support for fistula repair centers.

Community level advocacy is important and should be conducted through both large-scale communication campaigns for behavior change and community-based education programs led by health care workers and former patients. Such efforts should involve community leaders, young men, religious leaders and older women, especially mother-in-laws. Communication and advocacy programs should focus on making sure that the community understands the dangers of prolonged and obstructed labor, and educate people in the community to undertake and support appropriate preventive and treatment strategies. Advocacy activities should be supported through additional strategies such as organizing community-funding schemes to cover the cost of hospital transport.

5. OBJECTIVES

The Situation Analysis of Obstetric Fistula in Bangladesh was conducted over a period of six weeks with the overall aim of providing an overview of the situation. This study was undertaken in order to achieve the following specific objectives:

- To identify individual, familial and socio-economic issues or conditions that increase probability of obstetric fistula.
- To identify the challenges in providing care, including rehabilitation for women and girls with fistula.
- To present an account of the services currently available for treating obstetric fistula.
- To provide an estimate of women suffering from obstetric fistula in Bangladesh.

6. METHODOLOGY

The information was collected through the following methods:

- In-depth interviews with key informants
- Observation of service delivery systems of different types of health facilities
- Rapid survey for an estimation of fistula cases in a given population.

6.1 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 Obstetric 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.

6.2 Service Delivery Observation:

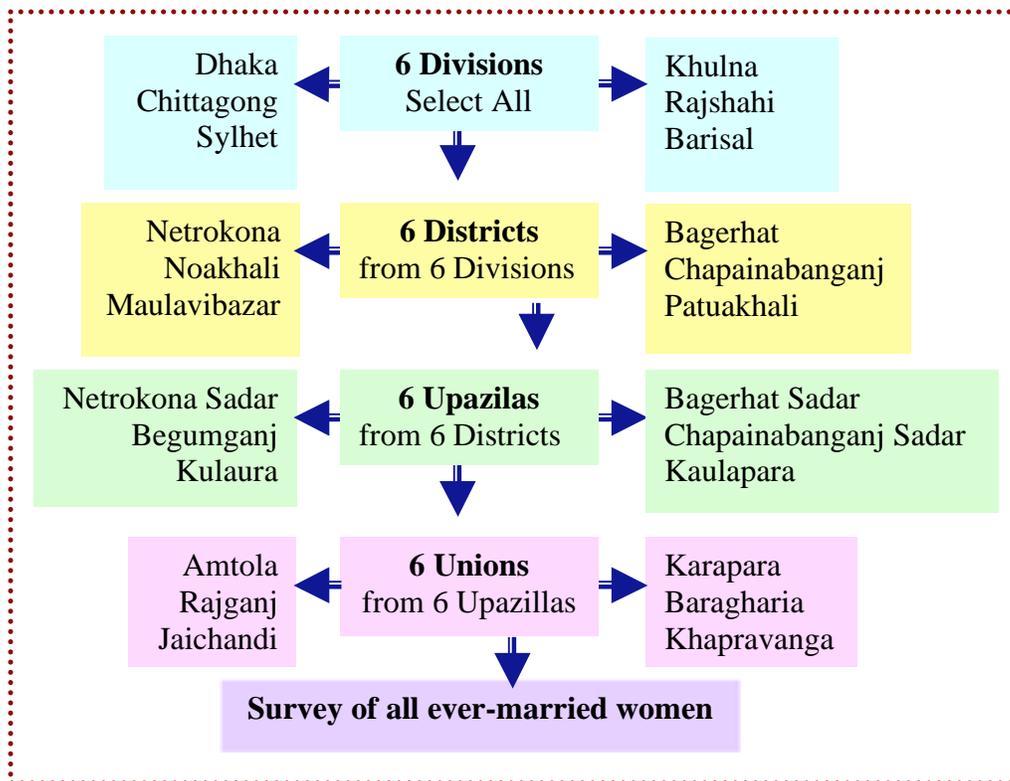
Assessment of the service delivery sites was done using a checklist. The primary purpose of this assessment was to better define the existing capability and gaps for providing fistula repair surgery. The sites included medical college hospitals, district hospitals and Upazilla health complexes. During 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.

6.3 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.

6.4 Sampling Scheme:

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



6.5 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 EngenderHealth 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

7. 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 Obstetric 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 Obstetric and

Gynecology Department of the respective District Hospitals. The selected districts were Netokona, Noakhali, Maulavibazar, Chapainabaganj, 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 Chapainabaganj, 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 Netokona, Rajganj of Noakhali, Jaichandi of Maulavibazar, Baragharia of Chapainabaganj, 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.

The steps of the situation analysis are shown in the flow chart as Appendix-2.

8. FINDINGS

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

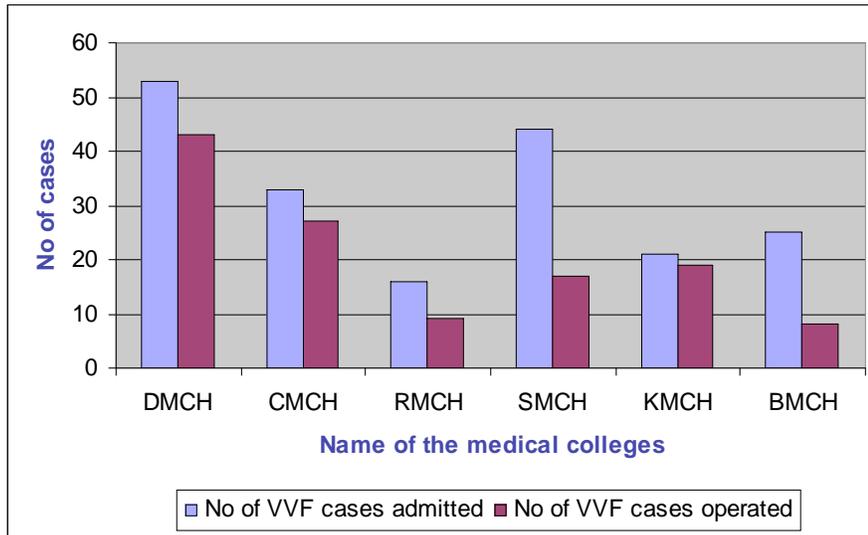
| Sl No. | Name of Medical College Hospitals | Total gyne admission | Major gynecological surgery | VVF cases admitted | % of gyne surgery to admission | % of VVF cases to admission | % of VVF cases to surgery |
|--------|-----------------------------------|----------------------|-----------------------------|--------------------|--------------------------------|-----------------------------|---------------------------|
| 1 | DMCH | 2736 | 1026 | 53 | 37.5 | 1.93 | 5.16 |
| 2 | CMCH | 3016 | 1220 | 33 | 40.45 | 1.09 | 2.75 |
| 3 | RMCH | 2111 | 480 | 16 | 22.73 | 0.75 | 3.33 |
| 4 | SMCH | 2453 | 507 | 44 | 20.66 | 1.79 | 8.67 |
| 5 | KMCH | 1148 | 465 | 21 | 40.5 | 1.82 | 4.51 |
| 6 | 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 out patient 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).

Figure-1: Number of VVF Case Admission and Operation in 2002



8.1 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

| SI # | Name of the Union | No. of ever married women | No. of fistula cases | No. of cases per 1000 ever married women |
|--------------|----------------------------|---------------------------|----------------------|--|
| 1 | Rajganj, Noakhali | 7017 | 14 | 2.00 |
| 2 | Bargharia, Chapainababganj | 4504 | 8 | 1.78 |
| 3 | Amtola, Netrokona | 3947 | 9 | 2.28 |
| 4 | Karapara, Bagerhat | 6162 | 9 | 1.46 |
| 5 | Joychandi, Maulavibazar | 4364 | 9 | 2.06 |
| 6 | Kaulapara, Patuakhali | 5895 | 5 | 0.85 |
| Total | | 31889 | 54 | 1.69 |

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

8.2 Facility Assessment

Medical College Hospitals:

All six Medical College Hospitals were moderately equipped and providing treatment for fistula. However, some specific supplies were not available in certain institutions, including cystoscope, vicryl, ureteric catheter etc. A cystoscope generally available in the Urology department of those hospitals, and vicryl was available in three hospitals. However ureteric catheters were available in none of these facilities. Surgical instruments, common for other general surgery, were available.

Repair of fistula requires special surgical skills. In the Medical College Hospitals there were one or two specialist surgeons who were well skilled to perform this surgery. However, considering the magnitude of the problem, the number of skilled professionals appeared to be insufficient.

District Hospitals:

The sample District Hospitals were equipped with instruments necessary for treatment of obstetric fistula, but had similar supply problems to those of Medical College Hospitals. However, in the district hospitals, there were no skilled providers available for fistula treatment. During the year leading up to the study those hospitals made only small number referrals.

Upazilla Health Complexes and MCWCs:

There are no skilled service providers for fistula treatment available at the Upazilla Health Complexes and MCWCs, and the few cases of obstetric fistula seen were referred to higher level centers.

8.3 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 list of service providers interviewed is attached as Appendix-3.

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.

8.4 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 | No |
|--------------------------------|----|
| 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.

| Age of the respondents | | Years of sufferings | |
|-------------------------------|----|----------------------------|----|
| Years | # | Years of sufferings | # |
| 15-30 Years | 13 | Less than 1 year | 5 |
| 31-45 Years | 10 | 2-5 years | 8 |
| 46-60 Years | 3 | 6-10 years | 2 |
| 61-75 Years | 1 | More than 10 years | 12 |

| Current marital status | | Knowledge of the respondents that how fistula can be avoided | |
|-------------------------------|----|---|----|
| Marital Status | # | Information | # |
| With Husband | 13 | Not known | 18 |
| Separated | 6 | Known | 6 |
| Divorced | 5 | Not mentioned | 3 |
| Widow | 3 | | |

[Interview with the fistula patients:](#)

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.

8.5 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

8.6 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.

8.7 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 sometime 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. Mutalib 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.

9. 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.

10. 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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Situation Analysis of Obstetric Fistula in Bangladesh

Interview Questionnaire for Fistula Patients (not received treatment)

Particulars of respondents:

Name of the Patient: _____
 Address of the Patient: _____
 Age of the Patient: _____
 Marital status: _____
 Name of the husband (optional): _____
 Occupation of the respondent: _____
 Husband's occupation: _____
 Monthly family income: _____
 No of children: _____

1. What are the problems you have been experiencing? When did these start? Can you describe me how the problems started?
2. Have you shared your problems with others? If so, with whom you have shared these problems? What were their responses?
3. In your opinion does your condition hinder your normal physical activities or might they in the future? In what ways?
4. In your opinion does your condition limit intimate relations with your husband or might it in the future? Can you describe how your condition limits your intimate relationship with your husband? Does your husband express his problem or dissatisfaction to you? If so, what are those problems or dissatisfactions?
5. Have you noticed any change of behavior in your husband? If so, would you describe those changes?
6. Have you noticed any change of behavior of others (name them – not necessary to name names of people) due to your physical condition? If so, would you describe those?
7. What is your husband's feeling about your condition?
8. Beside the persons with whom you have shared your problems, who else knows about your problems? In your opinion how do other people perceive your problem?
9. Are you facing any social criticisms? If so, what are those and why made them feel this way toward you?
10. Do you know where you can get help/cure of your condition? Is it difficult to get the services for treatment? What might be the potential obstacles to get the services? Who can help you to get the services you need? Who do you think should help you out but is not currently helping you?
11. In your opinion how can this problem are avoided?

Situation Analysis of Obstetric Fistula in Bangladesh

Interview Questionnaire for Fistula Patients (received treatment)

Particulars of respondents:

Name of the Patient: _____
Address of the Patient: _____
Age of the Patient: _____
Marital status: _____
Name of the husband (optional): _____
Occupation of the respondent: _____
Husband's occupation: _____
Monthly family income: _____
No of children: _____
Treatment received from: _____

1. When and how did you problem start? How did you get information about the service center?
Who are the people who helped you in to get to the facility?
2. What were the problems you had been experiencing? With whom had you shared these problems?
What were their responses?
3. In your opinion did your problems hinder your normal physical activities? If so, in what ways?
Do you think now you will be able to do your normal physical activities?
4. In your opinion did your condition limit intimate relations with your husband? How? Did your husband express his problem or dissatisfaction to you? If so, what were those problems or dissatisfactions? Do you think that now that your fistula has been repaired, your husband will no longer feel dissatisfied with you?
5. Did you notice any change of behavior of your husband due to your physical condition? If so, would you describe those changes?
6. Did you notice any change of behavior of others (name them – is it necessary to name people for this study?) due to your physical condition? If so, would you describe those changes?
7. How did your husband feel about your condition?
8. Who else knew about the problems you were experiencing? In your opinion how did they perceive them?
9. Did you face any social criticism? If so, what were those and what do you feel caused this type of criticism?
10. Do you know any other person having similar symptoms as you? What do you feel would be a good way for them to get information about services for treatment?
11. In your opinion how can you prevent fistula?

Situation Analysis of Obstetric Fistula in Bangladesh

Interview Questionnaire for Relatives (husband and others) of Fistula Patients

Particulars of respondents:

Name of the respondent: _____
Address of the respondent: _____
Age of the respondent: _____
Marital status: _____
Occupation of the respondent: _____
Relationship with the patient: _____

1. Based on your knowledge what are the physical problems your wife (relative) has been experiencing? When and how did her problem start?
2. What do you observe to be the social or familial issues your relative has been facing?
3. (for relatives) Have you noticed any change of behavior of her husband due to her physical problems? If so, would you describe those changes? (this question should be in the interview guide for the client)
4. (for husband) Have you notice any change of behavior of others (name them – is it important to have the names of people when doing a study like this?) due to her physical problems? If so, would you describe those?
5. How does your wife (cousin) feel about her problems?
6. Had she faced any social criticisms? If so, what were those and what made people feel this way?
7. Do you know of any other person having a problem similar to the one you are having (cousin)? How did you get that information?
8. In your opinion how this problem could be avoided?
9. (for un-repaired cases) Has she sought treatment? If so, where and how has she gone about this? How have you helped her?

Situation Analysis of Obstetric Fistula in Bangladesh

Interview Questionnaire for TBAs/RMPs

Particulars of respondents:

Name of the TBA/RMP: _____

Address of the TBA/RMP: _____

Age of the TBA/RMP: _____

Years of working experience: _____

Information on obstetric fistula:

1. Sometimes after prolonged labour, mothers endure complications. Can you Have you seen any patient who leaks urine or feces uncontrollably?
2. Has any patient with those symptoms approached you for treatment? If so, how you have managed that? Have you referred any woman with those symptoms? If so, where you have referred her? What you know of the referred site?
3. Had anybody come to see you after getting treatment from other places? If so, what were their reasons for coming to see you?
4. If you know somebody with these symptoms, what familial and social problems they are facing?
5. In your opinion, why does the leaking occur? How this can be avoided?

SITUATION ANALYSIS OF OBSTETRIC FISTULA IN BANGLADESH

Interview Questionnaire for Health Care Providers from Medical College Hospitals, District Hospitals and Upazilla Health Complex

Tell the respondent that we are doing the “Situation Analysis of Obstetric Fistula in Bangladesh” to find out the overall situation of obstetric fistula in our country.

Name of the respondent: -----

Designation: -----

Name of the Hospital/Center: -----

General:

1. What are your views about obstetric fistula problems in Bangladesh?
2. Why is it occurring?

Prevention:

3. Is obstetric fistula problem preventable?
4. If it is preventable can you suggest some ways for its prevention?
5. In your opinion which of the suggestions is the most effective one?
6. By strengthening prevention how much can we reduce the occurrence of obstetric fistula?
7. Do you take any preventive measure if you suspect that patient may develop obstetric fistula?
8. How can we raise awareness among women regarding the obstetric fistula problems?

Treatment:

9. Is obstetric fistula problem treatable?
10. Are all fistula patients aware that treatment of obstetric fistula is possible?
11. How many of the patients come to seek treatment?
12. What are the possible hindrances for not seeking treatment?
13. Do we have special centers for treating fistula patients?
14. Do we have enough expertise for repairing of obstetric fistula?
15. Do the patients need special intensive care for treatment?

Training and Management:

16. What types of special equipment are required in repair of obstetric fistula?
17. Is there any special training programme for doctors/nurses in fistula management?
18. Do you think a separate fistula ward is needed in each tertiary hospital?
19. Do you think a separate fistula ward in Gynae department will improve the treatment quality for fistula patients?
20. Is repair/treatment of obstetric fistula too expensive?
21. What are your ideas about the expense for fistula repair/treatment?
22. What essentials are required to set up a fistula ward in a hospital?

Referral:

23. When do you think that a fistula patient should be referred?
24. What advice and treatment do you give to such referred fistula patient?

Rehabilitation:

25. Along with treatment do you think we should have an opportunity for rehabilitating the fistula patients?
26. What kind of rehabilitation do you think we should have for the fistula patients?
27. Do you think that as a part of the fistula treatment and rehabilitation the fistula patients should get associated with income generating projects so as to increase women empowerment?

Situation Analysis of Obstetric Fistula in Bangladesh
Record Review

1. Name of the Hospital: _____
2. Record review period (12 calendar months): From: _____ To: _____
3. Total gynecological admission: _____
4. Total gynecological surgery: _____
5. Total major gynecological surgery: _____
6. Total number of gynecological cases attended the OPD: _____
7. Approximate number of fistula cases attended the OPD: _____
8. Number of VVF cases admitted: _____
9. Management of the VVF cases: _____
 Number of Surgery: _____
 Referred to other center: _____
 Sent back home: _____
 Outcome of surgery: _____
10. Number of RVF cases admitted: _____
11. Management: of the RVF cases: _____
 Number of Surgery: _____
 Referred to other center: _____
 Sent back home: _____
 Outcome of surgery: _____
12. Number (percentage) of patients came through referral: _____
13. Number (percentage) of patients came by self: _____
14. District wise distribution of fistula patients of _____ Division:

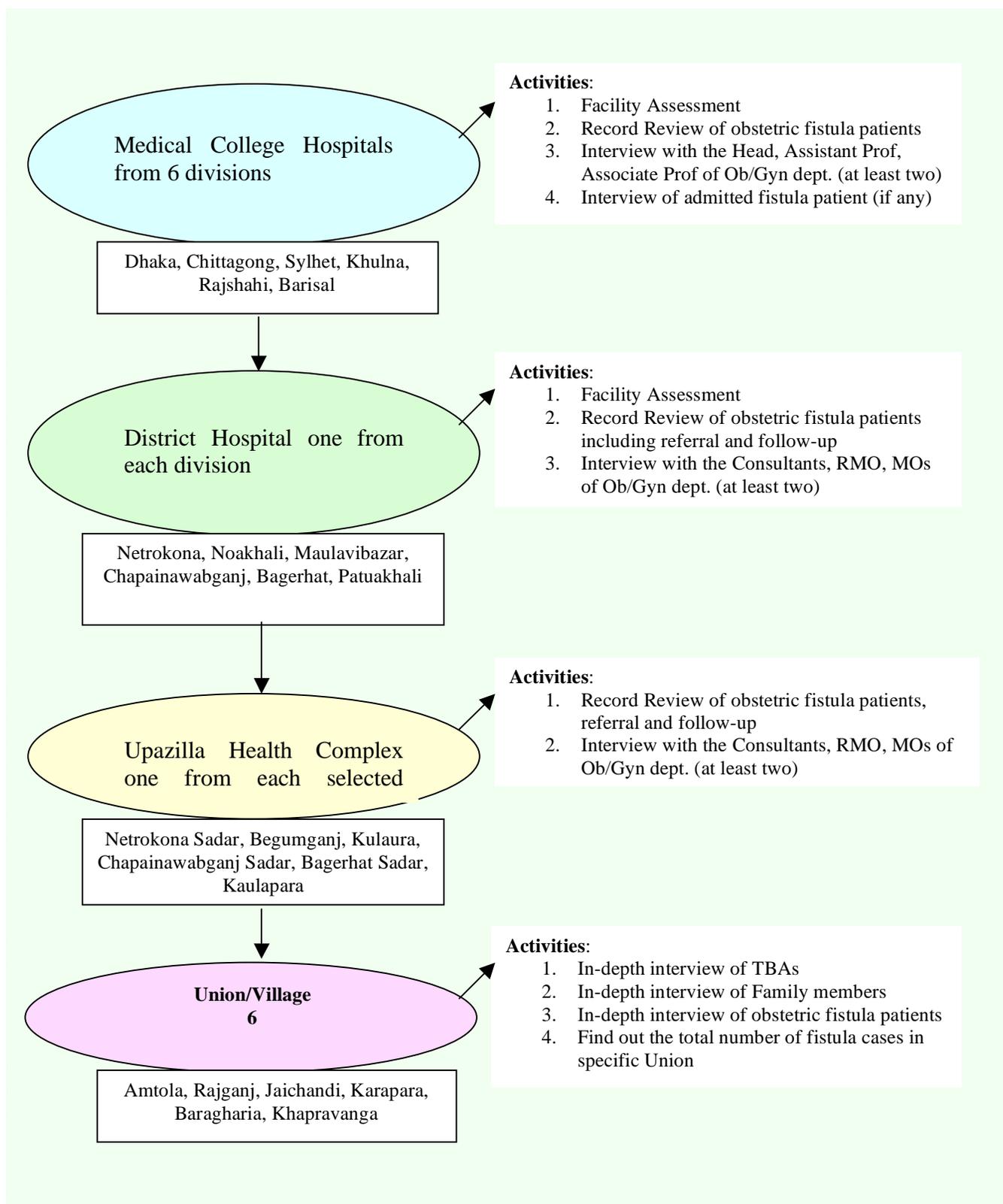
SITUATION ANALYSIS OF OBSTETRIC FISTULA IN BANGLADESH
Facility Assessment Checklist

This checklist will be used for assessing the facility at the Medical College Hospitals, District Hospitals and Upazila Health Complexes. Please put check (√) mark in the appropriate column and write any specific findings in the comments column.

Name of the Facility: _____

Date of assessment: _____

| SI # | Particulars | Yes | No | Comments |
|------|---|-----|----|----------|
| 1 | Restricted areas are clean and having arrangements for keeping street shoes | | | |
| 2 | Separate arrangement of changing room/space | | | |
| 3 | Arrangement of scrubbing area | | | |
| 4 | Separate instrument processing area | | | |
| 5 | Arrangement for sterilization and HLD | | | |
| 6 | Arrangement for clinical waste disposal | | | |
| 7 | Operation Theater | | | |
| 8 | Equipment and supplies for repair of obstetric fistula | | | |
| | Sims speculum | | | |
| | Right angled retractor | | | |
| | Babcocks forcep | | | |
| | Fine curved scissors | | | |
| | Curved needle holders | | | |
| | Vicryl | | | |
| | Catgut | | | |
| | Cystoscope | | | |
| | Ureteric catheter/ Metallic catheter | | | |
| | Special B.P. handle with knife | | | |
| | Sponge Holding Forceps | | | |
| 9 | Equipment and supplies for general and regional anesthesia | | | |
| 10 | Post operative room/ward with provision for keeping patients for two weeks | | | |

Action Steps of Situation Analysis

List of the People Interviewed for the Analysis

1. Dr. M A Zahid Hussein-Associate Professor-Department of Urology, Dhaka Medical College Hospital
2. Prof. Syeba Akhter-Professor & Head-Department of Obs/Gyn, Dhaka Medical College Hospital
3. Prof. Shamsun Nahar-Professor & Head-Department of Obs/Gyn, Chittagong Medical College Hospital
4. Dr. Rokeya Begum-Associate Professor-Department of Obs/Gyn, Chittagong Medical College Hospital
5. Dr. Qumrunnesa Runa-Resident Physician (R/S)-Department of Obs/Gyn, Chittagong Medical College Hospital
6. Prof. Anowara Khatun-Professor & Head-Department of Obs/Gyn, Sylhet MAG Osmani Medical College Hospital
7. Dr. Nayeema Akhtar-Resident Physician (R/S)-Department of Obs/Gyn, MAG Osmani Medical College Hospital, Sylhet
8. Dr. Shahana Ferdous Chowdhury -Assistant Professor-Department of Obs/Gyn, Sylhet MAG Osmani Medical College Hospital
9. Prof. Merina Khanum-Professor & Head-Department of Obs/Gyn, Rajshahi Medical College Hospital
10. Dr. Salma Arzumand Banu -Resident Physician (R/S)-Department of Obs/Gyn, Rajshahi Medical College Hospital
11. Dr. Shamsun Nahar-Associate Professor-Department of Obs/Gyn, Khulna Medical College Hospital
12. Dr. Afroza Khanom -Resident Physician (R/S)-Department of Obs/Gyn, Khulna Medical College Hospital
13. Dr. Mrinal Kumar Sarkar -Assistant Professor-Department of Obs/Gyn, Khulna Medical College Hospital
14. Dr. Muhammad Shah Alam -Associate Professor-Department of Obs/Gyn, Sher-e Bangla Medical College Hospital, Barisal

15. Dr. Akhtari Khanom -Resident Physician (R/S)-Department of Obs/Gyn, Sher-e Bangla Medical College Hospital, Barisal
16. Dr. Md. Nazmul Alam-Consultant-Department of Obs/Gyn, Sadar Hospital, Bagerhat
17. Dr. Nazmun Nessa-Lecturer-MATS, Bagerhat
18. Dr. Moyzuddin-Consultant (Surgery)-Chapai Nabagong Sadr Hospital
19. Dr. Tzuddin-Resident Medical Officer (RMO) -Chapai Nabagong Sadr Hospital
20. Dr. Nazrul Islam-UH & FPO-Shibgong UHC
21. Dr. Saiful Islam-Resident Medical Officer (RMO)-Moulvibazar Sadar Hospital
22. Dr. Md. Hadi Hossain-Consultant-Department of Obs/Gyn Moulvibazar Sadar Hospital
23. Dr. Rawshan Akter Khan-Consultant-Department of Obs/Gyn, Sadar Hospital, Netrokona
24. Dr. A. K. M. Rafiqul Islam Khan -Resident Medical Officer (RMO) -Sadar Hospital, Netrokona
25. Dr. Masum Akhter-Consultant-Department of Obs/Gyn, Sadar Hospital, Noakhali
26. Dr. Salma Sultana-Medical Officer-Noakhali Sadr Hospital
27. Dr. Nikhil Chandra Das-Resident Medical Officer (RMO) -Begumgong UHC, Noakhali
28. Dr. A. K. M Nazrul Islam-UH & FPO-Begumgong UHC, Noakhali
29. Dr. Nurun Naher Begum-Civil Surgeon-Patuakhali
30. Dr. Md. Mahmudur Rahman -Junior Consultan-Department of Obs/Gyn, General Hospital, Patuakhali