

Opportunities for Integration of RTI/STD Services into FP-MCH Programs

**Syeda Nahid Mukith Chowdhury
Senior National Fellow**

**Ismat Bhuiya
Research Officer**

**Sk Nazmul Huda
Research Officer**

**Abu Jamil Faisal*
Country Representative**

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PO Box 6016, Gulshan, Dhaka 1212
(House CES(B) 21, Road 118, Gulshan)
Telephone (880-2) 881227, 886657, Fax 883127, 883132
Email PCDHAKA@POPCOUNCIL.ORG

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Preface

The background to this Project was a concern that Bangladesh relies heavily on a handful of contract research organizations to generate most of its population data, and in many cases to provide population policy guidance to the Government. A more desirable situation would be that the country has a number of stable research institutions with well trained researchers capable of conducting policy relevant research for the Government and others.

The objective of the Project then, has been to provide the opportunity to a group of less experienced researchers to gain experience by participating in a number of studies under the guidance of more experienced researchers. In addition to their involvement in every step of the research process, from study design and questionnaire development, through the fieldwork and data collection phase, to writing the final report, these researchers have received formal training in data collection, data analysis, presentation techniques, and other aspects of research from the hands of the senior members of the Project.

In addition to the above mentioned objective of building policy research capacity, a further objective was to make the studies relevant in their own right. For this reason all the studies were designed to focus on issues of current importance as the whole field of population research is evolving to include broader aspects of reproductive health. The titles of the five studies reflect this emphasis.

- (i) Opportunities for Integration of RTI/STD Services into FP-MCH Programs
- (ii) Strengthening STD Services for Men in an Urban Clinic Based Program
- (iii) Study of Adolescents: Dynamics of Perceptions, Attitudes, Knowledge, and Use of Reproductive Health Care
- (iv) Traditional Family Planning in Bangladesh
- (v) Increasing the Financial Sustainability of Family Planning Service Delivery in Bangladesh

The completion of these five studies from recruitment of the research staff through the initial design, to the production of the final study reports, has taken place over the past twelve to eighteen months. Needless to say this has been a period of intense activity, but we hope the readers will consider the products to be worthwhile.

While we believe this Project has contributed to the building of the research capacity of our team, there remains the issue of building research institutions for researchers to function in. We encourage the Government, the development partners, and our fellow researchers to continue to strive to achieve this important goal.

Kim Sweatfield
Project Director

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AITAM	Associates in Training and Management
ANC	Antenatal Care
AVSC	Access to Voluntary and Safe Contraception
BM	Burning Micturation
CSW	Commercial Sex Workers
DCI	Data Collection Instrument
DGFP	Director General of Family Planning
EPI	Expanded Programme on Immunization
F Up	Follow up
FP	Family Planning
FP-MCH	Family Planning - Mother and Child Health
FPI	Family Planning Inspector
FWA	Family Welfare Assistant
FWC	Family Welfare Center
FWV	Family Welfare Visitor
GO	Government Order
GOB	Government of Bangladesh
GRH	General Reproductive Health
H&FWC	Health and Family Welfare Center
HB	Heavy Bleeding
HBsAg	Hepatitis B surface Antigen
HIV	Human Immunodeficiency Virus
HLD	High Level Disinfection
IEC	Information, Education and Communication
Inj	Injection
IP	Infection Prevention
IUD	Intrauterine Device
KAP	Knowledge, Attitude and Practice
LAP	Lower Abdominal Pain
MAT	Medical Assistant Training
MBBS	Bachelor of Medicine and Bachelor of Surgery
MCH	Mother and Child Health
MCHTI	Mother and Child Health Training Institute
MCWC	Maternal and Child Welfare Center
MFSTC	Mohammadpur Fertility Services and Training Center
MIS	Management Information System
MO	Medical Officer
MR	Menstruation Regulation
MSM	Men who have Sex with Men

MSP	Multiple Sex Partner
NGO	Non Government Organization
OT	Operation Theater
PC	Population Council
PV	Parvaginial
PID	Pelvic Inflammatory Disease
PNC	Post natal Care
RH	Reproductive Health
RTI	Reproductive Tract Infection
SC	Satellite Clinic
SS	Social Scientist
SACMO	Sub Assistant Community Medical Officer
SP	Service Provider
STD	Sexually Transmitted Diseases
TBA	Trained Birth Attendant
TFPO	Thana Family Planning Officer
THC	Thana Health Complex
TPHA	Treponema Pallidium Hemagglutination Test
USG	Ultrasonogram
VD	Vaginal Discharge
VDRL	Venereal Disease Research Laboratory
VI	Vaginal Itching
VU	Vaginal Ulcer

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We strongly feel that the contributions of these people have resulted in a document which will contribute in enhancing the reproductive health status of women in Bangladesh.

Authors

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EXECUTIVE SUMMARY

BACKGROUND

One of the principle challenges for the Bangladesh National Family Planning and Maternal Child Health program is to integrate the services required in the reproductive health agenda into existing programs. This study is based on one of the most important reproductive health concern that is the RTI/STDs. In service delivery points, which provide family planning and MCH services, RTI/STD services are an area of continued neglect. Yet RTI/STDs have a tremendous significance in the context of the FP-MCH program. The population at risk of pregnancy and in need of family planning services are the same as the population at risk of contracting RTI/STDs. The most common symptoms of RTI/STDs such as abnormal vaginal discharge, itching, lower abdominal pain are similar to the side effects of certain family planning methods like IUD and injectables. The users of the methods often perceive these symptoms as contraceptive side effects resulting in method discontinuation. Since women are already visiting various tiers of FP-MCH infrastructure for services, it is logical to consider the potential for integration of RTI/STD services in the same structure.

This study documents the service delivery process with particular attention to the management of RTI symptoms during existing reproductive health service delivery at GoB and NGO service points.

Methodology

The study was conducted in collaboration with AVSC International, in 45 purposively selected Service Delivery Points (SDPs) both from GoB and NGO in and around greater Dhaka city. Five categories of services were observed: new FP acceptors, FP follow up and complications management, ante natal care, post natal care and general reproductive health care services.

Findings

All the clients were female and married. During in-depth interviewing before receiving services, 81 per cent of clients said they had suffered from at least one RTI symptom during the three months preceding the survey. Seventy seven per cent were suffering from at least one RTI problem at the time of interview and 37 per cent mentioned that their husband suffered from at least one RTI/STD problem.

However a large percentage of clients who reported vaginal discharge, lower abdominal pain, painful coitus and urinary problem during interview, did not state their complaints to the provider spontaneously. This is probably because the entire service delivery process is driven by the clients' primary reason of visit, as a result clients do not mention these problems and providers also do not explore them. Spontaneous reporting of RTI problems was found more commonly among FP clients with side effects where they

report these as method related complications. A small number of clients came exclusively for the treatment of RTI problems.

A comprehensive reproductive history is an essential element of FP service delivery, but the service providers seldom obtained comprehensive reproductive history.

Counseling was rarely comprehensive. During the observations out of 68 cases of new FP acceptors, 52 received counseling but most of them did not get full information, particularly information on side effects, complications and follow-up.

The quality of counseling also varied across the SDPs. In the NGO facilities, 16 out of 21 cases of all new FP acceptors received counseling. Yet in most GoB facilities less than one third of the clients received any counseling. Counseling was better in coverage and quality in FWCs compared to THCs and larger facilities.

It is apparent that the current practice of counseling is inadequate to provide the client with correct information. The policy issue is how to give input in order to enhance providers' skill as well as their attitude in communicating with clients.

Pelvic examination is a basic screening tool for almost all reproductive health care. Ideally pelvic examination should be performed for all new FP acceptors, FP clients with side effects and clients with other reproductive health problem. In the observations, out of 68 cases of new FP clients who came to the SDPs for services, routine pelvic examination was performed in only 40 cases. Overall the providers missed the opportunity in 62 per cent cases to address the problems of RTIs.

The quality of pelvic examination showed a wide variation across the SDPs. Often poor infection prevention practice such as not following aseptic precautions during swabbing, use of unsterile equipment, not wearing gloves and poor hand washing practice was observed. This enhanced clients risk of iatrogenic infections.

The providers could detect RTIs in only 21 per cent of cases. One third of these cases received specific treatment (metronidazole/antibiotic) and the rest got only symptomatic treatment. Treatment to the client's partner was provided in two cases.

There were ten general reproductive health clients who came exclusively for RTI related conditions. In only half the cases the providers detected RTIs only on the basis of clients complaints, out of which three received specific treatment, one was referred and one was only counseled. In the other five cases, providers made no attempt to explore the RTI conditions. Although 4 post natal clients presented with RTI-like symptoms providers could not detect RTI in any of them and hence none received any treatment.

Fifty per cent of the clinical service providers were FWVs, 32 per cent were doctors and 17 per cent were nurses and nurse aides. Most of the providers were experienced, trained in FP and also had orientation on RTI/STDs.

Stated practice of the providers regarding pelvic examination reveal that all providers in the THCs, FWCs and satellite clinics performed a pelvic examination in both new and

old IUD clients. In the special facilities one third of providers and more than eighty per cent of providers in FWC and satellite clinics stated that they perform pelvic examination in case of all injectable clients. In the NGO clinics more than two thirds of the providers mentioned about pelvic examination in case of IUD and injectable clients and less than half mentioned it for general reproductive health problems.

Stated practice of management of RTI/STDs condition shows that most doctors prescribe and provide medication for both partners. Some doctors prescribed treatment for the clients and asked the partner to come for treatment at the SDPs. More than one third of the FWVs/nurses mentioned providing prescriptions and drugs for the client as well as the partner, and about one fifth mentioned providing prescriptions for both. It seems that the providers have some awareness regarding the importance of partner management. As there is no protocol, the management depends solely on the provider's own judgment.

Personal hygiene was the most commonly mentioned element of RTI counseling by the doctors as well as the FWVs. However doctors mentioned condom use, low risk sexual behavior and partner management more than the FWVs.

Most of the common RTI/STDs can be diagnosed by direct microscopy. However stated practice of the providers shows that very few of them ask for direct microscopy such as gram stain or wet mount. Two thirds of the doctors mentioned VDRL/TPHA and HBsAg which are diagnostic tests for syphilis and hepatitis B respectively. It seems the providers do not have adequate knowledge on basic laboratory investigation for the diagnosis of common RTI/STDs.

Policy Implications

Women recognize their problems of RTI/STDs. Their health seeking behavior for family planning and maternal services provides an opportunity to address their RTI problems.

Basic building blocks for RTI services are present in the system. Service delivery protocol can be revised so that each contact is seen as an opportunity, and client provider interaction is maximized.

Providers need to be more proactive in utilizing these opportunities. The policy challenge is to change providers attitudes, improve their skills in dealing with clients as well as technical competence, and create an environment which enhances effective client provider interaction.

Existing training programs can be utilized to orient providers on an holistic concept of reproductive health approach and the inter-link between RTIs and the other reproductive health services.

To ensure effective utilization of training and quality of services providers need support and competency based supervision.

CHAPTER 1

Background

1.1 INTRODUCTION

One of the principle challenges for the Bangladesh National Family Planning and Maternal and Child Health program is to integrate the services required in the reproductive health agenda into existing programs. Progress has been made in the area of essential obstetric care with the development of model programs at Thana and District levels in THCs, district hospitals and MCWCs. Antenatal care initiatives which reach into the community and are attentive to the identification of high risk women are also being implemented.

The same GoB personnel who have been providing family planning services are being employed to assist with the delivery of the broader reproductive health agenda. Thus, FWAs are being used at the community level, initially to identify all pregnant women and then refer those at high risk to service sites. At the service sites, FWAs are encouraged to attend the normal deliveries and to refer those which need emergency obstetric care or assisted delivery.

An area of continued neglect, however, is the management of RTIs in service points which provide family planning and MCH services. Minimal experimentation has begun in the use of syndromic management for RTIs but no systematic training for potential providers or treatment for clients has been developed. The purpose of the study described in this report is twofold: (1) to identify where RTI/STD intervention fits into the on-going MCH/FP program, and, (2) to identify what RTI/STD intervention activities can be undertaken which are in accordance with the objectives and strategies of the present program.

This study is based on a serious public health concern. RTIs are one of the most common health problems affecting women of reproductive age in South Asia. Studies undertaken so far in India and Bangladesh have revealed that more than 50 per cent of women are suffering from some kind of RTI. Some RTIs are sexually transmitted. In a recent study a 3.8 per cent prevalence of gonorrhoea (Chowdhury et al., 1995) was found among women in the general urban population. This indirectly reflects the presence of high risk sexual behavior.

Untreated STDs have profound impact on reproductive health and health care initiatives. Gonococcal and chlamydial cervicitis can ascend upwards in the reproductive tract and lead to pelvic inflammatory disease (PID). PID, untreated, leads to scarring and blockage of the fallopian tubes, ectopic pregnancy, infertility, foetal wastage, low birth weight babies and blindness in newborns. Syphilitic infection of the mother can lead to congenital infection and malformation of the foetus, mental retardation and stillbirth. Bacterial vaginosis, the most common RTI, can cause premature delivery and low birth weight babies.

It is clear from available health information that RTIs of all types compromise fertility, pregnancy outcome and child survival. The management of the complications of RTIs is expensive and increases health care costs. Hence there is an urgent need to improve the availability and accessibility of preventive and curative RTI/STD services within the existing infrastructure.

Only one element of the current health infrastructure in Bangladesh consistently reaches women. This is the MCH/FP program. The population at risk of pregnancy and in need of family planning services are the same as the female population at risk of contracting RTIs. Since women are already visiting various tiers of MCH/FP infrastructure for services, it is logical to consider the potential for integration of RTI/STD services in the same structure.

RTI/STDs have a tremendous significance in the context of the MCH/FP program. Side effects of the contraceptive methods, or other health reasons, are by far the most commonly reported reasons for discontinuing use of the oral pill (45 per cent), injectables (58 per cent) and IUD (37 per cent) (BDHS 1993-94). The most common symptoms of RTI/STDs are similar to the side effects of certain family planning methods. The users of the methods often perceive these symptoms as contraceptive side effects. In a recent study, nearly 10 per cent of the IUD users reported lower abdominal pain and discharge, ultimately leading to removal of the IUD. With appropriate counseling and management of side effects, women are more likely to continue the methods.

RTIs can also be caused by unhygienic medical procedures. A recent study on service delivery quality of clinical family planning methods revealed poor practice of aseptic technique among the family planning service providers (Barkat et al., 1994).

This study examined the service delivery for clients who presented for family planning, ante and post-natal care, and general reproductive health complaints. Current practice was observed to determine the present quality of RTI services and areas where these services could be improved.

1.2 LITERATURE REVIEW

The present study is designed to examine opportunities for integration of RTI services in existing family planning and MCH services. Studies which related to this work include situation analysis of supply-side program issues, studies which have examined aspects of quality of care in family planning and MCH services, evaluation of the quality of service delivery for specific methods, and studies on RTI prevalence in Bangladesh.

Three situation analysis studies have been conducted in Bangladesh. These focused on supply-side issues and facility preparedness. 1) examined the nationwide delivery of clinical methods at GoB services points (Barkat et al., 1994), 2) observed Rajshahi Division service points and their delivery of MCH/FP services (Rahman et al., 1996) and, 3) focused on a limited number of service points which provide family planning services in the GoB sector (Islam et al., 1996). Findings of each situation analysis consistently highlight serious gaps in staff training and placement, equipment and supplies, and in the facility maintenance. These gaps directly and indirectly affect the quality of care which can be provided. Barkat et al. found that autoclave, as well as other equipment for sterilization of instruments, was not available in many clinic sites. Breaches in infection prevention, particularly for the delivery of IUD services, were routinely observed. Several gaps were noted in FWCs which are the primary service point for injections and IUD services. Injection sites were disinfected in only 22 per cent of the FWCs. The service provider washed her hands before a pelvic examination in only 33 per cent of FWCs. A sterile speculum was used in only 33 per cent of the IUD insertions in the FWCs.

There was considerable difference in the way IUD clients were served at different types of facilities. History of vaginal bleeding and discharge was sought from the client in only 8 per cent of FWCs but in 83 per cent of Model Clinics. Providers asked about pelvic pain in only 8 per cent of FWCs and 60 per cent of the MCWCs. The study concludes that "Compliance with proper aseptic procedures is a *sine qua non* for ensuring high quality clinical contraception services. In general, the lower tier SDPs, namely FWCs and THCs, comply less with the aseptic measures than the higher tier SDPs. The non-compliance with aseptic procedures were observed to be more prevalent among the service providers in the FWCs"

Rahman et al 's MCH/FP situation analysis covered all types of service delivery points in Rajshahi Division. Great differences were found in the readiness to serve clients properly at the different types of facilities. The authors conclude that "MCWCs and FWCs are specially designed and constructed to provide MCH and FP services in specific localities. Physical facilities in MCWCs and FWCs, like waiting space, rooms for service dispensation etc. were most satisfactory. These facilities in almost all cases were underutilized when the number of recipients of services on a daily basis (10-12 per day) were considered. MCH/FP unit at the THC were located in 3-4 rooms, generally in the back wing of the THC building. These rooms were supposed to provide waiting space, sitting room of MOs and FWVs, clinic room, insertion room, sterilization room, laboratory, dispensary room, delivery room etc. The space was inadequate to manage quality of MCH & FP service. Similarly, the satellite clinics were held in one room of a simple village home. The number of clientele per day made it difficult to provide proper service to the clients"

Regarding essential equipment, Rahman et al found that, "In a sizeable number of clinics, all the equipment required for smooth service delivery was not available". MCH kits were not available in 45 per cent of FWCs, 37 per cent of THCs and 18 per cent of MCWCs. MR kits were not available in 45 per cent of FWCs and 29 per cent of THCs and MCWCs. As important as the lack of equipment is the readiness to use the equipment. Rahman et al found that "In about one fourth of the cases, the service providers did not have knowledge to maintain this equipment". Equipment for sterilization of instruments was found in a " large majority of the clinics (MCWC 94 per cent, THC 87 per cent, FWC 36 per cent). However, a number of these were not found in working condition". This renders them useless for the intended purpose.

Quality of service was observed and Rahman et al concluded that "The service providers in majority of the cases neglected the basic principle of history taking and clinical examinations. The service providers, particularly the FWVs have (70-80 per cent) lack of skill in palpation of abdomen of a pregnant woman to diagnose, position of the foetus, duration of pregnancy (height of fundus) etc. Incompetence was observed most in cases of FWVs. This may be due to (1) inadequate knowledge (2) lack of interest or unconcerned attitude (3) non-availability of medicine in proper quantity"

A third situation analysis (Islam et al , 1996) focused on quality of care in family planning services in MCWCs, THCs, FWCs and satellite clinics. Quality varied greatly at the different tiers. While in MCWCs clients were treated in privacy this was not found in the other service points. In all cases clients were treated hurriedly. Satellite clinics were reported to be particularly poor on quality of care. "Privacy of clients were not maintained, checkups were often done publicly. Satellite clinics were found to be unclean and unhygienic with inadequate facilities for sterilization and scarcity of clean water. Providers would often not wash their

hands. Contraceptive methods were often not explained, side effects not discussed. In only 3 of the 21 clinics did observers feel that the premises were sanitary and the providers courteous and helpful."

Annual evaluations (Kamal et al 1990) of the IUD service delivery program were conducted for three years, 1988-1990. Regarding elements of quality of care, the latest evaluation reports: "There are some encouraging trends in terms of clinic facilities and procedures. The percentage of providers who had access to a means of sterilizing equipment has increased substantially and there has been a smaller upward shift in the availability of a table for inserting IUDs. Actual sterilization procedures, however, have not changed much over the three years, which is disappointing in view of the apparent improvements in equipment, and the marked increase in refresher training." This is a disturbing finding which implies that the provision of equipment and solving other supply-side problems in the program may not impact on improved quality of services.

Kamal also reports that "A large number of clients suffer side-effects and have the device removed for this reason." While the author opines that "This problem cannot be avoided," he goes on to recommend that "Detailed instruction for treatment of main side-effects (heavy menstrual bleeding, pain) should be issued to FWVs. In view of the significant minority of clients (6 per cent) who complain of vaginal discharge, a detailed medical study of reproductive tract infections might be useful. In the longer term, better training of FWVs in diagnosis and treatment of RTIs would be very beneficial."

An evaluation of the quality of Norplant services (Kamal et al 1991) found that "88 per cent of women were satisfied or highly satisfied with the service they had received. Only 2 per cent of the clients were not at all satisfied." Clinical quality for insertion and removal was observed in a very limited number of cases and found to be satisfactory in most cases. However, the following lapses were observed: "In three out of the 7 centers, the physicians use one set of instruments for insertion and removal of multiple cases without proper sterilization of the instruments between cases. The usual practice was to clean the instruments with savlon solution, which does not meet with accepted guidelines for aseptic procedures. In 5 out of 7 centers physicians put gloves on one hand only, generally without washing their hands." At the time of this evaluation, Norplant services were limited to clinic trials in seven clinics.

Quality of clinical contraceptive service delivery, particularly sterilization and IUD, was assessed by a joint GoB and AVSC International team (Ahmed et al, 1992). The team concluded that one of the major factors for the decline in clinical contraceptive acceptance was "the erosion in the medical quality of sterilization and IUD services because of inadequate training and supervision, and the development of increasingly negative 'contraceptive images' of these contraceptives, especially for IUDs, in the community and among service providers." Of particular concern to the team was infection prevention. They concluded that "asepsis is not well maintained and infection control practices are quite deficient. In many sites autoclaves are broken, too small, sitting idle because of lack of kerosene, or are not properly used, autoclaving is frequently done by lower level staff (e.g. peons) who have no formal training and are not closely supervised. Aseptic techniques are frequently disregarded by FWVs during IUD insertion. Scrub facilities are frequently inadequate, and clean running water is often not available." In the two years prior to the assessment (1990 and 1991), there had been a total of 22 sterilization related deaths. Of these, 100 per cent were tetanus deaths in 1990 and 60 per cent in 1991.

The prevalence of RTIs in the population who would be attending the clinic for family planning or MCH services is relevant to this study. Limited prevalence studies have been published in Bangladesh (Chowdhury et al 1995, Hossain et al 1996, Wasserheit et al 1989). Though the populations studied were from quite different locations, findings in these studies show similar prevalence in married women of reproductive age. Chowdhury et al found a prevalence of 60 per cent RTIs in an urban clinic setting while Hossain et al reported 56 per cent in a rural clinic-based sample.

Wasserheit et al, 1989 found IUD users and tubectomized women were 4 times more likely than nonusers to report abnormal discharge or lower abdominal pain while users of hormonal methods were 1.6 times more likely to report these symptoms. Among women who had a confirmed RTI, 24 per cent were tubectomized and 22 per cent were IUD users compared to rates of 5.6 per cent in users of hormonal contraception and 3.5 per cent among nonusers. This suggests that tubectomized women and IUD users were 7 times more likely to have a confirmed RTI than nonusers.

One limited sexual behavior study has been done in a rural area in Bangladesh (Naved 1996). The findings indicate that women have misperceptions and misbeliefs about how STDs are transmitted. No women interviewed took any precautionary measure even when they understood that their partner had an infection. They used neither condoms nor abstinence in these cases.

Until very recently, there has been little interest in furthering knowledge about RTIs. However, ICDDR,B and other organizations in Bangladesh are currently undertaking several studies which will add to the available information. These studies are focused on different aspects of the RTI/STD problem. Some will increase information about prevalence in specific at-risk populations (CSWs, men who have sex with men, and drug users), as well as slum-dwellers and the urban and rural population who attend clinics. Others are examining the role of rural practitioners in RTI screening and treatment. Finally, studies are being conducted on suitable RTI control programs in the Bangladesh context.

The studies completed thus far, and those that are now in progress, indicate that service points may not be ready to provide appropriate counseling, health education, diagnosis and treatment to clients who have RTIs. In some cases it is possible that infections are being introduced by inappropriate aseptic procedures in clinics, particularly with the inappropriate delivery of IUD services or pelvic examinations. This study should provide insights into how RTI services can be integrated into existing family planning and MCH services.

1.3 MCH-FP INFRASTRUCTURE

Bangladesh has a fairly established maternal and child health based family planning service delivery infrastructure in the rural areas in the public sector. In the urban areas the infrastructure is not as well organized. Within the rural service delivery infrastructure there are the Thana Health Complexes (THCs), Health and Family Welfare Centers (H&FWCs), Satellite clinics and then are the community based field workers/service providers named Family Welfare Assistants (FWAs). At the district level there is the Maternal and Child Welfare Centers (MCWCs) and in eight medical colleges there are Family Planning Model Clinics.

Beside the FWAs the other service providers are Medical Officers with different designations Family Welfare Visitors (FWVs)/nurses and Sub Assistant Community Medical Officers (SACMOs) The FWVs are all females and the SACMOs are mostly males The FWVs are supervised by a Senior Family Welfare Visitor stationed at the thana headquarters

Much of the MCH-FP services are rendered by the FWVs and the SACMOs The Medical Officers also play a vital role in the service delivery system They perform supervisory and technical service delivery functions According to the current Bangladesh policies voluntary sterilization and Norplant services shall have to be provided by a Medical Officer The Medical Officers are always the first line of technical consultation for the FWVs and SACMOs providing support to the management of major side effects and complications of the different contraceptives The Medical Officers according to their job description are supposed to provide on-site training to lower level service providers

The FWVs are the most important provider in the Bangladesh FP-MCH service delivery system She has a long list of duties to perform The list includes

- a Attending women in the antenatal and postnatal period
- b Conduct normal deliveries
- c Attend to children particularly weighing them maintain the growth monitoring chart, immunization and provide treatment of minor ailments
- d Undertake counseling and provide contraceptive services particularly pills, condom, injectable and IUDs Assist the medical officer in performing sterilization and Norplant procedures Attend to clients coming back with all complaints and complications and refer them where necessary
- e Conduct health family planning and nutrition education sessions
- f Conduct satellite clinics
- g Visit clients at their homes as felt necessary
- h Maintain all clinical records, prepare reports and perform other administrative functions

The SACMOs/MAs are located at the H&FWCs Their responsibilities includes attending patients and prescribing them for all minor ailments, provide first aid and attend all emergencies, perform minor surgeries, assist the FWVs in attending the sick children, assist the Medical Officer in performing voluntary sterilization procedures, maintain all infection prevention steps at the H&FWCs, associate in all preventive health care and control of any epidemic in the area Besides the technical jobs her she has to also perform certain administrative functions

In the NGO sector most of the rural service delivery points are similar to the H&FWCs and these are managed by paramedics equivalent to the FWVs in the public sector The cadre of paramedics include FWVs coming from the public sector, nurses, female MAs, midwife, specially trained health auxiliary staff and female laboratory technicians etc Almost all of the paramedics have received basic or refresher training on family planning services These paramedics perform almost all of the functions as the FWVs They also have to do some of the jobs assigned to the SACMOs in the public sector

There are some NGO service centers where there are physicians and paramedics available. In many of the urban NGO clinics there is another category of service providers namely counselors. Some of the counselors are of social science background but others are paramedics. There are very few NGO service delivery centers where the physicians or the paramedics are involved in performing MR. In comparison all FWVs of the public sector are involved in doing MR at the static facilities or in their private practice.

Unlike the Senior FWV supervising the FWVs and also the MO (MCH-FP) conducting medical monitoring functions, in the NGO sector there is no uniform supervisory system in the different organizations. In the public sector there is a physician stationed at the district headquarter designated as Assistant Director (Clinical Contraception) responsible for medical supervision of the FP-MCH service delivery in the respective districts. There is no equivalent in the NGO sector.

In Bangladesh the profit making private sector FP-MCH service delivery system is not well organized. The true private sector is yet to develop themselves like the NGO or the public sectors. The private sector service providers are mostly physicians and very few FWVs/nurses are available at the district and thana levels. It is interesting to note that the bulk of private practicing physicians are actually full time paid public sector employees. These private sector service providers are involved mostly with MCH services and very little FP.

1.4 PURPOSE AND OBJECTIVES OF THE STUDY

The purpose of this study is to identify where RTI/STD intervention fits in the ongoing MCH/FP program and to determine what RTI/STD intervention activities can be undertaken in accordance with the objectives and strategies of the present program.

The objectives are

- 1) To document the service delivery process with particular attention to the management of RTI symptoms during existing reproductive health service delivery (family planning, ante and post-natal care, general reproductive health) at GoB and NGO service points.
- 2) To define strategies for integration of RTI/STD services in the family planning service delivery in the existing infrastructure.
- 3) To review certain social variables like perceptions of the service provider and clients regarding inclusion of RTI/STD services within the existing MCH/FP infrastructure. Particular attention will be given to the special issues of partner management.

1.5 RESEARCH QUESTIONS

The principle research questions are

- 1) In the existing MCH/FP services are clients provided the information and services which they may require to either prevent contracting an RTI or to cure an RTI if they are already infected?
- 2) Where required information and services are not currently available, are there ways that these can be created with the human and material resources within the MCH/FP system?

1 6 METHODOLOGY

1 6 1 Study Site

The study was conducted at different levels of Service Delivery Points (SDPs) within Dhaka district. These include Thana Health Complexes, Family Welfare Centers, Satellite clinics, Maternal and Child Welfare Centers, Model Clinics attached to medical colleges (including MFSTC) and selected NGO clinics.

1 6 2 Selection Of The Service Delivery Points And Sample Size

Purposive selection of the SDPs was conducted based on the Government Management Information System (MIS). SDPs with good performance record were selected to ensure observation of required number of service delivery processes. A primary selection of 67 SDPs was made, out of which 45 SDPs were actually visited during the data collection period. Twelve SDPs had to be excluded because during preliminary visits some of these places were found closed and no service provider could be found. A total of 6 Thana Health complexes, 10 Family Welfare Centers, 10 Satellite clinics, 7 large facilities (Model clinics, MFSTC, MCHTI, MCWC), 12 NGO clinics were included in the study.

Type of Services	Special facilities N= 7	THC N= 6	FWC N=10	Satellite N=10	NGO Clinics N=12	Total N=45
IUD (New)	4	2	6	0	6	18
IUD (Followup)	4	1	3	1	11	20
IUD (Removal)	0	1	1	0	2	4
Injection(New)	7	5	5	1	7	25
Injection(Follow up)	3	4	2	2	8	19
Pill (New)	2	2	1	0	3	8
Pill (Resupply)	1	2	2	0	2	7
Norplant (New)	3	0	0	0	3	6
Norplant (Follow up)	1	0	0	0	2	3
Tubectomy (New)	5	4	0	0	2	11
Antenatal	8	5	6	7	4	30
Postnatal	3	0	2	3	3	11
General RH	1	1	3	5	0	10
Total	42	27	31	19	53	172

Interviews were conducted with 112 service providers and 172 pre service clients. One hundred and seventy two service delivery processes of different categories were observed at different SDPs.

As the study was done in clinic based settings services provided by the FWAs could not be observed. However, focus group discussions were conducted at the THC with FWAs. In 40 SDPs, basic inventory and physical facilities were observed.

1.6.3 Data Collection

1.6.3a Field Investigation Team

The field investigation team included female medical officers (5), female social scientists (4) and male field supervisors (4). The medical officers were selected from a team of experienced Clinical Master Trainers attached to AITAM. They were responsible for observation of the service delivery processes, infection prevention practices, interview of the doctors and paramedics and conducting focus group discussions. The social scientists also had previous experience in conducting interviews on MCH-FP issues. They were responsible for conducting the pre-service client interview, interview of the non-clinical service providers, observation of the general physical facility of the SDP and assisting focus group discussions. Field supervisors were responsible for organizing and managing the field activities and conducting interview of FPIs, SACMOs. They also organized the focus group discussions with FWAs.

1.6.3b Data Collection Instruments

Data collection instruments used in the study were

- Semi-structured questionnaire for client and provider interview
- Checklist for observation of the service delivery process
- Checklist for inventory and physical facilities
- Guide line for focus group discussion

A three-day workshop was conducted for designing the data collection instruments in collaboration with AVSC and AITAM. The draft data collection instruments (DCI) were field tested in two Thanas (Burichong and Chandina) of Comilla District. On the basis of field testing DCIs were edited and finalized.

1.6.3c Data Collection Process

The field investigator team was given a three-day training on data collection. All SDPs were visited by the field supervisors prior to the field visit by the investigator team. Concerned persons (TFPO, MO-MCH) of the SDPs were issued an official letter explaining the purpose of the study and requesting access to the SDP and a letter of authorization from the Director, Administration of FP Directorate.

1. Client Selection and Interview

- Clients were selected by the Medical officers (MO) and social scientists (SS) in consultation with the service provider and were given a serial number (token). This serial number was put on the top right hand side of the client interview form by the SS. Types of clients selected were IUD (new acceptor, removal, side effects),

injection (new acceptor, resupply, side effect) pill (new acceptor, resupply, side effect) norplant (new acceptor, side effect, removal), tubectomy (new acceptor, follow up), antenatal care, postnatal care and general reproductive health care

- Interviewers were instructed to cover all categories of clients from every service delivery points. Clients were told about the purpose of the study and the interview was conducted with informed consent. If a client refused to give interview, the case was dropped and another respondent who met the criteria for an interview was selected. The client interview was performed by the social scientist before observation by the medical officer.

ii Service Delivery Observation

- On completion of the pre service interview the social scientists would hand over the completed form to the medical officer. The medical officer would collect the token from the client before she went for her required service and matched the token number with that of the interview form.
- MO followed a client throughout the service delivery procedure. An observation checklist was used to record the findings. During observation the doctors kept the checklist with them and filled it according to their observation during the service delivery process. In addition MOs also took elaborate critical observation notes on the service delivery process which highlighted deviations from the standard protocol for that particular service and also relevant observations which could not be captured in the observation checklist.
- In order to verify provider's skills in determining clinical signs on pelvic examination, the MOs asked the service providers about the P/V findings and also looked for signs of RTI carefully to see whether the service provider has been able to detect these signs or missed them.
- If a client is reluctant to be observed by the MOs the case would be rejected and replaced by another client.
- At the end of the day, MOs completed the missing points in the checklist with the help of critical observation notes.
- The MOs were instructed not to intervene if a life threatening situation arose in the presence of a medical doctor of that SDP, during the observation. However the MOs were instructed to intervene where there was no medical doctor, if they felt confident to solve the problem.

iii Interview of the Service Providers

- The interviewers informed the service providers before hand and fixed a time for interview. The doctors and nurse /paramedics of the SDPs were interviewed by the MO on the last day of observation in order to minimize influence on the actual service delivery process. Support staff (ayah, cleaner, messenger) were interviewed by the social scientists and FPI and SACMO were interviewed by the male field supervisors.
- The critical observation notes were also used during interviews of the MOs and FWVs/paramedics for further clarification on specific service delivery issues or

deviations from the standard protocol. For example, if the service provider provides treatment to a case of IUD with severe abdominal pain or discharge without performing a pelvic examination, then during interview this point should be clarified with the provider as to why she did not perform the examination.

- Focus Group discussion of the FWAs were conducted by MO while the SS and FS assisted in note taking.

Duration of the data collection was sixty days. During this period each SDP was visited for two to three consecutive days.

1 6 4 Data Compilation And Analysis

The data collected were first manually edited for any visible inconsistencies. The open ended questions were coded following a coding instruction. Coding sheets were developed for data coding. Data were entered into FoxPro data entry screen directly from coding sheets. After entering data into the computer, consistency checks were carried out for further data cleaning. Errors detected through this process were corrected before the data file were used for analysis. Analysis was carried out by using SPSS for WINDOWS software. Analysis was completed by first week of June, 1997.

CHAPTER 2

Chents' Profile

2.1 BACKGROUND CHARACTERISTICS OF CLIENTS

One hundred and seventy two clients were interviewed at different Service Delivery Points (SDPs). All the study clients were female and married. The clients were of age range of 14 to 40 years. It was found that more than 50 per cent clients were 20-29 years of age. Sixteen per cent were in the age group less than 20 years and 30 per cent over 30 years. The mean and median age of the clients were 25.7 and 25 respectively. Nearly one third (32 per cent) of them were illiterate, 29 per cent completed primary level of education and 39 per cent went beyond primary. The mean and median years of schooling were 3.5 and 2 respectively. Majority of the clients were housewife. Only less than one fifth of the clients (18 per cent) were employed. Among those in employment, 55 per cent were engaged in handicraft, garment factory and sewing cloth at home, 36 per cent in agriculture and only seven per cent in white color job (Table 2.1).

Table 2.1	
Background Characteristics of the Clients	
Age of the Clients (Years)	% of Clients (N=171)
<20	16.3
20-29	52.9
30+	30.2
Mean	25.7
Median	25.0
Education of the Clients	% of Clients (N=171)
Illiterate	32.3
Some primary	28.5
Primary completed	39.2
Mean No. of years schooling	3.5
Median No. of years schooling	2.0
Occupation of the Clients	% of Clients (N=31)
Skilled labor	54.8
Agriculture	35.5
Service	6.5
Others	9.7

Regarding the occupation of their husbands, almost all of them were employed. They were employed in business (24 per cent), service holder including overseas job (22 per cent), driving vehicle (15 per cent), working in shop and industry (19 per cent) and five per cent in agriculture. Nearly one third (60 per cent) had completed primary level of education, 20 per cent some primary while 20 per cent illiterate. The mean and median years of schooling were 5.4 and 5 respectively (Table 2.2).

Table 2 2	
Background Characteristics of the Client's Spouse	
Education of Chents Spouse	% of Chents (N=168)
Illiterate	19 6
Some primary	20 2
Primary completed	60 2
Mean No of years schooling	5 4
Median No of years schooling	5 0
Occupation of Chents Spouse	% of Chents (N=171)
Business	24 0
Service	22 2
Working in shop	19 3
Driving	14 6
Day labor	14 6
Agriculture	5 3

2 2 LISTENING TO CLIENTS' RTI PROBLEMS

During in-depth interviewing, the clients were asked about their experience of any reproductive health problems during the three months preceding the survey. Eighty one per cent mentioned that they had suffered at least one of the RTI problems during the last three months. Of them, 69 per cent had suffered from vaginal discharge, more than half (55 per cent) had lower abdominal pain, 30 per cent burning sensation during micturation, 27 per cent painful coitus, 25 per cent vaginal itching, 23 per cent heavy bleeding and eight per cent genital ulcer (Table 2 3)

Table 2 3		
Percentage of Chents by Type of RTI Symptoms Suffered during last three Months		
RTI symptoms	% of Chents	N
Vaginal Discharge	69 1	165
Lower Abdominal Pain	55 2	165
Burning sensation during micturation	30 1	163
Painful Coitus	27 0	163
Vaginal Itching	25 0	164
Heavy Bleeding	23 0	165
Genital Ulcer	8 0	162
At least one of the above symptoms	81.0	172

Multiple responses were possible

The clients were asked whether they were suffering from any RTI problems at the time of interview. Seventy seven per cent of them were suffering from at least any one of the RTI problems. Of them 62 per cent mentioned vaginal discharge, 52 per cent lower abdominal pain, 26 per cent painful coitus, 25 per cent burning sensation during micturation, 23 vaginal itching, 21 per cent heavy bleeding and six per cent genital ulcer. But many of them had multiple symptoms.

Table 2 4		
Percentage of Clients by Type of RTI Symptoms They are Currently Suffering from		
RTI symptoms	% of Clients	N
Vaginal Discharge	62 3	167
Lower Abdominal Pain	52 1	165
Painful Coitus	25 9	165
Burning sensation during micturation	24 8	162
Vaginal Itching	23 0	163
Heavy Bleeding	20 6	167
Genital Ulcer	6 1	165
At least one of the above symptoms	76 7	172

Multiple responses were possible

The age and educational distributions of the clients who came to the health centers and those who said to the interviewers that they were suffering from RTI problems, were examined. Most of the clients who had RTI symptoms were 20 to 29 years of age. Similar was the case with education – the highest proportion with RTI problems were educated (Table 2 5)

Table 2 5							
Age and Educational Distribution of RTI Clients							
	VD	HB	LAP	VI	VU	PC	BM
Age in Years							
< 20	19 4	11 8	20 7	26 3	30 0	29 5	25 0
20 - 29	48 5	61 8	51 7	55 3	60 0	45 5	55 0
30+	32 0	26 5	27 6	18 4	10 0	25 0	20 0
Education							
Illiterate	32 0	29 4	34 5	28 9	20 0	34 4	31 7
Some primary	31 1	29 4	26 4	31 6	40 0	25 0	29 3
Primary completed	36 9	41 2	39 1	39 5	40 0	38 6	39 0
N	104	34	87	38	10	44	41

Multiple responses were possible

VD Vaginal discharge, HB Heavy bleeding, LAP Lower abdominal pain, VI Vaginal itching, VU Vaginal ulcer, PC Painful coitus, BM Burning sensation during micturation

The clients were also asked about whether their husbands ever suffered from any RTI symptoms. Thirty seven per cent mentioned that their husbands suffered from at least one of the RTI problems. Of them 17 per cent mentioned pus/discharge from penis, 15 per cent mentioned genital itching and burning sensation during micturation. Sixty per cent said their husbands never suffered from any RTI problems (Table 2 6)

Table 2 6			
Chents Whose Husband ever Suffered from Different RTI Problems			
RTI Symptoms	% of Chents (N=171)		
	Ever Suffered	Not Suffered	Don't Know
Discharge from penis	17 0	77 7	5 3
Genital itching	14 7	80 0	5 3
Burning sensation during micturation	14 5	81 4	4 1
Swelling in the groin	8 3	85 2	6 5
Painful coitus	6 6	89 4	4 0
Pain in testes	5 8	87 8	6 4
Urethral ulcer	4 1	91 2	4 7
Suffered from at least one RTI problems	36 6	59 9	3 5

Multiple responses were possible

2 3 WHAT CAUSES RTI?- CLIENTS' PERSPECTIVE

Clients' knowledge about causes of RTI was also assessed. In connection to vaginal discharge 13 per cent believed that poor personal hygiene practices might causes vaginal discharge. They also believed that men's sexual behavior like having multiple sex partners, sex with commercial sex workers and sex during menstruation (five per cent) increase the chances of acquiring vaginal discharge. A very few of the respondents (one per cent) said that sex with infected partners was the cause of vaginal discharge. More than half of the clients had no idea about causes of this problem. There were also wrong beliefs among the clients about the causes of vaginal discharge. Of them, 17 per cent believed that *Kosha* (dryness of the body) was the cause of vaginal discharge, nine per cent believed poor nutrition, while eight per cent mentioned use of FP methods such as IUD, injection and ligation as causal factors. When the clients were asked about the causes of heavy bleeding, 19 per cent said that use of FP methods, such as IUD, injection and ligation, might cause heavy bleeding, seven per cent said that evil eye and 44 per cent said that they did not know anything about it.

Regarding lower abdominal pain and painful coitus, nearly ten per cent believed that sexual behavior like having multiple sex partners, sex with commercial sex workers, too frequent coitus, intercourse during menstruation and pressure during intercourse might cause lower abdominal pain and painful coitus. Eight per cent said that use of FP method might cause lower abdominal pain. In case of vaginal itching and vaginal ulcer more than half of the clients believed that personal hygiene was the cause of these problems while more than ten per cent mentioned having multiple sex partners, sex with commercial sex workers, sex with infected partners and too frequent coitus may be responsible for acquiring vaginal itching and vaginal ulcer. Regarding burning sensation during micturation, nearly half (45 per cent) of the clients believed that *kosha* was the main cause of this while other half did not know about its causes (Table 2 7).

Table 2 7							
Distribution of Clients by Knowledge about Causes of RTI							
Causes of RTI	% With Correct Knowledge						
	VD	HB	LAP	VI	VU	PC	BM
Sexual behavior	4 7	5 2	8 1	14 0	16 3	11 0	5 2
Infected partners	1 2	1 2	2 3	12 2	11 0	2 9	0 6
Poor personal hygiene	13 4	1 2	2 9	55 2	51 7	0 6	2 3
	% With Incorrect Knowledge						
Kosha	17 4	0	5 8	0 6	0	0 6	45 3
Poor nutrition	8 7	0 6	0	0	0	0 6	2 9
FP method	8 1	19 2	7 6	1 2	2 9	2 3	1 2
Physical strain	1 2	3 5	5 8	0	0	1 7	1 2
Evil eye	0	7 0	7 0	0	0 6	0	0
Others	6 4	11 6	16 3	5 2	7 0	1 7	4 1
Don't know	52 3	43 6	50 6	70 9	71 5	19 8	56 4
N	172						

Multiple responses were possible

VD Vaginal discharge, HB Heavy bleeding, LAP Lower abdominal pain, VI Vaginal itching, VU Vaginal ulcer, PC Painful coitus, BM Burning sensation during micturation

The occupational distribution of the husbands of the clients who came to the health centers and were suffering from RTI problems, was examined. Salaried job (service) including overseas job, was the dominant occupation of the clients' husbands who came with vaginal discharge, lower abdominal pain, vaginal itching, vaginal ulcer and burning sensation during micturation. The clients who came with heavy bleeding, one fourth of their husbands (26 per cent) were working in shops followed by business (Table 2 8)

Table 2 8							
Occupational Distribution of Clients' Husbands Who were Currently Suffering from RTI Problems							
Occupation	% of Clients with						
	VD	HB	LAP	VI	VU	PC	BM
Service	24 3	17 6	26 8	27 0	44 4	22 7	24 4
Business	21 4	23 7	19 8	13 5	11 2	25 0	14 6
Day labor	14 6	11 8	15 3	21 6	22 2	13 6	17 1
Working in shop	22 2	26 4	16 4	18 9	0 0	20 5	22 0
Driver	16 5	17 6	16 3	13 6	22 2	15 9	19 5
Agriculture	1 0	2 9	5 4	5 4	0 0	2 3	2 4
N	167	167	165	163	165	165	162

Multiple responses were possible

VD Vaginal discharge, HB Heavy bleeding, LAP Lower abdominal pain, VI Vaginal itching, VU Vaginal ulcer, PC Painful coitus, BM Burning sensation during micturation

2.4 WHY DID THE CLIENTS COME TO THE HEALTH CENTER?

Clients were asked why they came to the service delivery points on that day. Nearly half (47 per cent) of them reported that they came for follow up and complications-related services of family planning methods, one third (25 per cent) of them for accepting new method of family planning, and only 5 per cent for general reproductive health care. All the clients who came for general reproductive health care had abnormal vaginal discharge (Table 2.9).

Reasons for Visit	% of Clients
FP follow up & complications	46.5
FP new acceptors	25.0
Ante natal care	17.4
Post natal care	6.4
General Reproductive Health	4.7
N	172

It was also revealed that among the 43 FP new acceptors, 51 per cent of clients were suffering from at least one of the RTI problems. Among the current users of family planning method, 89 per cent of clients were suffering from at least one of the RTI problems. In case of general reproductive health clients all of them were suffering from at least one of the RTI problems. It was revealed that RTI problems were more prevalent among the clients who came for the services of family planning methods related complications and follow up and general reproductive health care (Table 2.10).

RTI Symptoms	Reasons for Visiting Health Facility				
	FP-New Acceptor %	FP-Follow & Comp %	Ante natal %	Post natal %	GRH %
Vaginal Discharge	41.9	76.3(76)*	50.0	45.5(10)*	100
Lower Abdominal Pain	30.2	58.4(77)	56.7	55.6(9)	87.5
Burning sensation during micturition	20.9	21.6(74)	30.0	30.0(10)	50.0
Heavy Bleeding	4.7	34.4(75)	3.3	33.3(9)	25.0
Painful Coitus	20.9	27.5(73)	37.7	13.6(8)	37.6
Vaginal Itching	11.6	28.5(74)	26.7	10.0(10)	37.5
Genital Ulcer	0.0	4.1(73)	13.3	11.1(9)	25.0
At least one of the symptoms	51.2	89.0	76.7	72.7	100
N	43	80	30	11	8

* The numbers within the parentheses are denominators

The investigators also tried to assess clients' opinion on whether they should seek treatment for these symptoms. Over 90 per cent felt that people suffering from these symptoms should seek treatment.

2.5 WHERE DO THE CLIENTS USUALLY GO FOR TREATMENT OF RTI PROBLEMS?

Clients were also asked where people usually go for RTI treatment. Among those who responded, for vaginal discharge 42 per cent said they usually go to GoB facilities, 9 per cent said NGO facilities, 58 per cent said private medical practitioner and 46 per cent said traditional healers. For treatment of lower abdominal pain, 45 per cent mentioned GoB facilities, 62 per cent private medical practitioner, 20 per cent traditional healers and only 9 per cent NGO facilities. A similar pattern was also observed in the case of treatment of heavy bleeding, vaginal ulcer, vaginal itching, painful coitus and burning sensation during micturation. In case of painful coitus it was found that greater proportion of clients did not know where to go for treatment of these problems while in case of other symptoms, the proportion were low. In fact, the majority of them usually go to private MBBS doctors for treatment of all RTI problems. GoB facilities were the second most visited for the lower abdominal pain, PV bleeding, genital ulcer and genital itching. It was surprising that a significant number of clients usually go to traditional healers instead of private doctors, GoB and NGO facilities. Here traditional healers included homeopath, *kab aj* quack, *Jharfuk* (spiritual healer), and TBA (Table 2.11).

RTI Problems	% of Clients with Source of Treatment					N
	GoB Facility	NGO Facility	Private Doctor	Traditional Healer	Don't know/No treatment	
Vaginal Discharge	42.4	8.7	58.1	45.9	4.7	170
Lower Abdominal Pain	45.3	8.7	62.2	19.8	4.7	171
Heavy Bleeding	45.3	9.3	58.1	21.5	8.1	170
Genital Ulcer	43.6	7.6	65.1	12.8	3.5	171
Vaginal Itching	40.6	7.6	65.7	15.7	4.7	172
Burning sensation during micturation	27.9	6.4	58.7	36.6	4.7	171
Painful Coitus	33.1	8.7	57.6	16.9	16.3	170

Multiple responses were possible

Conclusion

The SDPs have largely been used by the clients for receiving care related to the side effects of family planning methods. Prevalence of RTI symptoms in the clients are indicative of the magnitude of the RTI problems. Nevertheless, they do not consider these SDPs as providers of RTI related services. The reasons for such a perception among the clients were not known. An understanding of this situation is important to make the SDPs more effective in the control of RTI/STDs.

CHAPTER 3

Service Delivery Process

3 1 IS THE CULTURE OF SILENCE AROUND RTI A MYTH?

It is commonly believed that a culture of silence around the issue of RTI related problems inhibits women to seek care. In this study, interviews with the clients at the SDPs revealed that many women who came to the clinics for other services had symptoms simulating reproductive tract infections. However, a large percentage of clients who reported vaginal discharge, lower abdominal pain, painful coitus and urinary problem, did not state their complaints to the provider spontaneously (Table 3 1). Problems related to menstruation or PV bleeding were mentioned more commonly than other problems like vaginal discharge, genital ulcer or itching.

Health Problems	Reported to the Interviewer N= 172 (a)	Reported to the provider N=172 (b)	Proportion reported b/a
Unusual vaginal discharge	104	38	36.5
Lower abdominal pain	87	38	43.7
Genital itching	38	8	21.1
Genital ulcer	70	0	0
Painful coitus	44	6	13.6
Burning sensation during micturition	41	4	9.8
Menstrual Problems/PV bleeding	34	24	70.6
Other Gynecological problems	0	0	0

Multiple responses were possible

Spontaneous reporting of RTI problems was found more commonly among FP clients with side effects and general reproductive health services. Of those ten clients who came for reproductive health problems, eight cases complained of vaginal discharge and the rest came with problems of menstruation, lower abdominal pain and painful coitus (Table 3 2).

Table 3 2	
Health Problems Mentioned by General Reproductive Health Chents, without Probing	
Health problems	N=10
Unusual vaginal discharge	8
Lower abdominal pain	4
Painful Coitus	1
Menstrual Problems / PV bleeding	3

Multiple responses were possible

Clients who came to the clinic with FP side effects or follow-up complained of menstrual problems, PV bleeding or unusual vaginal discharge spontaneously to the service provider as side effects of FP method (Table 3 3)

Table 3 3					
Health Problems Mentioned by Chents with Side Effects and Follow Up, without Probing					
Health Problems	IUD N=20	Inj N=19	Norplant N=3	Pill N=7	Total N=49
Unusual vaginal discharge	9	6	1	4	20
Lower abdominal pain	7	6	1	3	17
Genital itching	0	2	0	1	3
Genital ulcer	0	0	0	0	0
Painful coitus	1	0	0	0	1
Burning sensation during micturition	1	1	0	0	2
Menstrual Problems /PV Bleeding	8	9	2	2	21
General Health problem	0	0	1	0	1
Gynecological Problem	0	0	0	0	0

Multiple responses were possible

The majority of the antenatal clients came for routine checkup and only a small number mentioned problems symptomatic of RTIs. Of the 11 post natal cases, 3 cases had symptoms of discharge, bleeding and fever respectively

3 2 ARE PROVIDERS PROACTIVE IN ELICITING REPRODUCTIVE HEALTH INFORMATION?

“Rafeza, age 27, came to a clinic for tubectomy. She has been suffering from unusual vaginal discharge, burning micturition and genital itching. She did not tell the provider any of these complaints. The provider only asked her about her last menstrual date and sent her to the OT where she had her operation done.”

Comprehensive reproductive history is an essential element of FP service delivery, which helps providers screen clients effectively for method related contraindications. The observation showed that the service providers seldom obtain comprehensive reproductive health information from the new FP clients. They focussed mainly on menstrual and obstetric history, as shown in Table 3 4a or 3 4b

Table 3 4a						
Menstrual History Obtained for New FP Clients						
Reproductive Health Information	IUD N=18	Inj N=25	Norplant N=6	Pill N=8	Tub N= 11	Total N=68
Menstrual History						
Date of last menstrual period	18	22	6	5	11	52
Length of menstrual cycle	9	5	0	0	3	17
Duration of Menstruation	10	8	3	0	2	23
Amount of Blood loss	4	3	3	0	1	12
Amenorrhoea	0	0	1	0	0	1
Spotting	1	3	1	0	1	6
Summary Information						
No Items Asked	0	3	0	3	0	6
At Least One Item Asked	17	22	6	5	11	61
All Items Asked	1	0	0	0	0	1

The menstrual history obtained by the provider placed emphasis on the date of last menstrual period in 52 out of 68 cases and duration of menstruation in almost one third of cases. Very little emphasis was given on amount of blood loss, amenorrhoea and menstrual cycle. Especially in cases of IUD and injectable, history of blood loss is an important screening element. However, in only four out of 18 cases of IUD and three out of 25 cases of injectable clients this information was elicited (Table 3 4a)

Table 3 4b						
Obstetric History Obtained for New FP Clients						
Reproductive Health Information	IUD N=18	Inj N=25	Norplant N=6	Pill N=8	Tub N= 11	Total N=68
Obstetrical history						
Last delivery history	10	11	4	1	5	31
Obstetric complication	3	2	2	1	2	11
Abortion/MR/D&C	7	2	0	0	5	14
Summary Information						
No items asked	7	14	2	7	3	33
At least one item asked	10	9	4	1	7	31
All items asked	1	2	0	0	1	4

In 52 per cent of cases, no past obstetric history was obtained. In 46 per cent of cases obstetric history focussed on the date of last delivery. Only in eight per cent of cases did the providers ask about obstetric compilation and history of abortion.

Certain FP methods produce side effects that are similar to the RTI symptoms, like vaginal discharge or itching. It is therefore important that providers screen for preexisting RTI conditions prior to giving a method. Otherwise a client may confuse the actual RTI conditions as side effects of the method and discontinue.

The IUD service delivery protocol requires screening for RTI conditions (vaginal discharge, lower abdominal pain). However in 13 out of 19 cases of new IUD clients, the providers did not ask relevant questions (Table 3 4c). In only one case the provider explored high risk sexual behavior of the spouse. Family planning history was obtained in less than one fifth of cases.

Table 3 4c						
RTI History Obtained for New FP Clients						
Reproductive Health Information	IUD N=18	Inj N=25	Norplant N=6	Pill N=8	Tub N= 11	Total N=68
RTI symptoms						
Unusual vaginal discharge	3	2	2	0	1	8
Lower abdominal pain	5	4	1	0	1	11
Painful coitus	1	2	0	0	0	3
Burning sensation during micturition	1	3	0	1	0	5
Genital itching	1	1	0	0	0	2
Genital ulcer	0	0	0	0	0	0
Summary Information						
No items asked	12	21	4	7	9	53
At least one item asked	6	4	2	1	2	15
All item asked	0	0	0	0	0	0
Sexual behavior						
Exposure history of husband	1	1	0	0	0	2

In case IUD clients with side effects or follow up providers probed on symptoms of vaginal discharge, lower abdominal pain, menstrual problems and PV bleeding. But for other methods the attention to client's concern is much less. Even though injection users reported unusual vaginal discharge, lower abdominal pain and menstrual problems, only half were asked about these symptoms by the providers. It appears that the service providers are aware of a relationship between RTIs and IUD but do not consider RTIs when dealing with the complications of other methods (Table 3 5).

Table 3 5								
Reproductive Health Information Obtained with and without Probing from Clients with Side Effects and Follow Up								
Reproductive Health Information	IUD N=20		Inj N=19		Norplant N=3		Pill N=7	
	No Prob	Prob	No Prob	Prob	No Prob	Prob	No Prob	Prob
Unusual vaginal discharge	9	9	6	3	0	0	4	1
Lower abdominal pain	7	8	6	3	0	0	3	1
Genital itching	0	0	2	2	0	0	1	2
Genital ulcer	0	0	0	0	0	0	0	0
Painful coitus	1	3	0	1	1	0	0	0
Burning sensation during micturition	0	2	1	0	0	0	0	0
Menstrual Problems/PV Bleeding	8	6	9	4	2	1	2	1

Multiple responses were possible

In case of post natal clients the providers are particular about asking the date and place of last delivery Information on type of provider was obtained in five out of 11 cases In only one and two cases the provider probed on foul smelling discharge and vaginal bleeding, respectively

According to the observation findings the culture of silence is not a clients problem but appears to be more on the provider's side While history was being taken, auditory privacy was maintained in only half the cases This lack of privacy certainly affects dialogue on private sensitive subjects like RTIs In addition, method specific service delivery, in other words focusing on the primary reason of visit, inhibits effective interpersonal communication between the client and the service provider As a result the presence of other reproductive health problems like RTIs remains unexplored and un-addressed

3 3 DO THE CLIENTS RECEIVE ADEQUATE COUNSELING?

"Hasina, a factory worker, had a baby 5 months back, and came for a FP method She wanted to take injectable The provider took her menstrual and obstetric history and gave her an IUD Hasina was not told why she was given an IUD and no information was given to her on IUD as well "

Counseling plays a very important role in all reproductive health services especially in case of RTI/STD During the observation out of 68 cases of new FP acceptors 52 received counseling Table 3 6 illustrates what was included in the counseling session during the observation

What is apparent is that the clients do not get full information, particularly information on side effects, complications and follow-up No matter which method is being

adopted, clients are not routinely provided the information to ensure the method's proper use. Only two out of 11 cases of IUD and six out of 25 cases of injectable clients received information on side effects and complications. The situation was somewhat better in case of Norplant where three out of six clients received full information on the method.

Table 3 6						
Quality of Counseling Done for New FP Clients						
Quality of Counseling	IUD N=18	Inj N=25	Norplant N=6	Pill N=8	Tub N=11	Total N=68
Counseling done	11	13	5	2	5	36
<i>Explained all the FP methods</i>						
Fully explained	2	6	0	1	1	10
Partially explained	9	5	3	1	2	20
<i>Provided information on chosen method</i>						
Fully explained	10	6	5	1	2	24
Partially explained	1	5	0	1	1	8
<i>Informed about side effects and complications</i>						
Fully explained	2	7	3	1	1	14
Partially explained	8	5	2	1	3	19
<i>Provided information on follow up</i>						
Fully explained	1	5	3	0	1	10
Partially explained	10	7	1	2	1	21
<i>Use of IEC material</i>	7	4	2	0	1	14

The use of IEC material during counseling was found to be poor for almost all methods except IUD where IEC material was found to be used in seven out of 11 cases of those who received any counseling.

The quality of counseling also varied across the SDPs. Table 3 7 shows the variation in counseling across the SDPs.

In the NGO sector more than 16 out of 21 cases of all new FP acceptors received counseling. In more than half the cases counseling covered full information on the methods, as well as side effects and follow up. Yet in most GOB facilities less than one third of the clients received any counseling. In the GOB sector counseling was better in FWCs than THCs and larger facilities in terms of coverage and quality (Table 3 7).

Table 3 7						
Quality of Counseling Done for New FP Clients by SDP						
Quality of Counseling	Special Facilities N=21	THC N=13	FWC N=12	Satellite N=1	NGO N=21	Total 68
Counseling done	8	2	10	0	16	36
<i>Explained all the FP methods</i>						
Fully explained	1	0	0	-	9	10
Partially explained	5	2	6	-	7	20
<i>Provided information on chosen method</i>						
Fully explained	6	0	6	-	12	24
Partially explained	2	2	0	-	4	8
<i>Informed about side effects and complications</i>						
Fully explained	3	1	1	-	9	14
Partially explained	3	3	5	-	7	18
<i>Provided information on follow up</i>						
Fully explained	1	0	1	-	8	10
Partially explained	6	1	6	-	8	21

It is apparent that the current practice of counseling is inadequate to provide the client with correct information. As a result if a client has any problem she is likely to seek help from inappropriate sources or discontinue the method.

To address the issue of RTIs the providers must have good counseling skills because RTI counseling deals not only with treatment compliance or follow-up but also with the issues of sexuality and partner management. The policy issue is how to input in order to enhance provider skill as well as their attitude in communicating with clients. A proper environment has to be created within the clinics for counseling services.

3 4 DO CLIENTS RECEIVE ROUTINE GENERAL EXAMINATION WHEN THEY VISIT SDPS?

Routine general examination for all clients attending a clinic is a part of general medical protocol. Some elements like blood pressure, anemia, jaundice and breast examination are also important screening criteria for FP clients, as well as antenatal clients.

Complete routine general examinations were seldom performed for the new FP acceptors (Table 3 8). Out of 68 observations, blood pressure was examined in 45 cases and was more commonly performed for injection, Norplant and tubectomy. Anemia was

examined in only 21 cases. None of the hormonal method acceptors had breast examinations or were screened for jaundice. This poor screening may result in selection of an unsuitable client who later is more likely to discontinue the method due to minor side effects.

General Examination	IUD N=18	Inj N=25	Norplant N=6	Pill N=8	Tubectomy N=11	Total N=68
Anemia	7	4	1	0	9	21
Jaundice	2	0	0	0	0	2
Blood pressure	9	17	5	3	11	45
Weight	1	10	6	2	1	20
Breast exam	0	1	0	0	0	1

When the FP clients return to the SDP with side effects or any other health problem, a careful examination is often required to determine the nature of complaint and provide appropriate care and counseling.

General Examination	New FP N=68	FP Follow Up N= 49	Antenatal N=30	Postnatal N=11	Gen Reproductive Health N=10
Anemia	21	7	19	0	0
Jaundice	2	3	0	0	0
Blood pressure	45	15	25	0	0
Weight	20	8	24	0	0
Breast exam	1	0	0	0	0

In the observation, the majority of the cases with side effects or coming for follow-up, did not receive any general examination. The most commonly checked vital sign was blood pressure, but even this was done in less than half the cases. Performance of general examination was better in case of antenatal care where 19 out of 30 cases were screened for anemia. In more than three quarters of the cases blood pressure and weight was taken. None of the general reproductive health clients received any general examination.

3 5 PELVIC EXAMINATION-A MISSING ELEMENT IN REPRODUCTIVE HEALTH CARE?

Pelvic examination is a basic screening tool for almost all reproductive health care and an essential element for RTI services. Ideally pelvic examination should be performed for all new FP acceptors, FP clients with side effects and clients with other reproductive health problem. These examinations would enable the provider to detect undiagnosed RTI cases and provide an opportunity to treat clients when they come for FP-MCH services.

Table 3 10				
Pelvic Examination by Type of Services				
Type of Client	New		Follow up	
	Total	Performed	Total	Performed
Family Planning				
IUD	18	17	20	15
Injection	25	11	19	4
Norplant	6	3	3	0
Pill	8	0	7	2
Tubectomy	11	9	0	0
Other Reproductive health				
Antenatal	30	1	0	0
Post natal	11	2	0	0
General Reproductive Health	10	0	0	0

In the observation out of 68 cases of new FP clients who came to the SDPs for services, routine pelvic examination was performed in only 40 cases. Almost all IUD acceptors received a pelvic examination. However, only half of the other clinical contraceptive acceptors received a complete pelvic examination.

Among the clients who came for FP follow-up and side effects, only 21 out of 49 cases received a pelvic examination, and this was largely for IUD follow-up (75 per cent). Of the clients who came exclusively for curative reproductive health services, none received a pelvic examination. Overall, the providers missed the opportunity in 62 per cent of cases to address the problems of RTIs.

In the majority of the cases, the providers did not give any reason for not performing the pelvic examination in cases where it was clinically warranted. Five new FP clients and two FP follow-up clients were refused a pelvic examination due to menstruation and PV bleeding.

3.6 CURRENT PRACTICE OF PELVIC EXAMINATION A QUALITY ISSUE FOR SCREENING AND PREVENTION OF IATROGENIC INFECTION

“Rahuma, age 27, had a pelvic exam in an SDP prior to tubectomy operation. She was very anxious about the procedure. The provider told her to lie down without explaining what she was going to do. She took a piece of cotton ball in her bare hand and swabbed both internal and external genitalia. Then she inserted a double bladed Sim’s speculum, one end of which had already been used on another client and not cleaned.”

The quality of pelvic exam showed a wide variation across the SDPs. Even when pelvic examination was done, most providers did not do all the steps correctly. There was a disregard for the client’s comfort and inattention to the essential steps, allowing transmission of infection and potentially overlooking existing reproductive health problems.

	Special Facilities	THC	FWC	Satellite clinic	NGO Clinic
Total Observation	N=42	N=27	N=31	N=19	N=53
Pelvic Examination Performed	13	11	11	0	33
Quality Indicators					
Explained the client about the process	5	3	5	-	25
Ensured bladder was empty	12	10	7	-	31
Inspect Genitalia	8	6	4	-	20
Swabbing of External Genitalia	5	8	9	-	29
Appropriate technique during swabbing	4	2	1	-	18
Speculum exam done	6	5	9	-	23
Speculum exam prior to Pelvic	1	3	1	-	15
Bimanual exam done	10	8	7	-	22
Check for discharge	4	5	6	-	22
Check for tenderness	4	7	2	-	16
Check for cervical abnormalities	5	5	6	-	25
Infection Prevention					
Wash hands	4	4	7	-	22
Wore gloves during speculum exam	5	6	6	-	8
Use HLD speculum	6	4	8	-	23
Precaution against exposure to body fluids	5	4	1	-	21

Explaining the procedure to the clients before a pelvic examination is an important element of quality of care. In GOB facilities out of 35 pelvic exam only 13 clients had the

procedure explained. In the NGO sector the situation is relatively better. Out of 33 cases, 25 clients were given an explanation prior to pelvic examination.

The majority of the providers followed the step of bladder evacuation prior to the pelvic exam in both GOB and NGO sector. Inspection of the external genitalia was done appropriately in 18 out of 35 cases in GOB sector. In the NGO sector, the practice was almost similar where in 20 out of 33 cases inspection was done.

Infection prevention practice was not adequate. In the NGO sector the majority of the providers performed swabbing of the external genitalia. In 29 cases out of 33 swabbing was done but aseptic technique was followed in 18 cases. On the other hand in the GOB SDPs, out of 35 cases swabbing was done in 22 but aseptic technique was followed in only seven cases. Variation in aseptic technique included swabbing by hand without gloves or with gloves, use of one swab for both internal and external genitalia, and not following the "without - inwards" method of swabbing (from inside to outside). This allowed transmission of infective organisms from skin surface to the reproductive tract.

Speculum examination was done in 20 out of 35 cases in GOB settings, and 23 out of 33 cases in NGO clinics. However speculum examination prior to pelvic examination was done more often in NGO than in GOB, where it was done only in five cases. This practice may make it difficult for the provider to detect any abnormal vaginal discharge.

The providers in the GOB sector performed bimanual examinations in 25 out of 35 cases, and in NGOs the situation was almost similar.

GOB providers looked for discharge in 15 out of 35 cases, compared with 22 out of 33 cases in NGOs. Tenderness was looked for in 13 cases in GOB and 16 cases in NGOs. Cervical abnormalities were looked for in 16 cases in GOB and 25 out of 33 cases in NGOs.

Infection prevention practice was better in NGOs as a whole. Two third providers in the NGO facilities and less than half of the providers in the GOB facilities practiced hand washing. Although use of HLD speculum should be universal but this was not the case in the GOB clinics. In NGO speculum was used in all cases.

The current practice of pelvic examination needs to be improved in both GOB and NGO SDPs. Following the step by step protocol, as well as taking precautions against iatrogenic infection, are essential.

3.7 HOW DO PROVIDERS DEAL WITH RTI PROBLEMS?

Out of 172 clients who were interviewed at the SDPs, 77 per cent reported at least one symptom indicative of RTIs. Subsequently, on observation of the service delivery process it was found that providers could detect RTIs in only 21 per cent of cases. One third of these cases received specific treatment (metronidazole/antibiotic) and the rest got only symptomatic treatment (antispasmodic/analgesic). Treatment to the client's partner was provided in two cases.

In the case of 18 new IUD clients, the providers detected RTI problems in seven cases and only two received specific treatment. Despite the presence of infection, an IUD was inserted in one case and in another case the client received a different method. The other five of these clients did not receive any method or any specific treatment.

Out of 20 IUD clients who came for follow up, providers detected RTI problems in seven cases. Four of these clients received specific treatment and treatment for the partner was given in only one case. None received any counseling on condom use.

Out of four cases of IUD removal, three complained of vaginal discharge and all four complained of heavy bleeding and lower abdominal pain. Only one client received specific treatment along with oral pill but was advised not to use condom. Two clients did not receive any treatment or method and one client was advised condom but no treatment. It is important to mention here that the provider prescribed treatment only by listening to client's problem without any examination.

Out of 29 follow up clients using hormonal methods, providers detected RTI problems in 15 clients. But only three clients receive specific treatment. In six cases the method was changed from injectable to condom and in one case method use was discontinued.

There were ten general reproductive health clients. In only five cases the providers could detect RTIs. Three of them received specific treatment, one was referred and one got symptomatic treatment.

Although four post natal clients presented with RTI like symptoms, none received any treatment.

Conclusion

The entire service delivery process is driven by the client's primary reason of visit. It affects both the clients and the service providers. On the positive side it means most clients get the service that they came for but in the majority of the cases quality was compromised in almost all steps, starting from history taking, counseling, examination and management. As a result of the singular focus the providers missed opportunities at every step to explore and address clients' pre-existing RTI problems. In addition, poor infection prevention steps during client examination is a potential risk for introducing RTIs. Lack of support and supervision in the system may be a reason why providers fail to provide good quality service. They need orientation on the relationship of RTI/STDs and other components of reproductive health. This supports the need for placing the activities of the providers firmly within a reproductive health context.

CHAPTER 4

Service Providers

4 1 BACKGROUND INFORMATION OF THE SERVICE PROVIDERS

Providers interviewed and observed under this study were FWVs, Nurse/Nurse Aides, and doctors. Fifty per cent of the clinical service providers were FWVs, 32 per cent were doctors, and 17 per cent were nurse and nurse aide. Nurses and nurse aides mainly worked in the NGO sector.

Eighty nine per cent of the FWVs and 58 per cent of the doctors were in the FP service for more than five years. Majority of the FWVs and nearly three quarter of the doctors had received training on family planning. About two thirds of the FWVs had not received training on MR. Majority of the FWVs received training on RTIs along with MR/FP training and only a few received special training on RTI.

Table 4 1		
Training Status by Type of Provider		
Type of Training	FWV¹ (N=39)	Doctor (N= 19)
Training on Family Planning	35	16
Training on MR	25	16
Training on RTI		
• Only RTI	5	6
• With MR/FP	33	7

4 2 WHAT DO THE PROVIDERS KNOW ABOUT RTI /STDs?

4 2 1 Common RTIs in Bangladesh

The providers were asked to name some common RTI/STDs in Bangladesh. Knowledge about common RTI/STDs varied by different types of provider. The most common RTIs mentioned by the doctors were pelvic inflammatory disease, trichomoniasis and gonorrhoea. The FWVs mentioned gonorrhoea, syphilis and pelvic inflammatory disease. The SACMOs also mentioned gonorrhoea, syphilis and leucorrhoea as the most common RTI/STDs. Although bacterial vaginosis is the most common type of RTI, only five out of 19 doctors and five out of 39 FWVs mentioned this. Chlamydia is another important RTI problem but only four out of 19 doctors mentioned this condition. Less than one third of the FWVs mentioned leucorrhoea and cervicitis as common RTI problems.

¹ FWV includes FWVs, Nurse and Nurse Aides

Knowledge	MO N=19	FWV¹ N=39	SACMO N=8
Bacterial vaginosis	5	5	0
Trichomoniasis	11	9	1
Candidiasis	10	7	0
Gonorrhoea	11	23	6
Syphilis	8	20	6
Chlamydia	4	0	0
Chancroid	1	1	1
AIDS	2	9	1
PID	14	17	2
Cervicitis	9	14	1
Leucorrhoea	2	15	5
Amenorrhoea	2	0	0
Other	0	2	3

Multiple responses were possible

4 2 2 Knowledge about the causes of RTI/STDs

Regarding knowledge about causes of RTI/STDs among men and women, both the FWVs and the doctors mentioned unsafe sex as the most important cause in men. However, according to the FWVs, poor personal hygiene was the most important cause of RTI/STDs in women followed by unsafe sex and partner's infection. The doctors placed emphasis on partner's infection and unsafe sex as the most important cause of RTI/STDs in women. Although few providers mentioned FP method as a direct cause of RTI, on subsequent questioning 100 per cent of the doctors, 39 per cent of FWVs and 50 per cent of SACMOs thought there was a relationship between RTIs and FP. It seems providers had some correct and some incorrect perceptions regarding the cause of RTI/STDs.

Causes	FWV¹ (N=39)		Doctor (N=19)	
	Men	Women	Men	Women
Poor personal hygiene	17	26	9	9
Unsafe Sex	37	26	17	10
Infected sexual partner	8	19	1	13
Poor infection prevention practice in health service	2	6	1	2
FP methods	0	6	1	2
Others	5	6	3	3

Multiple responses were possible

Other family planning workers like FWAs and FPIs had some idea about RTI/STDs. In focus group discussions, the FWAs reported that 10 to 15 per cent of the female population they come in contact with complain of RTI symptoms.

Even the unmarried women of the household they visit report these symptoms to the FWAs. Almost all FWAs believed that all the FP methods act as a direct cause of RTIs. In addition, unsafe sex, like having multiple sexual partners and sex with commercial sex workers, may also cause RTI/STDs.

Interviews of the Family Planning Inspectors (FPI) revealed that they had some correct and some incorrect perceptions regarding the cause of RTI/STDs. Out of nine FPIs, only three and two mentioned sex with CSWs, and poor infection prevention in the health services, as a cause of RTI/STDs respectively. Four FPIs mentioned IUD and MR as a direct cause of RTI/STDs. One third of them mentioned dryness of the body and excessive sex.

FPIs' Perceptions about the Causes of RTI/STDs	
Causes of RTI	Number of Responses (N=9)
Visit CSW	3
Poor Infection Prevention in health services	2
Due to STD	2
Dryness of the body	3
Due to IUD	4
Due to MR	4
Excessive sex	3

Multiple responses were possible

The majority of the FPIs had some knowledge about the spread of RTI/STDs. Out of nine FPIs, sexual transmission and high risk sexual behavior (CSW, multiple sexual partners) were mentioned by eight and seven respectively. Poor hygiene was also identified as an important mode of spread of RTIs. Regarding means of prevention, the majority placed emphasis on cleanliness and almost half mentioned safe sex and treatment of these conditions (Table 4 5).

It was also revealed that FPIs were aware about the high risk sexual behavior in their communities and two thirds of them mentioned that people in their localities visit CSWs. More than half mentioned prevalence of sexual encounters before marriage, and extramarital sex in their community.

Table 4 5	
FPIs' Perceptions about Spread and Means of Prevention of RTI/STDs	
Route of Transmission	Number of Responses N=9
Through sexual intercourse	8
Multiple sex partners	7
Use of infected needles	2
Visit CSW	7
Through blood transfusion	1
Poor hygiene	8
Touching RTI patients	3
Means of prevention	Number of Responses N=9
Cleanliness	7
Safe sex	5
Social awareness	1
Treatment	5
Change method	1

Multiple responses were possible

4 2 3 Consequences of RTI/STDs

All categories of providers had some knowledge about the consequences of RTI/STDs. Most of the doctors mentioned sterility as the most important complication followed by problems in the reproductive organs, and pelvic infection. Most FWVs mentioned problems in the reproductive organs as the most important complication, followed by sterility. Only a small proportion of doctors and FWVs mentioned transmission of infection to the sexual partners, and fetal complications.

Although SACMOs are not direct providers of FP services they provide curative services. Out eight SACMOs interviewed half of them mentioned transmission of infection to the sexual partners and complication in the fetus in addition to sterility.

Table 4 6			
Knowledge about Consequences of RTI/STDs by Type of Provider			
Knowledge of Consequences of RTI	Doctor N=19	FWV¹ N=39	SACMO N=8
Sterility	14	19	4
Pelvic infection	7	6	1
Problems in Reproductive organs	12	27	6
Complication in Fetus	3	6	4
Affect Sexual Partner	2	6	4
AIDS	0	2	0
Others	0	13	0

Multiple responses were possible

4 3 HOW DO THE PROVIDERS DEAL WITH RTI PROBLEMS?

4 3 1 Pelvic Examination

In order to assess the gap between stated and observed practice the providers were asked about the practice of pelvic examination on different type of clients (Table 4 7) All providers in the THCs, FWCs and satellite clinics stated that they performed a pelvic examination in both new and old IUD clients In the special facilities one third of providers, and more than eighty per cent providers in FWC and satellite clinics, mentioned pelvic examination in case of injectable clients In special facilities only one third of the providers mentioned pelvic examination in clients with general reproductive health problems but none mentioned a pelvic exam prior to ligation In the NGO clinics more than two thirds of the providers mentioned about pelvic examination in case of IUD and injectable clients and less than half mentioned it for general reproductive health problems

Type of Client	Special Facilities N=9	THC N=6	FWC N=7	Satellite N =5	NGO N=12	Total N=39
IUD	8	6	7	5	10	36
Inj	3	4	6	4	9	26
Norplant	1	1	1	0	4	7
Pill	1	2	4	2	4	13
Ligation	0	3	0	0	2	5
GRH	3	0	1	1	5	10
ANC	3	0	0	1	4	8
MR	4	3	2	0	1	10
All New	0	0	0	0	0	0
Never done	1	0	0	0	0	1

**N denotes number of FWVs at the SDPs*

4 3 2 Partner Management

The clinical service providers, that is the doctors, FWVs and SACMOs, were interviewed regarding their practice of partner management in case of clients with RTI symptoms The common practice mentioned by the doctors was to prescribe and provide medication for both partners Some doctors gave treatment for the clients and asked the partners to come for treatment at the SDPs More than one third of the FWVs mentioned providing prescriptions and drugs for the client as well as the partner, and about one fifth mentioned providing prescriptions for both However one fifth of the FWVs and almost half of the SACMOs, mentioned that they do not provide any treatment for the partner Only one SACMO mentioned that he provides a half dose of drugs to the client and asks the client to send her partner to the center (Table 4 8) It seems that the providers have some awareness regarding the importance of partner management As there is no protocol, the management depends solely on providers own judgement

Type of Management	Doctor N=19	FWV ¹ N=39	SACMO N=8
Give Prescription & Medicine for both	6	14	0
Give medicine for client and prescription for partner	4	7	0
Give only prescription for both	4	8	0
Ask partner to come to the center	5	2	2
Treat the client only	0	0	2
Provide half dose medication for the client and asked client to send her husband	0	0	1
No management for spouse	0	8	3

4 3 3 Counseling

Doctors and FWVs were asked about their practice of counseling for clients with RTI symptoms. The data in table (4 9) shows that in both the groups commonly mentioned elements of counseling were personal hygiene, proper intake of drugs, low risk sexual behavior or safe sex, condom use and importance of partner management.

	Doctor N=19	FWV ¹ N=39
Take medicine properly	6	15
Come for follow up	3	9
Use condom until cured	8	10
Abstain until cured	2	3
Low risk sexual behavior	8	15
Partner management	6	9
RTI complications	2	3
Personal hygiene	9	22
Use saline water	2	4
Drink more water	2	1
Avoid savlon & soap	1	0
Take nutritious food	3	0
No counseling	0	2
Refer to doctor	0	1

Multiple responses were possible

Out of these personal hygiene was the most commonly mentioned elements by the doctors as well as the FWVs. However, doctors mentioned condom use, low risk sexual behavior and partner management more than the FWVs. Very few doctors as well as FWVs, mentioned RTI complications as an element of counseling. The providers have

some knowledge about RTI counseling but need to be oriented on a risk approach in order to make clients understand the risks of RTIs and aim for a behavioral change

4 3 4 Laboratory Diagnosis

Providers were asked about the type of laboratory tests they request, for the diagnosis of RTI s /STDs Two thirds of the doctors mentioned VDRL/TPHA and HBsAg Gram stain and wet mount was mentioned by only two and one doctor respectively More than one third of the FWVs mentioned urine examination but none mentioned gram stain or wet mount However six out of 39 FWVs and half of the SACMOs mentioned VDRL/TPHA The majority of the common RTI /STDs can be diagnosed through direct microscopy (wet mount, gram stain) The data therefore reveal that the providers do not have the proper knowledge about simple laboratory diagnosis for common RTI s/ STDs

Table 4 10			
Stated Practice of Lab Investigation by Type of Provider			
Lab Test	Doctor N=19	FWV¹ N=39	SACMO N=8
Urine examination	6	11	0
High vaginal swab	4	2	0
Gram Stain	2	0	0
Wet Mount	1	0	0
VDRL/ TPHA	12	6	4
Pap smear	5	3	0
Prostatic smear	2	0	0
Blood(routine)	1	9	0
HBsAg	15	1	0
Ultrasonography	1	2	0

4.4 HOW TO IMPROVE RTI/STD SERVICES? - PROVIDERS PERSPECTIVE

All categories of providers gave priority to training in order to improve RTI services Besides training, doctors identified medicine supply, increasing the number of service providers at the SDPs and awareness of RTI as important elements The majority of the FWVs emphasized increasing instrument supply, improvement of laboratory facilities, medicine supply and increase in the number of service providers

The majority of the SACMOs suggested awareness of RTI, increased medicine and instrument supply at the SDPs However very few doctors and FWVs suggested improvement in the infection prevention practice at the SDPs

Table 4 11			
Suggestions for Improvement of RTI/STD Services at SDP by Providers			
Suggestion	Doctor N=19	FWV¹ N=39	SACMO N=8
Training of staff	14	32	6
Medicine supply	9	4	7
Instrument supply	3	9	6
Increase number of SP	6	4	4
Awareness on RTI	5	3	7
Improve Infection Prevention	2	1	2
Improve quality of service	0	0	2
Improve Laboratory facilities	9	6	0
Separate RTI section	1	0	0
Improve skill of SP	0	1	2

Multiple responses were possible

The FPI inspectors were asked about how men can be involved in RTI /STD intervention. All FPIs suggested that awareness of men on these problems can be created through proper motivation, but only one mentioned sex education.

More than half of the FPIs mentioned that FWAs can play an important role in prevention of RTI /STDs through motivation and referral.

Table 4 12	
Measures to Create Awareness among Men by FPI	
Measures	Number of Responses (N=9)
Motivation	8
Health education	2
Promotion of safe sex	1
Postering	1

Multiple responses were possible

Conclusion

The majority of the service providers were experienced and trained. Their knowledge on RTI/STDs, although not comprehensive, had a positive pattern. They could relate RTI/STDs to sexual behavior. This was also true for the non-clinical FP workers. However, the clinical providers do not understand the relationship of their own activities, such as the poor infection prevention process with RTIs. It is possible that all providers equate the term RTIs with STDs. When the providers talk about the practices they talk about an ideal situation, which shows they know about partner management and some elements of RTI/STD counseling. Variation in stated practice may be due to lack of a standard protocol to deal with these problems.

CHAPTER 5

Service Delivery Points

5 1 SERVICES AVAILABLE AT SERVICE DELIVERY POINTS

More than 90 per cent of the static SDPs provided condom, pill, injection IUD antenatal and post natal care services Norplant was available in ten SDPs and vasectomy was offered in seven In 25 SDPs, general reproductive health services were offered

In the seven satellite clinics investigated, antenatal care was provided by all IUD services were offered at two clinics, and six clinics provided injectable and pill Condoms were distributed at five clinics According to the providers, five clinics also provided other reproductive health services, for example diagnosis and treatment of RTIs

5 2 TYPE OF PROVIDER

In two-thirds of the SDPs, FWVs provided clinical methods One-fourth of SDPs had both doctor and FWVs (Table 5 1) In 26 fixed SDPs, FWVs also provided non clinical methods and in only seven fixed SDPs, FWA distributed non-clinical methods In only one SDP, support staff and counselors were the providers of condom and pills

Type of Clinical Method Provider	
Type	SDP(N = 33)
FWV/nurse	22
Doctor and FWV	8
Doctor	1
No Response	2

In all satellite clinics, FWVs provided clinical services and also pills and condoms in five clinics In three clinics, FWAs distributed pills and condoms from the clinics

5 3 AVAILABILITY OF PROVIDERS AT THE SDPs

Of the 33 SDPs investigated, no doctors were posted in twelve In eight SDPs, one doctor was posted, and more than one doctor was posted in 13 In five of the 21 SDPs where one or more doctor was posted, no doctor was found on duty In nine SDPs, only one doctor was found on duty Two doctors were found at five clinics Four doctors were on duty at three clinics and eight doctors were found on duty in one clinic only

One FWV was posted in 16 SDPs Two FWVs were posted in two places In ten SDPs more than two FWVs were posted In only one SDP, no FWV was currently posted On the day of visit, one FWV was found present in 19 clinics, two FWVs were present in seven SDPs, and more than three FWVs were present in the other three SDPs

5 4 PHYSICAL FACILITY

5 4 1 Waiting area

Out of 33 fixed SDPs, a separate waiting room for clients was found in 13 facilities (39 per cent). In 17 SDPs (52 per cent), clients wait on the verandah of the facilities. In three SDPs, clients wait in the room of the service provider. Where clients wait in the service provider's room it is very difficult to maintain the privacy required for history taking and physical examinations.

One out of seven satellite clinics had waiting area for the clients. In three clinics, clients waited on the verandah. In four clinics, clients waited in an open area. In two clinics, clients waited in the same room with the service provider. It is important to mention that in three clinics, services were provided from an open verandah.

5 4 2 Water Source

In 30 static SDPs tap water supply was available. Tubewell water was available in two SDPs and in one SDP there was no source of water for washing.

Regarding washing facilities in satellite clinics, tubewell was the water source for five clinics. In one clinic tap water supply was available. In another clinic there was no water supply at all. In one clinic, hand washing arrangement for the service provider was from tap water, in three clinics it was pond water, and in two clinics it was tubewell water. The service provider informed in one clinic that she does not need to wash her hands for service providing. Toilet facilities were available in all seven clinics. In five satellite clinics the toilet was clean.

5 4 3 Facility for pelvic examination

5 4 3a Space

Investigation for the availability of facilities for pelvic examination revealed that in 25 facilities (out of 33) there was a separate room for pelvic examination. In six SDPs, the pelvic examination was done in a partitioned space in the service providers room. In two SDPs, there was no specific place for pelvic examination. Pelvic examination was performed in three satellite clinics out of seven. In two clinics, PV was done on a mat on the floor. In another clinic it was done on a bench. In one satellite clinic only, there was a separate room for pelvic examination.

5 4 3b Light source

In 20 SDPs pelvic examination was performed under natural light. In 11 facilities a spotlight was available for pelvic examination and in two facilities a torch light was used. In satellite clinics torch lights were available in two clinics for pelvic examination. In another clinic, PV was done without any light source.

5 4 3c Privacy

Visual and auditory privacy is important for client comfort. It is essential for appropriate history taking, counseling and physical examination. Visual privacy was maintained in 26 SDPs, while in five SDPs it was insufficient. In two SDPs visual privacy was not maintained at all. Auditory privacy in pelvic examination was maintained in fifteen SDPs only.

5 4 4 Instruments

Different types of metallic and non-metallic instruments and supplies are used in FP-MCH service delivery process.

Instrument	Number of Instrument in SDPs			
	0	1	2	>2
Vaginal Cuscos	1	7	6	20
Sim's Speculum	10	16	2	5
Sponge Holding Forceps	1	8	10	14
Long Artery Forceps	2	8	6	17
Uterine Sound	3	7	7	16
Tenaculum/Volselum	2	8	8	15
Gully pot	8	9	5	11
Instrument Tray	3	10	7	3
Lifter	12	15	3	3
Scissors	1	8	6	18
One set of above instrument				7
Two sets of above instrument				2
Incomplete set				22
Regular supply of Gloves				28 SDPs
Regular supply of gloves not available				5 SDPs

Table 5 2 shows type and quantity of instrument available in the SDPs. Only one complete set comprising of at least one of each type is available in seven SDPs. More than one set is available in only 2 SDPs. However, in 22 SDPs the instrument set was incomplete.

In only one satellite clinic, one set of instrument was found available. In another clinic only one artery forceps was available. Surgical gloves were found to be in two satellite clinics.

5 5 INFECTION PREVENTION STATUS

Infection Prevention (IP) practice is a very important indicator of quality of care in FP-MCH service delivery system. Poor IP technique may induce infection in the client during the service delivery process.

IP practice was observed in 28 fixed SDPs (17 GOB and 11 NGO). The investigation team tried to collect information on availability of IP equipment and supplies, practice of different steps of IP including decontamination, cleaning, high level disinfecting practice (HLD) and autoclaving.

5 5 1 Availability of equipment and supplies for Infection Prevention

Different equipment and supplies are used in IP. Table 5 3 shows the equipment and supplies required in different steps of the IP process.

Step	Equipment	Supplies	Remarks
Step 1 Decontamination	Bucket	Bleaching powder	done immediate after using instrument
Step 2 Cleaning	Brush/Bucket	detergent	
Step 3 HLD (Boiling)	Boiling pan/ Hot water bath	Electricity, Gas or Kerosene	acceptable and widely practiced for many services
Step 4 Autoclave	Autoclave machine	Electricity, Gas or Kerosene	Final step of disinfecting process

An autoclave machine is an important tool in IP process. Out of 33 SDPs, autoclaves were available in 25 facilities.

HLD (boiling) is an alternative to autoclaving and acceptable for a wide range of services. Equipment for boiling like boiling pan or hot water bath was available in 29 SDPs and stove or other heating instrument was available in 26 SDPs. At least one type of power source (kerosene/gas/electricity) was available in all the SDPs.

Cleaning is an essential step in IP process. But cleaning tools such as a brush (even an old tooth brush) were available in only 16 SDPs. Regular supply of detergent was available in 13 facilities only.

Bleaching powder is required for decontamination. But regular supply of bleaching powder was available in half of the SDPs only.

Table 5 4 shows availability of different IP supplies by type of SDPs. Of the six special facilities and Model Clinics, autoclave machines were available in all. While a boiling pan was available in five. But cleaning utilities like brush were available in only

three facilities and detergent supply was present in two facilities of this category only Bleaching for decontamination was available in only one SDP of this type

Type & Number of Facility	Autoclave machine	Boiling pan/hot water bath	Stove	Brush	Detergent	Bleaching powder
Special Facility (7)	6	5	4	3	2	1
Thana Health Complexes (5)	5	5	4	3	1	0
FWCs (9)	2	8	8	3	1	2
NGO Clinics (12)	10	4	10	10	9	11

In THCs, autoclave machines and boiling equipment were found in all But there was no brush available in two THCs and detergent supply was available in only one Supply of bleaching powder was not found in any THCs

Among the FWCs, usable autoclave machines were available in two out of nine clinics In eight FWCs there were usable boiling instruments Cleaning brushes were found in only three FWCs, and detergent was available for decontamination in only one FWC One FWC did not have any boiling or auclaving facilities

In 12 NGO clinics, autoclave machines were present in ten clinics while boiling instrument was available in four clinics Cleaning brushes were available in ten clinics and detergent supply for cleaning was available in nine clinics

Availability of instruments was certainly better in NGO clinics In GOB clinics the situation of supplies for IP was relatively poor Though bleaching powder is essential for decontamination, it was available in 3 GOB clinics out of 21 The same was true for detergent supply Out of 21 GoB SDP regular detergent supply was available in 4 clinics

5 5 2 Observation on IP

Metallic instruments and surgical gloves are routinely used in clinical FP service delivery and other RH services Observation of the disinfecting process of metallic instruments and surgical gloves was attempted in the study This process could be observed in 28 cases out of 33 SDPs

5 5 2a IP of Metallic Instrument

There are three or four essential steps in IP of metallic instruments 1) decontami - nation, 2) cleaning, 3) HLD, and/or 4) autoclaving Decontamination of metallic instruments was practiced in 11 facilities (39 per cent) Cleaning as the direct first step, was found in sixteen facilities Autoclaving as last step was practiced in 14 cases (50 per cent) HLD as last step was also practiced in 14 SDPs The optimal IP process like decontamination followed by cleaning and then HLD or autoclaving, was observed in 11

facilities (39 per cent) A common practice found in 15 SDPs (54 per cent) was cleaning follow by autoclaving or HLD, with no decontamination

Table 5 5 shows the summary of IP Process of metallic instrument by type of SDPs

Type of SDP	Decontamination done	Autoclaving as last step	HLD as last step
Special Facility (N=6)	1	2	1
THC (N=4)	0	3	1
FWCs (N=7)	1	2	5
NGO Clinic (N=11)	9	9	2

Special Facilities The IP process of six of the special facilities was documented Decontamination of used instrument was practiced in one SDP only Cleaning of metallic instrument after using was practiced in four SDPs In two SDPs of this category, autoclaving was the last step of IP process, whereas three SDPs it was HLD boiling

In only one SDP, all three steps of IP process were practiced, meaning decontamination followed by cleaning, then autoclaving or boiling In three SDPs it was just cleaning followed by HLD or autoclaving

THCs Out of five THCs IP practice was observed in four THCs In all these SDPs cleaning was the first step of IP process Decontamination practice was not followed in any THC investigated However the practice of autoclaving was observed in three SDPs, whereas HLD as the last step was found in one SDPs

FWCs Among nine FWCs investigated, decontamination practice was observed in only one center Cleaning as the first step of IP process was practiced in six FWCs Autoclaving as the last step was found in two SDPs whereas HLD as the last step was found in five SDPs Decontamination, followed by cleaning then autoclaving or HLD, was seen in one FWC Without decontamination this process was observed in six FWCs

NGO clinics IP practice was observed in all the NGO clinics except one Decontamination practice was observed in most of the NGO clinics (nine out of 12) Cleaning was the first step in only two clinics Decontamination followed by cleaning and then HLD or autoclaving was observed in nine SDPs In two SDPs it was done without decontamination

Satellite clinics Instruments and surgical gloves for service delivery at satellite clinic were processed and packed at the FWC But in two satellite clinics it was observed that the service providers brought unwrapped instruments in used polythene bags

Table 5 6 shows the reasons for not doing decontamination in the SDPs where this not practiced It was revealed in most SDPs (14 out of 17) the reason was lack of supply of bleaching powder

Though decontamination is an important step in the IP process in the study it was observed in eleven facilities only Fourteen out of 17 SDPs where decontamination was not practiced identified lack of bleaching powder supplies as the main cause for not practicing decontamination Other responses were 1 No Government Order - one respondent, 2 No Need of decontamination - one respondent 3 No Training of the provider - one respondent

In most of the SDPs the support staff (ten out of 11) makes the decontamination solution In only one SDP, the FWV makes it

For cleaning instruments, the support staff were identified by all the respondent as the only responsible people In 24 SDPs, FWVs boil the instruments whereas in four SDPs it was done by the support staff Final preparation of the instrument tray was done by support staff in 11 SDPs, and by FWVs or paramedics in 17 SDPs

Table 5 6	
Causes of no Decontamination Practice	
Causes	Number of Responses
No Bleaching Powder	14
No Govt Order	1
No Training	1
No Need	1

5 5 2b Surgical Gloves

Reusable surgical gloves are routinely used in pelvic examinations and in other RH services Decontamination practice of surgical gloves was found in eight SDPs Cleaning as first step was observed in most of the SDPs (64 per cent) Autoclaving as last step was found in 21 SDPs while HLD as last step was found in four SDPs Only cleaning as last step was found in three SDPs Good practice, decontamination followed by cleaning and then HLD or autoclaving, was found in eight SDPs Cleaning followed by autoclaving or HLD was found as a common practice in 14 SDPs (50 per cent)

Conclusion

In all the SDPs at least one type of provider was available FWV was the most common service provider for both clinical and non-clinical methods Although most SDPs had basic physical facilities for service delivery but a large proportion did not have some essential elements like light source, minimum number of basic instruments and cleaning and decontamination reagents These are likely to affect the quality of clinical examination, infection prevention practice and thereby enhance risk of iatrogenic infection

CHAPTER 6

Discussion and Policy Implications

6.1 DISCUSSION

The RTI /STDs are important health problems affecting women of reproductive age but often remain unexplored in the current service delivery system. The myth of the culture of silence around RTIs /STDs is that it is always considered as a client's issue. This study identified that women do not hesitate to discuss these problems when they get an opportunity. However, providers are seldom proactive to explore or give the client's scope to talk.

Most SDPs observed under this study had adequately trained staff, space, equipment and other necessary facilities for diagnosis and treatment of RTI/STDs. The study identified a number of missed opportunities and gaps in the knowledge and practice of the providers.

There is an overall lack of initiative to elicit necessary reproductive health problems even for FP clients, across all types of SDPs. The clinical service providers had some orientation on RTIs/STD problems during other training programs. The study revealed that providers had some knowledge about the common RTI/STDs, causes and consequences. But during service delivery, most providers failed to address the problems. The pattern of client-provider interaction observed, left little scope to look beyond fertility regulation or pregnancy care. Both client and provider have a singular purpose. Moreover, providers see each client as an entity: a FP client or an antenatal client.

In the current FP - MCH service delivery system, there are no separate RTI/STDs interventions but this should cut across all other existing services. The current service protocol for FP - MCH clients are such that it provides some opportunities to explore and address these issues for example performing a proper pelvic examination or adopting necessary infection prevention. In most cases, the protocols were not followed in spite of availability of trained staff and necessary equipment (e.g. not performing a pelvic examination for a new FP acceptor or a FP user complaining of RTI-like symptoms). Providers were negligent in following the appropriate step-by-step protocol and proper aseptic precautions. This not only made it difficult for them to detect the problems but enhanced iatrogenic risks as well.

The stated practice of the providers regarding RTI/STDs, especially counseling and partner management, portrayed an ideal situation which did not coincide with the practices observed. There is an overall lack of empathy and concern about clients well-being. Possibly, the providers relate all RTIs as STDs and do not realize that their clientele can be in an at-risk group. Besides, they also lacked insight regarding the gaps in their own clinical practice that can lead to iatrogenic infection.

In most of the SDPs, there were adequate equipment and supplies. The majority of the providers mentioned that they needed more equipment and staff for management of

RTI/STDs Probably the providers lack vision as to what is actually needed to address these problems in the existing system with available equipment and supplies

This gap in knowledge, attitude and practice reflects that there is some need for training on reproductive health, and the inter-relationship of its various components including RTIs /STDs In order to utilize training the providers also need support, encouragement and supervision of their activities

6 2 POLICY IMPLICATIONS

Women recognize the problems of RTI/STDs Their health seeking behavior for family planning and maternal services provides an opportunity to address their RTI problems

Basic building blocks for RTI services are present in the system Service delivery protocol can be revised so that each contact is seen as an opportunity, and client provider interaction is maximized

Providers need to be more proactive in utilizing these opportunities Policy challenge is to change providers attitude, improve their skills in dealing with clients and create an environment which enhances effective client provider interaction

Existing training programs can be utilized to orient providers on an holistic concept of reproductive health approach and the inter-link between RTIs and the other reproductive health services

To ensure effective utilization of training and quality of services providers need support and competency based supervision

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APPENDIX

CASE STUDIES

1 A CASE OF MANY MISSED OPPORTUNITIES

Nilufa, aged 26 years and pregnant has come to the SDP for her very first ante-natal check up. She is married to a shopkeeper and both of them had six years of school education. While waiting for her turn to see the provider, Nilufa willingly talked to the interviewer. She stated she had white discharge for the past three months and her husband had a swelling in the groin. Nilufa had a mixture of correct and incorrect information to explain these problems. She did believe that these were symptomatic of a disease which needed treatment. She thought that problems, like ulcer and discharge, were caused by poor personal hygiene while urinary problems were the result of "*kosha*".

Nilufa waited at the SDP from morning until noon. Finally the provider told Nilufa to come another day as she had too many clients that day. As she left, Nilufa was certainly disappointed but she did not say whether or not she would return another day.

There were several missed opportunities. The potential outcome of not seeing Nilufa that day may be that she will not return to the SDP. This could mean that she receives no tetanus immunization and no treatment of herself, and her husband, for their RTI problems. This untreated RTI may have adverse affect on her pregnancy outcome.

2 A CASE OF CARELESS TECHNIQUE

Rahima, aged 27 years, married to a truck driver came to an SDP for tubectomy. She had been using injectables for two years but had gained weight, so her husband does not approve of the method. Since they also had completed their family size, they decided that Rahima would have a tubectomy.

Rahima was very nervous and crying before the procedure but the provider made no attempt to ease her anxiety. She performed pelvic examination without explaining what she was going to do. During the procedure she did not wear any gloves and took a piece of cotton, soaked in Savlon in her hand. With that she swabbed both the external and internal genitalia. She then took a double bladed Sim's speculum, one end of which had previously been used on another client but not cleaned. She held the used end of the speculum in bare hand and inserted the other end into the vagina of the client.

Following the pelvic examination, Rahima was taken into the operating theater. The door was left open throughout the procedure. This provider assisted in the operation, where she touched all the sterile instrument with contaminated hands. The provider performing the procedure made futile effort to maintain aseptic precautions. The first provider was trained and experienced, failed to consider the rights of Rahima as a client in

two ways. She did not counsel her about her fears of the procedure and insure that she was making a free and informed choice. Moreover, by not maintaining aseptic precautions and by being careless, the providers may have caused her unnecessary harm.

3 A CASE OF ABUSE OF CLIENT'S RIGHTS FOR INFORMATION AND CHOICE

Hasina is a factory worker with one child who is five months old. She came to the SDP to adopt the injectable as a family planning method. Hasina told the interviewer that she had occasional dysuria, painful coitus and white discharge.

When she talked to the service provider, Hasina told her primary reason of visit and complained of amenorrhoea. The provider took her menstrual and obstetric history but did not screen for RTI and method-related contraindications. Without providing any other information, the provider asked Hasina to lie down on the examination table. She left the room and returned with a loaded IUD.

The provider proceeded with the IUD insertion. She performed a bimanual examination and inserted the Sim's speculum. She then held the cervix with a curved artery forceps and the IUD was introduced by pushing the white rod without sounding. The IUD string was cut at the level of the vaginal orifice.

Hasina was neither not told why the provider chose to give her an IUD rather than the injectable which she requested nor counseled her on the method given. The provider had 16 years work experience and training in FP.

4 A CASE OF IUD SERVICE IN A CLIENT WITH RTI

Minara, aged 30, came to the SDP for IUD insertion. She was a new FP acceptor.

During the interview, she reported symptoms suggestive of RTIs. She had suffered from white discharge, genital itching, and occasional lower abdominal pain for two years. In the last six months, she has had burning micturation. Her husband had a pus-like discharge from his penis.

Minara had a limited understanding of how these symptoms occurred. She believed that white discharge was caused from family planning methods while men get penile discharge because of physical strain. She thought burning micturation was caused by dehydration or limited water intake.

At the SDP, a counselor took her personal history and some clinical history related to menstruation, last delivery and about two specific RTI symptoms---vaginal discharge and lower abdominal pain. She then sent Minara to a clinical service provider who checked her blood pressure and took a vaginal and cervical swab to detect RTIs. Another provider did the pelvic examination beginning with a bimanual examination. She swabbed the cervix in

an inappropriate technique and then inserted the speculum. Sounding was done with a 5mm MR cannula. Then the IUD was inserted.

Following the insertion, the provider did not explain to Minara about maintaining hygiene while checking the IUD thread. Minara was also given metronidazole and cotrimoxazole for her RTI conditions without any counseling. No treatment was prescribed for her partner.

This SDP was a specialized centre, and the providers were experienced and trained.

5 A CASE OF AN INDIFFERENT SERVICE PROVIDER

Momtaz, aged 35, married to a migrant worker, came to an SDP for treatment of white discharge, lower abdominal pain and burning micturation. In the last four months, she also experienced painful coitus. During interview Momtaz informed that she had an MR done two years previously by a *dai*.

Momtaz tried to get service for her symptoms from the female provider but she would not attend her. Without giving her any reason, she sent her to the SACMO. Because the SACMO was a man, Momtaz could not state her complaint. He prescribed her some vitamin tablets. Consequently, Momtaz left the SDP without any treatment for her RTI problem at all.