Obstetric Fistula in Bangladesh : Looking into the Future

USAID, EngenderHealth, and Fistula Care organised a roundtable on "Obstetric Fistula in Bangladesh : Looking into the Future " on May 11,2013. We publish a summary of the discussions. *--Editor*

Dr. Abu Jamil Faisel, Country Representative, EngenderHealth Bangladesh

I want to focus on present condition of fistula patients in the country and what we can do in the future. In 2003, EngenderHealth did an assessment in collaboration with the government and UNFPA. The assessment showed that there is a backlog of 71,000 cases, with an estimation of 1.69 cases per 1000 ever married woman. This condition has not that much improved since then. The condition of the girls who are getting married at an early stage, the condition of the birth attendants, the condition of the deliveries all of these indicators have not actually changed. We have been able to reduce the maternal mortality which is still too high. WHO has said in their estimation that 7,300 women are dying due to maternal mortality, and 5 times more women are suffering from morbidities such as fistula. Every year many new cases are being added with the past 71,000. We have been able to serve a very little number of these patients. Usually, we discuss about prolonged labor and delayed labor as the cause of fistula but there is another rising trend, now, that is to be kept in mind. When the operations are being performed by the surgeons somehow Fistula is occurring.

Who are the main victims of the condition? What are the characteristics? Mostly the adolescents, teenage girls, who are getting married and become pregnant at a very early age, and the very poor who are not going to the facilities for any obstetric care are the victims of fistula. The vast majority of these patients is illiterate and not do not have any formal education. The nutritional level is very much low. Most of them are living in remote rural areas. Even, they are not allowed to go to any formal facilities for health care. And the access to family planning services is limited. So these girls are having obstetric fistula during their delivery due to the obstruction that cause an unnatural opening from where the urine and the stool would dribble. That is why the woman would always be foul smelling. There are many other physical problems such as infection, kidney problem etc. Family members usually denies this conditio. The stigma of the society regarding fistula is that this is a curse. We have cases where some women committed suicide. Though there are services for these women that are completely free but they are not going to these facilities. Mostly the causes are lack of awareness, lack of access due to time, distance or transportation cost, low acceptance of the modern health care among these people. In Bangladesh, we have a large workforce working both on the Health and Family Planning sector. But their involvement is limited in the fistula area. UNFPA have been supporting the national fistula centre to train the service providers, but there is still lack of trained providers.

Prevention is the first strategy we should start working. There has to be multi-sectoral collaboration. High quality treatment/operation for the women who are already suffering should be the second strategy. If the opening is very big and complex there are possibilities that the first surgery even if it is a very good one may not be successful. Sometimes more than one surgery is required. The programs and services should be sustainable. The third component is rehabilitation and reintegration for the treated women, as most of the time they are not taken back by their husbands. We need to ensure income for these women. There has to be strong community participation. Financing is an important issue for these fistula service operations. There should be larger amount of money allocated for these services by the government and the donors. Finally, a well articulated national strategy is necessary. In the four hospitals, supported by USAID the operated patients have been followed up very closely by the hospital workers and community level people. Their success rate is around 82%.

Dr. S. A. J. Md. Musa, Director PHC, DGHS

Surgery is the sole means of treatment of obstetric fistula. In this regard, government is providing free operation services at 10 Medical College hospitals. The situation is a complex one; we have to deal with both delivery and fistula care. It is some sorts of special care in addition to the basic care.

There is a huge backlog of fistula patients and that is increasing day by day. We have to reach a consensus on how to proceed further. We need highly trained manpower, well equipped facilities, good referral linkage and strong social mobilization.

Mr. Gregory J. Adams, Director (Acting) OPHNE, USAID, Dhaka

USAID through EngenderHealth with support from UNFPA did the first survey of fistula patients in Bangladesh in 2003. Perhaps it is time for a new survey/assessment that should be carried out. USAID is very proud of providing support to the Fistula Care project managed by EngenderHealth. Since 2005, we have provided US $ 3 million. We are thankful to the government hospitals for their help and commitment. What strikes me most about obstetrical fistula is not the medical condition but the social nature that ostracizes the woman who has to suffer. We need strong collaboration of government and non-government sector in Bangladesh to prevent this situation. USAID would continue to support the fistula program which would be a great help to the women of Bangladesh.

Ms. Niru Shamsunnahar, Joint Chief (Planning), MOHFW

Ministry of Health and Family Welfare has shifted from the project approach to program approach since1998. Since then we have been implementing a sector wide approach. From July 2011, we are implementing the third sector program called HPNSDP with 32 operational plans, each having individual objective, work plan and procurement plan. Within each operational plan, there are thousands of activities for improving our health sector. We have our strategic plans, result framework and indicators to make these operational plans successful. Most importantly, the only goal for all these plans is to ensure primary health care for every citizen of Bangladesh. We are rendering fistula services through these operational plans. I think our efforts should not be confined only in roundtable sessions. We need to spread these out and interlink our programs and activities with the community. We should take more concentrated efforts for the girls who are getting married at a very young age and in most of the cases getting pregnant unknowingly at the very first night in her married life. We have to reach them before they are getting married. Finally, we need collaborated efforts, not dispersed. We will have to develop multi-pronged activities involving the communities.

In most of the operation plans, the DPAs are mentioned but there is no DP or development partners mentioned for giving the direct project aid. The scenario is that at 60 % cases there are no DP coming for the DPA fund. Now we are planning further and trying to show our development partners the real situation here. If we do not get any commitment from the development partners, we will have to think about the size of our programme. Without approval of the ministry, not a single word can be incorporated or removed from the national action plan. To make any type of change there have to be a revision proposed to the MOHFW. Those who are related with the fistula activities are doing a specific and very delicate type of job. In the government facilities there is a system that 50% of the user money can be given to the doctors or technicians who are doing the MRI or CT scan or other such services. It is also possible to develop this system for the fistula cases. It should be come into the knowledge of the policy makers. As the gynaecology departments in every district hospital is very busy, a special department for fistula should be there. The lower number of patient and underutilization of the facility happen due to social causes. Fistula can also occur because of the faults of the doctors. There is a large number of private clinic operating at the district level whose authenticity is questionable. They are using false permission. They are working with poor or no waste management, absence of necessary equipments and insincere doctors. We should develop a system which will ensure that even the doctors are bound by the law for their activities.

Professor A.B.M. Abdul Hannan, Director (ME), DGHS

I would go into some statistics in relation to the obstetric fistula. According to the estimation of WHO, some 50,000 to 100,000 women develop obstetric fistula per year. Currently more than two million women are living with obstetric fistula in Asian and Sub Saharan countries. Most of these patients are under the age of 30 while 50% of them are under the age of 20. About 72% to 95 % obstetric labor occurring outside the facilities leads to obstetric fistula. We should compare these statistics with our's to understand the situation of our country. During the 20th century, obstetric fistula was missing from international global health agenda. In 2000, development goals were adopted after the United Nations Millennium Summit. The fifth goal of the MDG that is improvement of maternal health is directly related to obstetric fistula. Since 2003, this issue is getting attention from the general public as well as UNFPA who have arranged the global campaign. Another 2008 WHO study shows that 2000 health professionals were trained in preventing and managing fistula problem in Asian and Sub-Saharan countries. Now there is a situation of increased political and social pressure to put an end to fistula. So we need to see dramatic rise in fund for fighting fistula. Government has to develop a national action plan including many preventive strategies like information sharing with the relevant parties, improving the nutritional condition of young mother and promoting education for girls. We need cesarean section with skilled and trained personnel in our hospitals to prevent iatrogenic fistula.

Dr. Dulal Chandra Podder, Director, Kumudini Hospital

We need to pay attention to the geographical location of the fistula services. The services are not well distributed all over the country. We should provide services through fistula camps in all the district hospitals with the partnership of public and private authorities. This will make us able to give the patients services near to their homes. I think service providers need motivation. In this regard, government should come up with a strong support. We should allocate some money for the attendant of the patients.

Dr. S. M. Shahidullah, Country Manager, Ipas

The statistics presented here seems to be very gloomy. The scenario is that though there are many surgeons in private hospitals the patients are not coming. Even the government hospitals are unutilized. We should develop fistula camps outside Dhaka. There is lack of confidence among the service providers that is why motivation is needed. At the government sector, there are workers but not enough field activities. We need information sharing between the centers and community activities for preventing fistula. This sort of round table discussion should be arranged in all the medical colleges where the services are being provided to make the providers more motivated. We are discussing the same case studies for a long period. New cases from the field research, which are more emotional and powerful, should be disseminated. I have seen patients who are suffering from fistula for 25 years. We need to publish their stories in Bangla which will be more effective and communicative. Let us listen to their stories soaked in tears and pain.

National Professor Dr. Shahla Khatun

I have a humble question for the doctors sitting here and those who work at the government hospitals. Do you think doctors in the government hospitals work for money only? Why are we talking about incentives for the surgeons at this point? In case of a private medical facility, there are definitely some costs. There is a shortage of trained persons and availability of facilities. However, since 2003 obstetric fistula has gained awareness amongst significant group of public and private health service providers and public health professionals. We should thank UNFPA and USAID for coming forward in helping these distressed women.

Prof Sayeba Akhter, Ex-President, OGSB

The problem is regarding the willingness of the doctors. The doctors or service providers give priorities to the emergency cases. But fistula does not fit the category. This system should be changed. We need doctors specially assigned to do fistula surgery. Some doctors should be assigned for particular years for providing fistula services only. Priortization of the problem is very important. The total number of fistula patients at this time is about 91,000. Till 2003, we have operated 3079 cases. Even if we prevent fistula 100%, it will take another 294 years to deal with these 91000 cases.

Dr. Zaman Ara, Senior Program Officer, UNFPA

We need to finalize the national fistula strategy and without it, we cannot develop national action plan. UNFPA and EngenderHealth have helped the government to develop that strategy. This strategy is in the process of being approved by the government. We will collect all the opinions gathered here and will send it to the MOHFW and DGHS.

Prevention should be our top most priority. UNFPA in collaboration with the MOHFW has developed a national fistula campaign design. Feedback would be incorporated and then implemented. It will highlight many issues like how to target different groups of population, how to make these people aware about the services, etc. We have started discussion with EngenderHealth and IDB to conduct another study in 2014. This will help us get the recent number of the fistula patients and women who received treatment successfully. We all know that family planning saves life. We can promote this service for adolescent boys and girls. It will work as a preventive measure for fistula. We have discussed about emergency fistula services. We know that 24/7 services are yet to be available at the sub-district level. We have to ensure availability and accessibility of these facilities. Skilled care is needed not only for fistula surgery but also for safe delivery. We have tried several times to include fistula indicators in our national MIS system and that is yet to be completed.

Dr. Bilkis Begum, Assoc. Prof. Ob/Gyn Department, Kumudini Women's Medical College Hospital

Regarding raising awareness of fistula services we have to address the chor area, coastal and hilly areas. In these remote places, there is no doctor for the delivery of a patient. In identifying a fistula patient, the health workers should be encouraged with some sort of incentives. The identification is a difficult job. About 15% to 20% patients are not totally cured because of their already damaged organs. Even the surgeons need continuous training support. At present we have only one rehabilitation centre at Dhaka Medical College. My proposal is to develop a complete rehabilitation system as well as to increase the number of rehab centre. Reproductive health education should be included in the primary and high school level. We want to change the fistula situation positively and remarkably within the next few years.

Dr. Nelson T Mondol, Medical Director, LAMB Hospital

In LAMB Hospital, we conduct three days long orientation program for volunteers many of whom are cured fistula patients. Then they go back to their community with kits and information about fistula. They deliver different health messages on fistula. Actually, we call this initiative Mother and Mother-in-law Project. This is a community level fistula program. Before this campaign, we experienced that the number of patients was going down. At present those trained people are bringing patients and we are reimbursing their travel cost. In our hospital, we have operated nearly 600 patients with 80% success rate.

Dr. Saikhul Islam Helal, Team Leader, PPH Prevention/Maternal Health, EngenderHealth Bangladesh

We need to talk about the financing of fistula care activities. It is quiet certain that government will not be able to fund all of the activities. The DPs should come forward to support the government in implementing fistula care and prevention activities. USAID needs to be thanked for their generous support to fistula activities through EngenderHealth. My request to the authority is to incorporate the indicators of fistula in the operational plan as early as possible. For national action plan, planning section of the MOHFW can start working. As the program progresses, all relevant Line Directors should be involved in the plan.

Professor Sohely Rahman, Head of Physical Medicine, DMCH

All obstetricians should advice their patients for doing pelvic floor exercise. It helps in reducing incontinence of urine. It should be done at the stages of ante-natal check up, post-natal check up and after the surgery. In our country, we do not follow this practice. At the hospitals abroad, patients have to go to the doctors for doing exercise even after two weeks of the surgery. We should include this in the course curriculum of Gynae and Obstetrics.

Dr. Humaira Begum, RTM International

We should publish booklets on fistula care with some touchy stories. It will help create awareness and reduce false perceptions about fistula.

Dr. Moazzem Hossain, BRAC

We are working with fistula patients in rural districts and in the slum areas of seven city corporations. Still, fistula care centers are inadequate to the large number of fistula patients. We need to establish fistula care centers at the district level.

Mr. Jagodish Roy, LAMB Hospital

When we go to an area for fistula campaign we bring a cured fistula patient of that area and represent her before the local people. A cured patient can tell and share her experience with all her emotion and feelings which is really helpful for building awareness.