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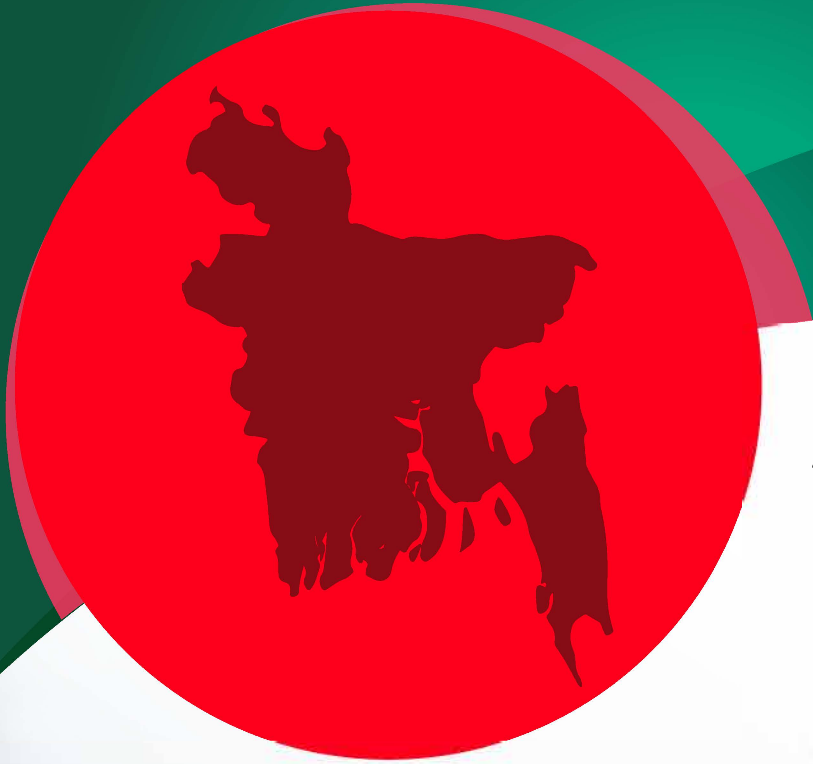

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Obstetric Fistula: The Search for a Remedy through Social Network

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Abstract

Obstetric fistula, one of the worst forms of maternal illness has a devastating impact on a woman's life. Based on interviews with women who came to receive treatment to treat their fistula at the Ad-din Women's and Children's Hospital in Dhaka and Jessore, Bangladesh, the author developed a framework to describe a pathway of how the women suffering from the disease managed to get treated after overcoming a myriad of challenges and sufferings.The author concludes that in a context of devastating multidimensional suffering caused by fistula, and limited access to information, institutional support and treatment facilities, only a wider empathetic social network can help the women get treated.

1 Introduction

Obstetric fistula, one of the worst forms of maternal illness, has a devastating impact on any woman's life. Caused mostly by obstructed labour, with no or delayed emergency obstetric care (Roush 2009, p. e21), obstetric fistula is a hole or tear in the tissue wall between the vagina and the bladder or rectum, or both. The constant wetness and smell caused by continuous leakage of urine not only results in physical discomfort, but also subjects the affected woman to isolation, stigma and poverty (Bangser 2006, p. 535). The continued prevalence of fistula in this modern day and its insufficient treatment facilities are markers of overall maternal health conditions of a region (Roush et al. 2012, p. 788) and violation of human right (Cook et al. 2004, p. 76). Although the socio-economic and cultural context of each country with a high prevalence of fistula is unique, sharing of knowledge between different countries and between different contexts would help plan and act more efficiently to eradicate obstetric fistula. This study unfolds the particular socio-economic structural and cultural setting in Bangladesh in which a medical condition like obstetric fistula can occur and may be treated.

This paper has two objectives: (i) to portray the socio-economic and structural contexts in the development of obstetric fistula and (ii) to explain the challenges and opportunities experienced by fistula affected women in their journey towards treatment. It is argued in this paper that in a context of devastating multidimensional suffering caused by fistula, and very limited access to information, institutional support and treatment facilities, only a wider empathetic social network can help the women seek treatment and progress towards recovery.

2 Method

To explore the suffering and challenges of the fistula affected women, it is important to gain direct access to their voices and how they articulate their experience and turn the challenges into opportunities to treat their condition. Stacey (1994) points out that people themselves can best explain their experience because they are the ones who live it. Their accounts do not only provide information of their experience but also render it meaningful as they relate their experience to their social and cultural context. For this purpose, in-depth interviews with women who came to receive surgical treatment at the Fistula Ward of Ad-din Women's and Children's Hospital in Dhaka and Jessore has been conducted.

2.1 Study Context, Recruitment and Research Participants

For this study, the Ad-din Hospital was purposely chosen because it is one of the 11 health facilties in Bangladesh equipped with qualified surgeons and technology to surgically repair obstetric fistula; this hospital provides such surgery free of cost. Eleven women were interviewed in this research. Theywere admitted in the fistula ward of Ad-din Hospital during the time of interview for the treatment of their fistula. While it is acknowledged that this number may be too small, even for a qualitative study, it provides an important insight into the contexts, causes and consequences of obstertric fistula. Such an insight may be very useful for programs to prevent and/or treat this disease and its unfortunate consequences for the women suffering from it.

An ethics approval for this research was obtained from The Flinders University Social and Behavioural Research Ethics Committee (Approval number 5535) to

ensure anonymity of the participants and confidentiality of the information they provided at the interviews. Permission to interview these women was also obtained from Ad-din hospital.

2.2 Analysis

Being a native of Bangladesh and fluent in both English and Bengali languages, the author herself conducted the interviews in Bangla, the language spoken by the women, so as not miss even the minutest expressions of feeling and despair expressed by the women; the interview transcripts were translated into English and processed with the help of NVivo 10 computer software for analysing qualitative data. Data were coded based on themes that appeared important in understanding the problem being researched (Fereday & Muir-Cochrane, 2006, p. 82). This process involves careful reading and re-reading of the transcripts (Rice & Ezzy, 1999, p.258) and a step-by-step approach (Braun & Clarke, 2006 pp.87-93) which allowed the most significant themes to emerge.

3 Results

3.1 Women Affected by Fistula at Ad-din Hospital

Almost all the women interviewed were suffering from fistula for five years or more, and in some cases for decades. Most of them got this condition due to prolonged obstructed labour. Table 1 suggests that most of the women experienced fistula at a very early age and suffered from the condition for the major part of their adulthood. Eight of the 11 women interviewed only had their first surgery and hoped the hole would be repaired without the need for any more surgery, but the remaining three women were at the hospital to have a second surgical attempt to repair their fistula.

4 Causes of Obstetric Fistula and the Extent of Women's Suffering

It has been mentioned before that the causes of fistula are mostly prolonged obstetric labour, no treatment, or untimely treatment. Obstetric fistula usually originates in a background of early childbearing, prolonged obstructed labour and delays in seeking healthcare. Wall (2005) identified poverty as the 'breeding point' of obstetric fistula, because usually in a poorly resourced social setting, girls remain undernourished, get married early and give birth to children early. Figure 1 presents a pathway describing the chain of events leading the women to the risks of developing obstetric fistula. This figure is developed based on interviews with women who had fistula.

Table 1: Demographic background of the particiapnts and information about the occurrence and treatment of obstetric fistula

Name and age	Age at marriage of the women	Age and order of birth when fistula developed	Duration of fistula (years)	Cause of fistula	Time elapsed between the onset of pregnancy complication and the occurrence of fistula	Health facility where the fistula occurred[1]	Number of attempts for fistula repair
Shefali (30)	15	25 (4th birth)	5	Obstructed labour	4 days	Local Clinic	1
Beli (40)	12	30 (5th birth)	10	Obstructed labour	2 days	District Hospital	1
Rosy (40)	11	20 (2nd birth	20	Obstructed labour	4 days	Home	1
Jobeda (25)	11	15 (1st birth)	10	Obstructed labour	1 day	Home	1
Shapla (22)	14	16 (1st birth)	6	Obstructed labour	5 days	District Hospital	2
Kolmi (23)	14	18 (1st birth)	5	Eclampsia	4 days	District Hospital	2
Papiya (35)	10	23 (3rd birth)	12	Obstructed labour	3 days	Home	1
Jahanara (35)	13	15 (1st birth)	20	Eclampsia	1 day	District hospital	2
Sultana (45)	13	14 (1st birth)	31	Obstructed labour	3 days	Home	1
Akbari Begum (23)	13	22 (2nd birth)	1	Surgical fault	1 day	Local Clinic	1
Shahanara (25)	12	14 (1st birth)	11	Obstructed labour	4 days	Home	3

Source: Akhter 2015, p. 179

[1]As reported by the interviewed mothers

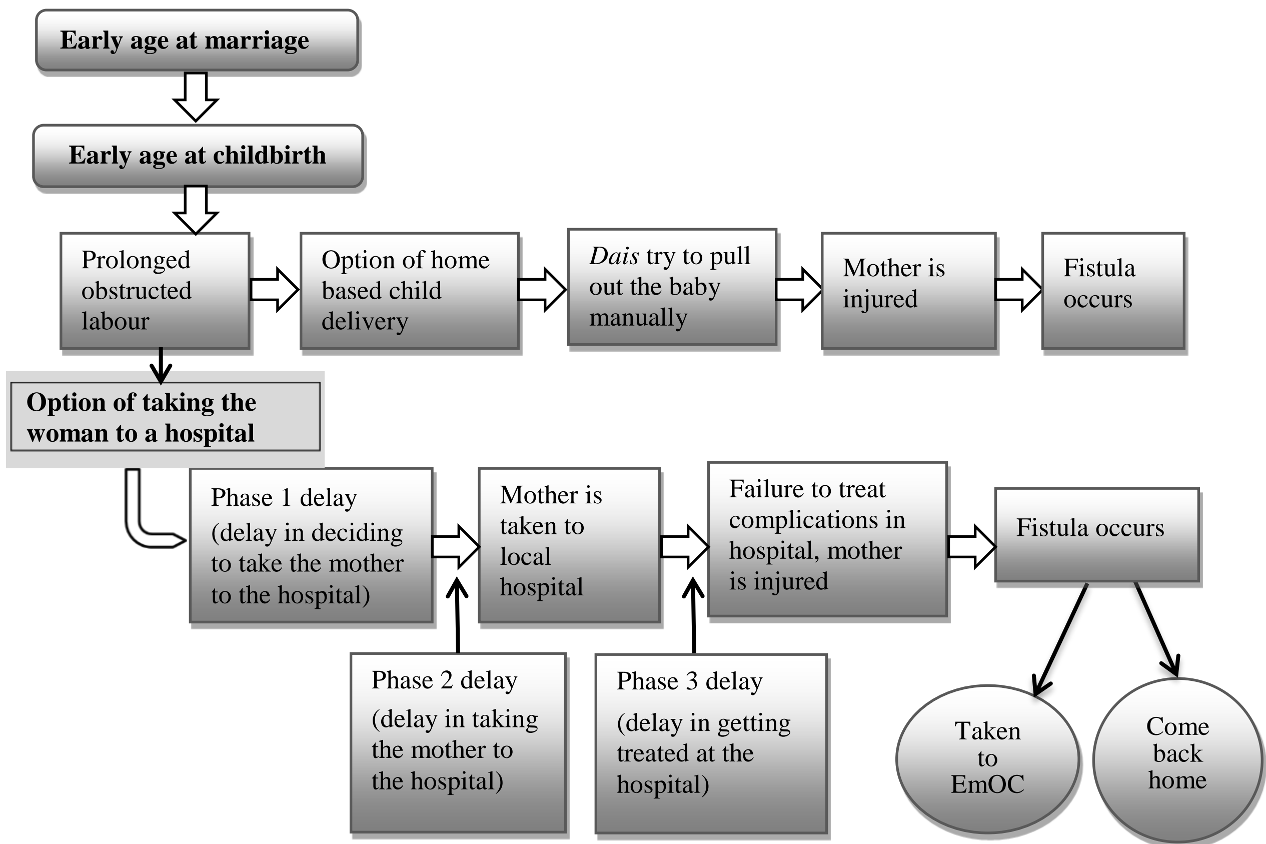

Figure 1: Pathway to the occurrence of obstetric fistula

Source: Drawn by the author based on interviews of women suffering from obstetric fistula

Table 1 shows that all but one of the women had their first pregnancy at the age of 15 or 16 and most of them got obstetric fistula during the birth of their first child.

It is shown that prolonged labour and birth injury were at the centre of the occurrence of the disease, but there were differences in the circumstances between one woman and another. In one group of women, prolonged labour, accompanied by the indecision to go to a hospital led to birth injury when an untrained traditional midwife (*dai*) tried to deliver the baby manually. In the other group, prolonged labour, accompanied by a delay in sending the woman to a hospital, delay in reaching the hospital and getting treatment at the hospital caused the occurrence of fistula.

The first type of scenario in which obstetric fistula happens is portrayed in Jobeda's childbirth experience.

Jobeda: I conceived in the first year of my marriage. The baby died in my womb. I was in serious pain. The pain stayed for a day and a night. My parents-in-law did not let me go to my parents' house. My parents also did not insist on taking me home. Ladies from the neighbourhood were around me during my labour. They (husband and parents-in-law) did not take me to a hospital, because they did not have money. There was no hospital nearby. There was one in Hobigonj. The transport cost from our home to Hobigonj is BDT125 (USD 1.5)

Researcher: Did they not have this 125 Taka?

Jobeda: Yes they had. But that's not enough. You have to spend money for every service at the hospital. ACaesarean section will cost lots of money.

Researcher: But CS is free in a government hospital?

Jobeda: My husband and parents-in-law did not know all this. That's why they did not take me anywhere. They kept me home. The baby was stuck inside me. Then the dai pulled it out using her hands, after that, my pain stoped but I started leaking urine. I was unconscious then. Seeing this urine leaking, the dai could not say anything" (Jobeda, aged 25 years, married at age 15 and pregnant at the same age).

As a part of the traditional childbirth behaviour, Jobeda stayed at home attended by the *dai*, who waited and tried to deliver the baby manually. There may be some other contexts in which a birthing woman's health can get the lowest priority and not considered worth spending money on. The experience of Kolmi reveals this kind of situation:

> My pain started in the morning. I stayed at home for the whole day and night. The following day at the time of *Magrib* (sunset) I was taken to the district hospital. When I was home, my husband shouted at my mother and sister-in- law and said, "why are you not taking her to the hospital? She will die, can't you see? Are you human beings?" I also said, "please take me to a doctor". But my brother-in-law (husband's elder brother) and sister-in-law did not want to spend money for me. My brother-in-law said, "why go to a hospital? She will deliver the baby here (at home)". But my husband did not agree. He shouted at them. Then my brother-in-law gave the money. I was taken to the hospital by ambulance. But once at the hospital I was left unattended outside a ward for the whole night. They did not even give me a bed. Then my brother-in-law gave BDT 1,000 (USD 12.5) to a staff in the hospital, who managed a bed for me. I was then taken to OT (Operation Theatre). The baby had already died. After taking me out from OT, they put me in the bed again. They cut the pipe (catheter) after four days of operation (Caesarean section). My whole bed was getting wet. The doctors said, we cannot do anything. Take her to Dhaka (Kolmi, aged 23 years).

The childbirth experiences of Jobeda and Kolmi highlight how the voices of birthing women are not heard in making decisions for seeking healthcare. This disempowerment of women in relation to childbirth (whether medicalized or natural) has been identified as a contributory cause for obstetric fistula (Roush et al. (2012, p. 788). Oakley (1984, p. 22) argues that even in natural birth practice, the birthing woman is not considered to be at the centre of her own childbirth experience.

In the second group (Figure 1) women were taken to the hospital. The irony is that by the time she was taken to a hospital, it was too late and the baby could not be saved and the woman had already suffered a lot and had irreparable damage leading to fistula. Thus, in this situation, bringing the woman to a hospital did not help her from developing the condition.

Molzan et al. (2007, p. 68) has shown that women in Eritrea reached the health facility after 24 hours to five days of obstructed labour and after damage leading to fistula had already occurred. A similar situation occurred in Bangladesh, with Jahanara, who had eclampsia (locally known as *Gorbho tonka*). Ladies from the neighbourhood who were present at Jahanara's childbirth mistook her convulsion to be labour pain. While the convulsion brought the baby down towards the cervix, the *dai* tried to pull the baby out manually, tearing the area and creating a hole in her uterine wall. Jahanara states,

> I went to my parents' house for delivery. I had *Gorbho tonka* (convulsion). The convulsion was so severe that the baby's head could be seen at the opening of my cervix. Then the *dais,* who were present there thought the baby should be born right there and then and they tried to pull out the baby using their hands. But the baby did not come out. It died inside. I stayed conscious for the following three days. Then my family took me to the district hospital. They brought the baby out by cutting a bit in the cervix. I think my *peshaber tholi* (bladder) somehow got cut at that time. Soon I realised that my urine was coming out without any control. When I tried to stand up, faeces came out too. (She took a deep sigh expressing her deep sadness).

A late intervention in receiving emergency obstetric care (EmOC) represents Phase 1 delay identified by Thaddeus and Maine (1994). In the cases of Jobeda and Jahanara (and other women in this study), the delay in transferring these women to a hospital can be explained by their poverty, inability to understand the severity and possible outcome of the long-obstructed labour, and the women's status within the family.

Once a decision is taken to take the pregnant woman to a hospital (sometimes very late) her family may experience delays, identified as Phase 2 delay by Thaddeus and Maine (1994, p. 1092) due to the time taken in managing the transport and in travelling the distance to the health facility.

The story of Shapla who has been suffering from fistula for five years, outlines the situation of how such delays further complicate an already bad obstetric condition. In particular, it portrays the second pathway of how obstetric fistula may occur in a hospital (as shown in Figure 1). It is acknowledged that there may be other situations such as surgical errors that may also result in fistula (as happened with Akbari Begum, age 25). According to Shapla:

> When my labour pain started, it was not yet time to deliver. I stayed home one day and one night. The *dai* was around me. Then the *dai* said, she could not do anything and suggested to take me to the doctor. There is a small government medical centre close to our house. I was taken there. But my labour was still not sufficient to deliver the baby. There I waited for a day. Then I was taken to Sodor (district hospital). There I was given saline. My labour was still not induced. Sodor was three miles away from our house.

I went there by a reserved *tempu* (a three-wheeled vehicle). My mother, my uncle and my husband went with me. They gave me saline, and pushed an injection. But still there was no labour induced. Then they tried to pull the baby out by cutting that place (cervix). Then they said, "It will not be possible by us. Take her to Sylhet if you want to save her". We came back home instead of going to Sylhet. We did not have enough money to go to Sylhet. Moreover, in Sodor, my uncle came to know a *dai.* That *dai* told my mother that she will be able to bring the baby out in an hour. She has connections with hospital doctors. So we came back home. I was bleeding heavily from that cut place. Then I stayed home for a day. The *dai* could not do anything. Then, I was taken to a clinic. People call him *Doctor Babu* (doctor Sir). That *Doctor Babu* told us that he will be able to bring the baby out. He tried to pull the baby with forceps. But he failed to pull it completely. Then again sent the baby back inside. And then he said to my uncle, take her to Sylhet as soon as possible, if you want to save her life. Then at 1.30 a.m I was brought to Sylhet in a rented car. It was 2.30 (am) when we arrived in Sylhet. Then they saw the baby with a pipe and told us that the baby was dead already. Then they did not clear the baby. Instead, they put a saline. Next day I had labour pain and the baby came out. The *ayas* took me upstairs. I could not tell anything after that, I needed two bags of blood and a few stitches. The baby was a boy, quite big. He died (at this stage Shapla sighed with deep grief and silent cry). After that I stayed in hospital for 19 days. Both urine and faeces were leaking. I was very sick, weak. I could not even move. (Shapla, aged 20 years)

All the women in this study were first taken to the local or nearby hospital to treat obstetric complications, after the *dai* could not deliver the baby at home. Some women experienced obstetric fistula at a local health centre during the time when the health provider was trying to pull out the baby or in some cases after the woman in labour was taken to an EmOC with an already damaged pelvic area.

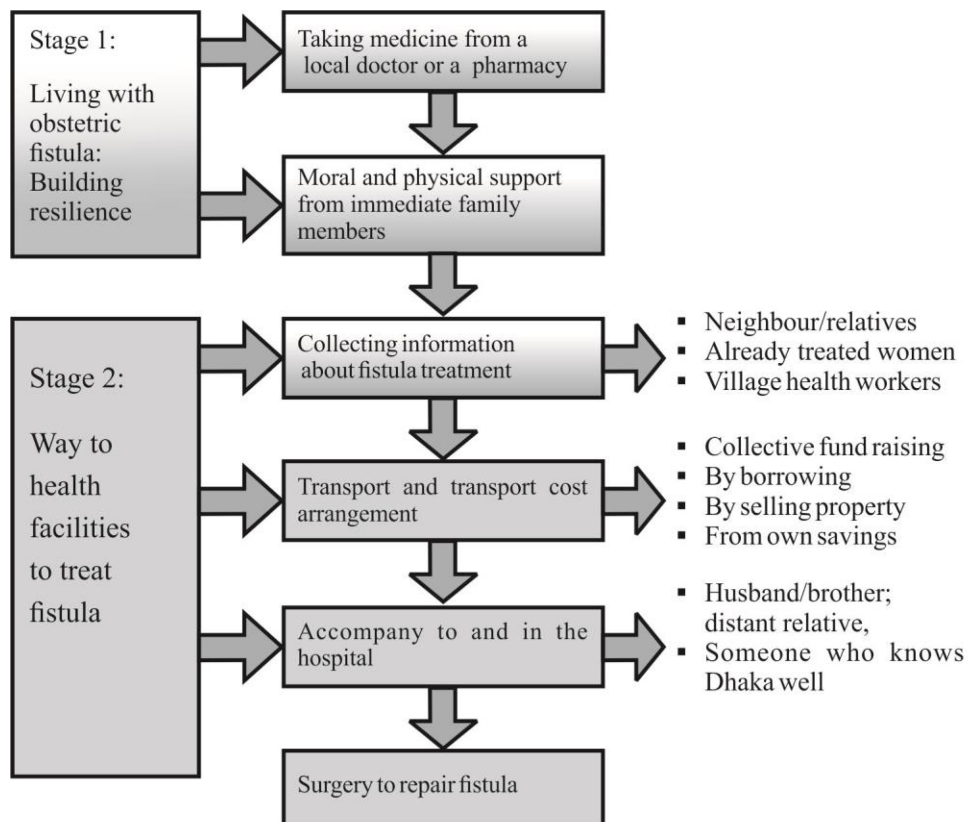

Figure 2: Health care seeking journey of women for treating obstetric fistula.

Source: Inspired by the illness response approach (MacKian 2003) and drawn from the interview data of the women suffering from fistula (Akhter 2015)

Gender inequality, low social status and disempowerment have a major impact on women's maternal health and access to maternal health care services. Ahmed et al. (2000) has shown that the probability of seeking any type of health care is almost twice as high among men as among women. This underlines the subjugated position of women in families, where women find it difficult to go to health facilities in an emergency. Thus, the occurrence of a maternal morbidity such as obstetric fistula cannot be fully explained by any particular cause or event, rather it occurs in a complex socio-economic and cultural context. This needs to be well understood to prevent obstetric fistula.

5 Health Care Seeking Behaviour for Obstetric Fistula: a Challenging Journey towards a Surgical Solution

Borrowing the idea from the 'illness response approach,' Figure 2 presents how a woman suffering from obstetric fistula copes with everyday life and how she seeks treatment. The illness response approach is based on the assumption that "behaviour is best understood in terms of an individual's perception of their social environment"' (MacKian 2003, p. 8).

The left side of the diagram represents the two stages of health care through which the women suffering from obstertric fistula must pass in order to receive treatment. In Stage 1, women live with fistula and build resilience to the condition with medicine and support from their family. In Stage 2, women find their way to a health facility for treatment. The various steps these women go through, first to build resilience and then to find their way to treatment, are shown on the right side of the diagram.

5.1 Living with Obstetric Fistula: Building Resilience

The lives of some fistula patients are impacted by a lack of resources necessary to care for their condition, such as time to wash their bodies throughout the day and soap to wash their clothes and beds frequently. Many women experience painful blisters on their inner thighs due to continuous leakage. In this condition, it is important that those women build resilience to continue life with the extra burden of maintaining their cleanliness. Bangser (2006, p. 535) noted such resilience among fistula suffering women in Africa as they continued to do their household work, care for their family members and keep themselves clean. The same is reflected in Akbari Begum's words,

> "I think my husband still loves me. Because, I try to keep him happy *(mon rekhe choli)*. I always keep myself clean, so that when he comes to me, he does not get any bad smell". (Akbari Begum, a fistula patient interviewed in this research).

Table 2: Major source of moral and financial support for treatment of obstetric fistula

Name of respondents	Types of support received			
	Source of financial support	Source of information about fistula treatment	Source of moral support	Person(s) who accompanied the woman to the hospital and waited with her
Shefali	Brothers	Woman from neighbouring village who has been already treated	Brothers	Brothers
Beli	By selling a cow	Another lady (Jobeda) coming here for treatment	Husband and son	Daughter-in-law
Rosy	Son	Son	Brother and son	Son
Jobeda	Brother	Distant relative and neighbour, who works in Dhaka	Brother	Alone (she knew this place as it was her second visit)
Shapla	Community donation	Doctor from the local clinic	Mother	Mother and husband
Kolmi	Husband and in laws	Sister-in-law, who works in Dhaka	Husband	Sister-in-law
Papiya	Borrowing from families and neighbour	Distant relative, (cousin's husband)	Husband	Husband
Jahanara	Savings	Cousin and Ad- din health worker from the neighbouring village	Cousins and sister	Alone
Sultana	Sons	Son	Husband	Daughter-in-law
Akbari Begum	Husband	Local clinic	Mother	Husband and husband's uncle
Shahanara	Brothers	Neighbour	No one	Alone

Source: Reference will be inserted after peer review

In spite of being isolated, stigmatized and poor, it is resilience that keeps these women going with high hopes of leading a normal life. It is their resilience and strength, according to Bangser (2006, p. 535), that encourages them to spend years looking for the money to get a surgical repair. The women in this study try to cope with their sufferings in two ways (Figure 2): First, through mental and moral support from their friends and family and second, which is more of a response to physical discomfort, is to go to a local healer or clinic to recover from the physical weakness or to get rid of the blisters between the inner thighs. For the women in this study, they were supported by at least one person

The support which may be in various forms, e.g., social, moral, motivational, financial, providing information etc. has come to the women in this study from a range of sources namely, parental family, husband, husband's family, distant relatives, neighbours, health workers (Table 2). The type of support received and the person providing that support is a major factor in defining the health care seeking behaviour of this group of women.

Jahanara, abandoned by her husband six months after having an obstetric fistula, has to work hard to earn her living. She also has to look after her ailing mother. Jahanara has received advice, information, financial help and clothes from her distant relatives and neighbours, and provided assistance. This extent of support is identified as community strength for the fistula affected women.

6 Receiving Comfort and Treatment from Local Healers

While waiting to receive surgical treatment for obstetric fistula, it is also very important for these women to address their other health and non-health problems that tend to reduce their working capacity. To do this, the women sought temporary treatment from local doctors or traditional healers. This not only reduced the incidence of health-related impacts of obstetric fistula but also helped the women to cope with their life. Jahanara stated her efforts to seek temporary comfort as follows:

> "I have a life of severe suffering. I always have to use *taana* (old soft clothes used as pad). Whenever, any scar or sore appears, I get medicine from the doctor. The husband of one of my cousins is a doctor. He runs his practice from a pharmacy close to our house. He gives me medicine almost free of cost. He has a lot of *maya* (sympathy) for me".

7 Looking for Treatment: Seeking Health Facilities

The length of time elapsed between the onset of obstetric fistula and seeking treatment (as shown in Table 1) indicates that treating fistula is not an easy task by any means -- for the suffering women, as well as their families.

The second part of the framework in Figure 2 illustrates the phases and challenges which the women have to go through to seek treatment. It suggests that they have to overcome four challenges in seeking treatment, namely collecting information, arranging transport and its cost, finding someone to accompany the woman to the hospital and waiting there.

8 Collecting Information about Fistula Treatment

> "I did not know *Apa* (sister) where to go for treatment- (said with a blank eye and with frustration in her voice). In the meantime, I saw some *Fakirs* (traditional healer). But this is not that type of disease that a *Fakir* can heal. This is a disease for a doctor. When the urinary tract gets sore or has scars, then a *Fakir's* medicine can give some comfort. But *Fakir* cannot heal *peshaber tholir futa* (hole in urinary bladder). Everyone advised us to go to Dhaka for operation, but no one told us where to go when in Dhaka. Moreover, everyone said it would need lots of money. How would we manage money? Now, my husband's sister lives in Dhaka. She works in the garment industry. She brought me here". (Jobeda, aged 25 years)

> "I and that girl (showing Azida lying on the bed next to hers) came here together. That girl is also from my village. Her sister-in-law (husband's sister) works here in Dhaka as a garment factory worker. Her sister-in-law told her about this place and brought her here. She told me, '*chachi* (aunty) let's go together'. Then we came here together. We don't need money here" (Beli, aged 44 years).

The above two statements reveal that getting information about the appropriate place for the treatment was the first and biggest challenge for them. There were hardly any official sources of information about fistula repair. Only one woman received proper information from any health facility about the places, the costs and surgical procedures involved in treating or repairing fistula. For most of the other women, the major source of information was distant relatives, neighbours or village health workers.

Wegner et al. (2007, p. S110) have discussed the importance of community networks that provide information about resources and support for women who have obstetric fistula or process of reintegration into the community after treatment. However, support and information that the women received from their social network does not in any way substitute for the importance of access to, and supply of information about obstetric fistula and its treatment in all institutionalized health care centres.

9 Transport Costs and Arrangements

The second challenge to repair fistula is arranging transport costs. Although the treatment for fistula is provided free of cost, the women at the Ad din Hospital had to raise money to meet their transport costs and other unanticipated costs.

Figure 2 suggests that the women were able to arrange transport costs from different sources, such as borrowing money, selling property, donations from the community or own savings.

> "Everyone in my village donated a little amount of money to meet my transport costs. Everyone had sympathy for me. They saw how I have suffered for such a long time. So, when they came to know that I was going to Dhaka for treatment, everyone helped me. When I started from home, all my neighbours came to my courtyard to see me off. They all said we will pray for you" (Beli, aged 40 years).

The money collection experiences of the women signify a great empathetic community support in Bangladesh, where informal social networks hold much importance in treating fistula. Wegner et al. (2007, p. 109) emphasize this importance of community network, including friends, family, husbands and neighbours in different steps of the treatment. They argue that as most fistula affected women live outside the mainstream of their societies, they are even less likely than other women to know that most fistulae can be repaired, let alone where to go to for treatment. Thus, social networks serve a pivotal role in the treatment seeking behaviour for fistula.

10 The Need for an Escort

Travelling to a health centre alone is a challenge for the fistula affected women. Thus, the third challenge in their path to repairing fistula is to get a person who can escort them to a fistula repair centre like Ad-din Fistula ward and do the initial formalities for admission. Women received support from family members and the wider community to find an escort to the hopsital. Most of the women reported that they were accompanied by someone who knew Dhaka well, be they distant relatives or friends. Again, this highlights the significance of a social network in dealing with fistula.

11 Treatment of Fistula: Physical, Social and Mental Healing

The women reported that they felt relieved and hopeful that they would get better as soon as they arrived at the hospital. Coming to the hospital gave the women not only hope for physical healing, but gave them reassurance about themselves by being associated with other women in a similar condition. They also felt happy with the level of care at the hospital which they had never received before. Success in fistula repair is usually defined by medical professionals in terms of its clinical outcome. Beyond this definition of surgical repair, it is important to also understand how women perceive the intervention, even when it does not repair the condition completely (Molzan et al 2007). The present study also found that being able to receive health care for fistula repair after years of suffering is a great stress reliever for the suffering women. Karimunnessa, lying in a bed with a catheter attached, told me with great happiness:

> I am feeling very good after coming here. I am staying in dry clothes. It seems to me that I have found a new life in this world of Allah. You can't think of how much suffering I had! In this winter time, I had to wake up at midnight, wash my clothes. I shivered in the cold. I used to make fire at midnight, dry my clothes and warm myself and then go to bed again. Now, I have to do nothing like that. I am feeling very good".

Thus, while repairing fistula is the ultimate goal of the treatment, even attempt to receive treatment has an impact on the affected women, not only in physical healing of their ailment but also in healing the mental sores.

12 Discussion

The findings suggest that the major underlying factor that played a pivotal role in making it possible for the women to treat fistula was their social network. The women were supported by their social network consisting of intimate family members, near and distant relatives, neighbours, friends and village health workers. They received support at every challenge they experienced towards receiving fistula repair.

The 'Social network' theory developed during the 1950s by a number of British anthropologists established

its links with health outcomes (Berkman et al. 2000, p. 845). Network analysis focuses on the structure and composition of the network, and the contents or specific resources which flow through those networks (Berkman et al 2000, p. 845). The proponents of this theory argue that one of the ways through which the structure of the network influences health is through the provision of social support, which may take the form of emotional, appraisal and instrumental support. The sources of such support can be varied, for example, intimate family, distant relatives, neighbourhood, voluntary or religious organisations etc.

However, while the theoretical discussion of the 'social network' focuses mainly on the structured network ties in different phases (Grootaert and Bastelaer 2002; Berkman et al. 2000), the social network from which the women in the present study received support is informal and loosely structured, and mostly built on community empathy towards the women. As social networks seemed to play a crucial role in shaping the health care seeking behaviour of these women, a more structured network within the community in which the women live could provide a stronger source of support for them. Such a network could provide not only information, moral, physical and social support but it could also give them a platform to empower and educate themselves in terms of maternal health. Story (2012, p. 83) identifying the importance of such networks, argues:

> Promoting diverse, heterogeneous networks that include individuals with decision making power, may give communities better access to resources and information, as well as to voice their claims and negotiated support.

13 Conclusion

Based on the interviews of 11 fistula affected women receiving treatment at the Ad-din Hospital, this paper addressed first, the situation of the sufferings of fistula affected women and the context and the causes of their contracting fistula, and second, their journey towards surgical repair of fistula, the challenges they encountered in this journey and how they met these challenges.

The context and causes of fistula are remarkably similar for all the women interviewed. They were married very young (on average three years below the stipulated minimum legal age at marriage in Bangladesh), they conceived soon after marriage when they were physically not mature enough (much smaller pelvic sizes), went through prolonged obstructed labour (and sometimes, eclampsia) and could not obtain emergency obstetric care (EmOC). Underlying all these physical conditions was their poverty and malnutrition. While campaigns for raising the age at marriage backed up by law are in progress, the husbands of these young brides should be given education and information about the need to postpone the (first) child birth at least until the wife is 20 years old, and motivated to use contraception for this purpose.

Regarding these women's journey to treat fistula and the challenges they faced and overcame in their journey, it was found that social and neighbourhood networks were at the centre of this journey.

The women were found to be very keen in treating their illness. Their major challenges in seeking care for fistula was gathering information about where to go for appropriate treatment. The other challenges consisted of arranging the cost and transport. The major support for these women to overcome these challenges and seek treatment came from their network of family, neighbourhood or the community. The importance of building a more structured social network has been mentioned before for providing women with treatment for fistula. However, information about the treatment of fistula should also be within easy reach of these women. While it may not be practicable or possible to equip the local health service centres or hospitals with sophisticated surgical procedures for repairing fistula or treating other morbidities, they should be equipped at least with a strong and effective support mechanism and referral capability. Earlier treatment (within three months of the onset of the problem) for obstetric fistula repairs the hole more effectively (Wall 2006, p. 1,204). That is why the support mechanism in local health centres and within the community, and communication between both, might help the fistula affected women in Bangladesh to quickly find treatment care options for this severe condition.

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