

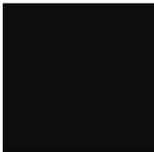
Involving Private Medical Practitioners In Family Planning Services

Final Report

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 This project was supported by the Asia and the Near East Operations Research and Technical Assistance (ANE OR/TA) project of Population Council. The ANE OR/TA project is funded by the Office of Population, U. S. Agency for International Development (USAID), contract No. DPE C-00-90-0002-10.

**Population Council
Dhaka, Bangladesh**

June 1998

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LIST OF ABBREVIATIONS

AVSC	:	Association for Voluntary Surgical Contraception
AITAM	:	Associate in Training and Management
BDHS	:	Bangladesh Demographic and Health Survey
BMA	:	Bangladesh Medical Association
CWFP	:	Concerned Women for Family Planning
DG-FP	:	Director General, Family Planning
DMPA	:	Depo-provera (Depo-medroxy Progesterone Acetate)
ENT	:	Ear, Nose and Throat
FFW	:	First Follow-up Workshop
FP	:	Family Planning
FI	:	Field Investigator
HIV	:	Human Immunodeficiency Virus
IMA	:	Indian Medical Association
ICDDR,B	:	International Centre for Diarrhoeal Disease Research, Bangladesh
MFSTC	:	Mohammapur Fertility Services and Training Center
MCI	:	Mystery Client Interview
MCQ	:	Multiple Choice Question
NIPORT	:	National Institute of Population Research and Training
NGOs	:	Non-government Organizations
NSAIDS	:	Non Steroid Anti-Inflammatory Drugs
OC	:	Oral Contraceptive
OCP	:	Oral Contraceptive Pill
ORS	:	Oral Rehydration Salt
PIACT	:	Program for the Introduction and Adaptation of Contraceptive Technology
PMP	:	Private Medical Practitioner
PID	:	Pelvic Inflammatory Disease
RTI	:	Reproductive Tract Infection
STD	:	Sexually Transmitted Diseases
SFW	:	Second Follow-up Workshop
SMC	:	Social Marketing Company

ACKNOWLEDGMENTS

The project "Involving Private Medical Practitioners (PMPs) in Family Planning Services" is an innovative initiative to involve the PMPs in protecting the reproductive health of couples, attract private investment in the family planning sector and eventually reduce the increasing financial pressure on the government.

The project was implemented in two phases. In phase I, the qualified PMPs from urban areas were given training on FP. In phase II, the non-qualified PMPs were given training on FP. There were many who helped in different ways in the implementation of this pilot project. Dr. Shamim-ul Moula, Mr. Mohidul Haque Khan, Mr. Iqbal Ahammed, Mr. Abdul Kader, and Mr. Uttam Kumar Biswas, with painstaking care, did the job of organizing the orientation courses, monitoring the field program, conducting the pre- and post-tests and monitoring the client surveys and mystery client interviews in the urban sites. Mr. Mufti Raihan Uddin, Mr. Abdul Mannan, Mr. Zahid Ishtiaque and Mr. Md. Mohshin Chowdhury performed the same tasks in the rural sites. We appreciate their sincere efforts, and gratefully acknowledge their contributions.

Mr. Khairuzzaman Chowdhury, the then Director General, Directorate of Family Planning; Dr. A. M. Zakir Hossain, Director, Primary Health Care & Disease Control, Directorate of Health; Mr. A. N. M. A. Salim Khan, Director (Training), NIPORT; Dr. Quazi Shahidul Alam, Secretary General, Bangladesh Medical Association (BMA); Mr. Farruque Ahmed, Population Specialist, World Bank; and Mr. David L. Piet, Director, Office of Population and Health, USAID encouraged us by participating in the inaugural sessions in the urban program. Mr. Gowrango Chandra Chakraborty, DD, Dr. Akhter Hossain, AD(CC), Mr. Shorodindhu Dey, AD(FP) of Moulvibazar District FP Office, Dr. Bashirul Islam, THA&FPO, Mrs. Luthfun Nehar, TFPO and Dr. Abdul Mannan, MO(MCH) of Komalganj Thana helped us tremendously in implementing the program in the rural sites. We are grateful to all of them. We gratefully acknowledge the contributions of the resource persons in the orientation sessions from the different government and non-government institutions. In this regard, we must mention the name of Dr. K.C. Motiul Alam, Assistant Director, Clinical Services, Directorate of Family Planning and Dr. Sukanta Sarker, Senior Program Officer, AVSC International. We gratefully acknowledge the effort and contributions given during orientation sessions by Dr. Sabera Rahman, Director of MFSTC; Dr. Rafiqus Sultan, Deputy Director (Clinical Services), Directorate of FP; Dr. Husne Ara Ali, Deputy Director, MFSTC; Dr. A. J. Faisel, Country Representative, AVSC International; Dr. Tahmina Sarker, Medical Director, Concerned Women for Family Planning (CWFP); Dr. Mizanur Rahman, Program Officer, AVSC International; Dr. Hasina Begum, Team Specialist, the Asia Foundation; Dr. S. M. Shahidullah, Director, AITAM; Dr. Sirat Nasir, Trainer AITAM; Dr. Selina Ahmed, Program Development Manager, Marie Stopes Clinic Society; Dr. Shahin Sultana Ahmed, Program Officer, Marie-Stopes Clinic Society and Dr. Rafat Newaz, Consultant, Azimpur Maternity Clinic, Dhaka.

We are deeply indebted to the PMPs who participated in the orientation sessions. We also gratefully acknowledge the significant contributions of those female interviewers who took the risks involved in conducting the mystery client interviews.

Dr. M. E. Khan, Program Associate and Dr. Bela C. Patel, Program Officer, Population Council, India shared their experiences from a similar project implemented in India and helped us in designing the orientation courses, IEC activities and reviewing the draft of the preliminary report of the mystery client interviews which added to its quality. We owe a great deal to both of them.

Ms. Chand Sultana Chowdhury, Ms. Nahid Nasreen and Ms. Shabnam Rahman did the tedious job for monitoring the field activities and analyzing the mystery client interview data, pre- and post-test

information and clients' survey data in the urban area. We appreciate their sincere efforts and gratefully acknowledge their contributions to this program.

Last, but not the least, we acknowledge our enormous debt to Mr. Francis Blazo and Mr. Mizanur Rahman Sarder who, with infinite patience, finished the lengthy and tedious job of word-processing the report.

Abu Yusuf Choudhury, Director

Executive Summary

1. INTRODUCTION

PIACT Bangladesh, a local NGO, has conducted two pilot projects to involve the private medical practitioners (PMPs) in family planning (FP). The first one was to involve the qualified PMPs in urban areas (Dhaka) and the second one was to involve the non-qualified PMPs in rural areas (Komalganj Thana of Moulvibazar District). The qualified PMPs are medical graduates and non-qualified PMPs that means rural medical practitioners (RMPs) are not medical graduates. The findings of the first project are presented in Part A and the second one in Part B of the report. The projects were implemented with technical assistance from Population Council.

2. OBJECTIVE

The overall objective of these pilot projects was to explore the feasibility of involving the PMPs and RMPs in providing selected FP services on a commercial basis with emphasis on counseling and side effect management.

PART A: INVOLVING QUALIFIED PRIVATE MEDICAL PRACTITIONERS (PMP) IN FAMILY PLANNING

1. IMPLEMENTATION OF THE PROJECT

1.1. Listing and Selection of PMPs for the Project: A total of 172 PMPs including 23 females were identified from Dhaka city and eventually 110 PMPs joined the program out of whom 96 (87%) continued the program up to the end.

1.2. Orientation for the PMPs: The PMPs were given three one-day orientations in batches: during the third, 5th and 7th month of the project period. A separate orientation on RTI was conducted with female PMPs. The main topics covered in the orientations were:

- Trends of FP acceptance and selected MCH indicators in Bangladesh
- Importance of counseling in FP and the importance of quality of services
- Discussion on condom, oral contraceptives and menstrual regulation
- Discussion on injectable, Norplant, IUD and sterilization
- Contraindications of the different contraceptive methods, major side effects and their management
- Discussion on reproductive tract infection (RTI) and sexually transmitted infections (STIs)

For a ready reference, the manuals of seven modern contraceptive methods, published by the Directorate of Family Planning, were supplied to each PMP¹. Other materials supplied included contraceptive updates, lecture handouts and graphs showing demographic and health indicators.

The 110 PMPs attending the first round of orientation constituted the base upon which the project activities continued. These PMPs were invited in the second and third orientations.

Unlike the first round orientation where the focus was on technical presentation by the resource persons, the second orientation was designed to share the practical experience of the PMPs and also to respond to the queries of the PMPs on specific methods by the resource persons. A technical session on RTI/STD was added to this workshop. A total of 83 PMPs (including 15 female PMPs) attended the second orientation.

The third orientation was attended by 79 PMPs. The objective of the third orientation was similar to that of the second orientation: to reorient the RMPs and allow them to share their experiences. A special RTI/STD session was held with the 15 female PMPs. The resource persons were chosen from the senior

professionals working in health and FP sector. Each PMP was given a copy of the latest (1996) version of the Contraceptive Technology².

1.3. Project Monitoring and Follow-up: Each of the PMPs was followed-up in his/her chamber at least once a month after the first orientation. The purpose of these follow-up visits was mainly to remind the PMPs about their responsibilities as discussed in the orientations. During the follow-up visits, the PMPs were asked whether they needed additional information and client record sheets³. The filled-out sheets were collected from them during the revisits.

1.4. Community Awareness Activities: IEC activities were carried out to inform the people living in the project areas as well the clients who visited the PMPs in the chambers to know about the availability of FP services from the trained PMPs. These included:

- Project personnel hung signboards (containing the name of the PMP and the information that he/she had received FP training) in front of the pharmacies/chambers of the trained PMPs
- Project personnel distributed a leaflet with the names and addresses of the PMPs working in the area
- PMPs distributed a brochure describing key objectives of the project to the clients
- Project personnel placed posters and stickers in the pharmacies and public places
- Project personnel hung banners in public places
- Project personnel distributed a newsletter describing the project activities
- Project personnel conducted group meetings with the community members
- NGO field workers communicated the messages to the couples

1.5. Recording, Reporting and Dissemination: Provisions were made to thoroughly document every event of the project. A mid-term dissemination of the project findings was organized in April 1997. This event was attended by policy makers, senior program managers, FP-MCH professionals, NGO representatives, donor representatives and the trained PMPs.

1.6. Establishing Referral System: Trained PMPs were linked with the nearby GOB and NGO facilities for referral of clinical contraceptives, and of clients presenting with complicated side effects. Such a referral system had been absent in the project areas before the launching of this project.

2. BACKGROUND INFORMATION OF THE PMPs

A total of 110 PMPs participated in the project and a baseline questionnaire was filled out by 103 PMPs. All the PMPs were medical graduates and over a quarter (28.2%) of them had post-graduation degree. About a quarter (24.6%) of the post-graduate doctors were specialists in public health and about one-third (31%) were obstetricians or gynecologists. The largest proportion of the PMPs (84.2%) were reportedly sitting in drug stores. Nearly 61 percent of the PMPs practiced in the chambers 4-5 days a week. About one-fifth of the PMPs were female. Male and female patients came almost in equal numbers to the PMPs for treatment (43% Vs. 42%).

3. ASSESSMENT OF THE PROJECT

The assessment of the effectiveness of the project was done in the following three ways:

- Comparison of the pre- and post-training knowledge and attitudes among the PMPs with regard to selected family planning methods and RTI/STDs
- Pre- and post-intervention comparison of FP service delivery by the PMPs (information obtained through mystery client interview)

1 The seven methods are: oral pill, condom, injectable, IUD, Norplant, male sterilization and female sterilization.

2 A book written by Hatcher R. A., J. Trussel, F. Stewart, G. K. Stewart, D. Kowal, F. Guest, W. Cates and M. S. Policer

- Pre- and post-intervention interviewing the FP clients serviced by the PMPs to determine the nature and quality of services provided

3.1. Attendance of PMPs: All of the invited PMPs participated in the first orientation. Seventy-five percent of them attended the second orientation. Seventy-two percent of the PMPs who attend the second orientation attended the third orientation.

3.2. Knowledge and Attitude Assessment of the PMPs: The three orientations were attended by 72 PMPs each. Therefore, the pre- and post-test analysis included only 72 PMPs. The PMPs who continued with the program were convinced that it would increase their earnings. The knowledge of the PMPs on quality of care and the different elements of counseling increased significantly after the orientation. The knowledge of the PMPs about the contraindications of pills also increased sharply. Their knowledge on when to start oral pills (first day of menstruation) increased by 92 percent (4% to 96%).

³ Client record sheets were provided to each trained PMP to keep records of the clients whom they provided FP services/counseling and the other services.

The knowledge of PMPs about the specific side effects of oral contraceptive pills, such as nausea and menstrual problems, also increased significantly. It was observed that before the orientation, over one-third (33.3%) of the PMPs did not know what to do if a client missed one pill. After the orientation, this figure dropped to 1.4 percent.

Prior to the orientation, 42 percent of the PMPs did not know the schedule for the Depo-provera injection. This figure similarly decreased to 13 percent in the post-orientation analysis.

Before the orientation, only a few of the PMPs (3%) had accurate knowledge about the length of time the Copper-T 380A could remain effective in situ. After the orientation, however, most of the PMPs (93%) reported the correct duration. The proportion of PMPs knowing the most common problems of IUD has increased significantly after the orientation. Knowledge of the PMPs about the selected aspects of RTI/STDs was quite high even before the orientation. In most cases, the orientation increased this knowledge.

3.3. Mystery Client Interviews: A total of 104 mystery client interviews, 64 before the orientation and 40 after the orientation, were conducted to assess the quality of services rendered by the PMPs to their clients. After third orientation, the PMPs knew more about the contraindications of the oral pill and they tended to ask the clients more about them. Instructions given to pills users had improved significantly after the orientation in respect of completeness and correctness of information.

It was observed that the PMPs had several misconceptions with regard to side effects of oral pill before the orientation. After the orientation, none of the PMPs provided incorrect information about the side effects of oral pills. The level of knowledge and confidence of the PMPs about suggesting alternate brand(s) of oral pills or changing the method when a particular brand of pill or other method did not suit a client had increased after the orientation.

Prior to the orientation, PMPs did not promote the injectable contraceptive due to its side effects. In fact, they discouraged the clients from accepting it. After the orientation, although the majority of the PMPs still preferred other methods, they did provide information about injectables.

The attitudes of the PMPs toward the IUD was positive both before and after the orientation. After the orientation, the PMPs were found to provide more information to the clients about the method in terms of its duration, side effects, effectiveness and convenience, and specifically advised the users against removing it.

All the PMPs prescribed medicine for treatment of the side effects reported by the mystery clients before and after the orientation. Overall, it was observed that there was significant improvement in the rational use of medicine for treatment of contraceptive side effects.

3.4. Client Interviews: From the records of 332 clients, 87 were randomly interviewed during a home visit. A large majority of the clients were housewives (70%). The average monthly income of the clients was ten thousands. One-third of the clients reported that they had visited the PMPs for the sole purpose of seeking advise about FP methods. Most of the remaining clients said that they had visited the PMPs for their own treatment or for the treatment of their children. Over a quarter of the clients reported that they had paid the PMP a fee for his advice on FP methods. The remaining 72 percent did not pay an additional fee for the FP advice. Of the clients who paid the PMP a fee for FP consultancy, the majority (60%) paid Tk. 50 per visit. A few of them (5%) paid more than Tk. 100 per visit.

Three-quarters of the clients reported that they were currently using a contraceptive method. Nearly 90 percent of the clients reported that they were satisfied with their discussion with the PMP on FP.

3.5. IEC Materials: Posters and stickers were hung in the chamber of each participating PMP and in some other public places. Leaflets were distributed in the community and were given to the clients by the PMPs. Over a half of the clients (53%) reported that they had seen the poster and over one-third had seen the sticker. About one-fifth of the clients said that they had seen the poster in the wall elsewhere.

PART B: INVOLVING NON-QUALIFIED PRIVATE MEDICAL PRACTITIONERS IN RURAL AREAS

1. IMPLEMENTATION OF THE PROJECT

The RMPs were given three orientation sessions at two month intervals. The training curriculum and materials which had been used in the urban PMP orientation were revised and used to train the RMPs. The first orientation session lasted two days. The second and third orientations were for one day, each. The trained RMPs were linked with the nearby health facilities for referral of clinical contraceptives, and also to refer clients presenting with complicated side effects. The RMPs kept a record of the clients they referred or provided FP services. Afterwards, a client survey based on those records was conducted.

After the first orientation, field officers hung signboards in front of the pharmacies/chambers of the trained RMPs. A leaflet listing the names and addresses of the participating RMPs was distributed to the clients. Also posters and stickers were placed in the pharmacies and other public places.

Before the first orientation session, RMP knowledge on selected aspects of FP and RTI/STD was assessed. This was done through the use of a pre-structured questionnaire. After all three orientation sessions were complete, the same questionnaire was administered again. Mystery client interviews were also conducted before and after the orientation with a sample of RMPs.

2. BACKGROUND INFORMATION OF THE RMPs

A large majority (83.3%) of the RMPs had at least passed their Secondary School Certificate examination. The average age of the RMPs was 38.7 years. The majority (58.3%) were found to practice in a pharmacy where they also sold medicine. The majority (62%) of the RMPs reported that they were engaged in full-time practice and over a quarter (26.7%) said that they practiced in the afternoon only. The median number of patients served by the RMPs per week was found to be 70. A large majority (83.3%) of the RMPs reported that people came to them for FP consultation. On average, RMPs charged Tk. 8 for a consultation. Twenty-two percent of the RMPs said that they did not charge their client a fee. These RMPs explained that they made their profit from the medicine they sold to the clients.

3. ASSESSMENT OF THE PROJECT

3.1 Knowledge and Attitude Assessment of the RMPs

Before the orientation, 59 percent of the RMPs stated that the first dose of oral pill should be taken on the first day of menstruation. After the orientation, almost all (98%) of the RMPs gave this response. The knowledge of RMPs about various contraindications of oral pills had also increased significantly after the orientation. Knowledge about the major side effect of the oral pill increased to a large extent after the orientation. Before the orientation, about 66 percent of the RMPs reported nausea/vomiting as a major side effect of the oral pill. After the orientation, all the RMPs said so. After the orientation, most of the RMPs knew what to advise the pill clients in case of spotting against only 22 percent before the orientation.

Before the orientation, a little more than half of the RMPs (52%) were able to correctly advise to an injectable client who suffered from excessive bleeding. After the orientation, almost all (96%) could provide at least one correct answer. After the orientation, 90 percent of the RMPs stated that they would assure the client that amenorrhea was not harmful for health; this was mentioned by only 10 percent of the RMPs before the orientation. Before the orientation, over a half of the RMPs (55.2%) could name a single side effect related to the use of the IUD. This figure declined to 10 percent after the orientation. Forty-three percent of the RMPs knew before the orientation what to advise or what treatment should be given to an IUD user suffering from excessive bleeding. This figure increased to 88 percent after the orientation. The knowledge of RMPs about what treatment or what advice should be given to an IUD user in the event of lower abdominal pain increased significantly after the orientation (29% to 70%).

The RMPs were asked to name three RTI/STDs. The most frequently mentioned RTI/STDs before and after orientation were Gonorrhea and Syphilis respectively.

3.2. Mystery Client Interviews

A total of six scenarios were developed: three types of prospective FP method users (newly married, mother with one child and mother with two children); one each for the side effects of pill (spotting), injectable (excessive menstrual bleeding) and IUD (lower abdominal pain). A total of 30 mystery client interviews were conducted with the six scenarios both before and after the orientation. Five interviews were conducted for each scenario.

After the orientation, the RMPs provided a wider range of FP method options, than they had prior to the orientation. Mothers who had one or two children were advised to accept clinical contraceptives after the orientation. Whereas IUD and Norplant were most frequently suggested after the orientation, Norplant had been suggested by none of the RMPs before the orientation.

After the orientation, all of the mystery clients who had spotting were advised against getting worried and to continue using the pills. In these cases, the RMPs assured the client that the problem would disappear over time. Before the orientation, the majority of the mystery clients were advised to change the brand of pill they were using.

After the orientation, all of the RMPs advised the injectable clients with excessive bleeding not to be worried-- that it would decline over time. This advice was given by only a few RMPs before the orientation.

Before the orientation, the majority of the clients were advised to remove the IUD. After the orientation, most of them were informed that lower abdominal pain and excessive bleeding were two major side effects of IUD, but that they disappear within 2-4 months, and were no cause for alarm.

RMPs prescribe drugs for treatment of the side effects reported by the mystery clients. Overall, it was observed that there was significant improvement in the rational use of medicine for treatment of contraceptive side effects. The harmful practices of prescribing inappropriate drugs for contraceptive side effect management declined significantly after the third orientation.

3.3. Records

The RMPs kept records of the 750 clients to whom they provided FP services. From these records, 125 clients were randomly selected and 104 cases were successfully interviewed. The majority (67%) of the respondents were from the lower socioeconomic class. A large majority of the clients (81.6%) were happy with the services/advice provided by the RMPs. The majority (64%) of the respondents said that availability of FP services at pharmacies would benefit them. Forty-three percent of the respondents reported that they were currently using a FP method.

5. LESSONS LEARNED

- PMPs and RMPs were interested in becoming involved in FP service delivery. It was learnt that PMPs participation can be ensured in the program if they are selected properly and approached by the senior program personnel. It was not a difficult matter to involve RMPs in the project.
- A very few clients approached the PMP/RMP for FP services before the orientation. During the course of the orientation, the community members learned that FP services were available from the PMPs and RMPs. Thus, more clients began to seek FP services from them.

- This program also learnt that involvement of PMPs and RMPs to rendering FP services is feasible. Since, before the orientation, PMPs did not initiate discussions about FP issues with their clients. But, by the end of the orientation, they had began to do so. This scenario is exactly same for RMP. Moreover, PMPs were interested to provide all clinical contraceptives and RMPs to injectable contraceptives.
- In order to maintain register of FP clients by the PMPs and RMPs were possible.
- Through the use of IEC activities it was possible to inform the community members about and motivate them to seek FP services from the PMPs and RMPs.
- It was possible to develop a referral system between the PMPs/RMPs and the government/NGO service centers.
- The design for a three-day orientation, held on three different days with an interval of two months was found to be most effective in improving the knowledge of PMPs/RMPs about FP, RTI/STD and encouraging them to provide these services.
- It was learnt that due to inadequate knowledge about FP methods RMPs provide less options for FP method. After the orientation, RMPs provided a wider range of FP method options.

6. RECOMMENDATIONS

- Considering that the PMPs are medical graduates and have a personal interest is being involve in FP service delivery, and that the approach it will address the three major challenges of the Bangladesh FP program (service quality, privatization and sustainability), it is recommended that the PMP project be gradually expanded to all urban areas of Bangladesh. Taking into account the fact, that RMPs provide health care services to a large majority of the rural population and that they have interest in getting involved in FP service delivery. The RMP program should gradually be expanded to all rural areas of Bangladesh.
- In order to obtain high-quality advice/service from the PMPs and RMPs, they should be continually provided with updated FP information-- particularly on critical issues such as side effect management and method choices. A reorientation session for PMP could also be arranged after a period of one year.
- To update the knowledge of the RMPs about FP methods and RTI/STD management, the RMPs should be provided with relevant and necessary information in this regard on a regular basis. Also refresher training for RMPs should be arranged for them at regular intervals of two years.
- In view of the interest and facilities available with the PMPs, it is recommended that the selected PMPs be trained to render clinical contraceptive services-- particularly injectable contraceptives-- along with the treatment of RTI/STDs. The female PMPs should be specially trained to insert IUDs and treatment for RTI/STDs. Bearing in mind that RMPs provide injections to their clients in the treatment of different diseases. Thus, they should be capable of administering injectable contraceptives as well. Therefore, in light of the fact that 60 percent of the clients who received FP service were female, this situation would serve as outstanding opportunity to promote the use of injectable contraceptives through RMPs.
- A large majority of the PMPs and RMPs kept records of the clients to whom they provided FP services/advice. They should be encouraged to continue this practice. Activities that could help to ensure this might include periodic visits, provision of contraceptive-related information, responding to their needs and concerns and recognizing their services.

PART A

**INVOLVING QUALIFIED PRIVATE MEDICAL PRACTITIONERS IN
FAMILY PLANNING SERVICES IN URBAN AREAS**

SECTION ONE

INTRODUCTION

1.1 Background

The economy of Bangladesh is in transition. The domination of the public sector is slowly making way for the emergence of the private sector. This process is more visible in urban than in the rural areas. In recent years, rapid privatization has become visible in both the education and health sectors. Many people, particularly in urban areas, are now spending a good proportion of their earnings on education and health care services. Only a few years ago people depended heavily on government facilities for these services. Maternal and child health (MCH) services such as pregnancy care and delivery, immunization and child care, are now partially commercialized in the urban areas. It has been observed that people who can afford services prefer to avail private rather than government facilities for such services.

However, privatization of family planning (FP) services has been much slower, and the role of the commercial sector has long remained limited to the sale of oral pills and condoms. The Social Marketing Company (SMC) is selling several brands of oral pills and condoms at subsidized prices through commercial outlets. In addition, imported brands of oral pills and condoms are available in the market.

Private sector contributions in the areas of contraceptives and the provision of information have been documented in various studies. The 1993-94 Bangladesh Demographic and Health Survey (BDHS) shows that about 10 percent of the current users of modern methods got their recent supply of contraceptives (or received information) from private medical sources and another seven percent obtained their contraceptives from other private sources. Moreover, private source procurement was reported for all modern methods ranging from 1.5 percent for female sterilization to 23 percent for oral pills and 53 percent for condoms.

There is no doubt that a greater involvement of the private sector in FP counseling and service delivery will create a silent movement toward the achievement of a sustainable program. In the urban areas, a large section of the population is receiving general health care services from qualified private medical practitioners (PMPs) on a commercial basis. The PMPs sit in pharmacies which serves a dual purpose: (i) pharmacies sell more prescriptions because of the increase client flow; and (ii) the pharmacy is an alternate location where the PMP can practice with no overhead, since most PMPs are employed elsewhere.

The PMPs are medical graduates. The curriculum of the medical degree covers reproductive physiology and family planning methods. Since people do not approach PMPs for FP service, PMPs rarely dispense these services. It is expected that if the knowledge of the PMPs can be updated regarding the latest contraceptive technology, as well as contraceptive side effects management, and if couples can be made aware of the availability of such services, it is very likely that couples will gradually begin to visit the pharmacy to receive FP services from the PMPs in exchange for a fee. This would also encourage the PMPs to regularly update their contraceptive knowledge in the interest of satisfying their clients' needs. Therefore, the PMPs can play a very important role in providing FP services in urban areas. Based on the above perspective, PIACT Bangladesh designed and implemented an exploratory study to involve PMPs in FP.

1.2. Objectives

The overall objective of this project was to explore the feasibility of involving the PMPs in providing selected FP services on a commercial basis (with special emphasis on counseling and side effect management). The specific objectives were to:

- Examine the extent PMPs take an interest in FP and participate in the service delivery;

- Assess the retention of knowledge imparted to the PMPs in the orientation and through other means;
- Assess the extent of FP services (in terms of prescribing FP methods/ products, counseling and side effect management) the PMPs provide after the orientation/training workshops;
- Ascertain the level of satisfaction among clients receiving FP services from the PMPs;
- Establish a referral system between the PMPs and the existing FP service facilities (e.g. clinic, hospitals); and
- Estimate the cost that would be involved in a nation wide replication of the program.

SECTION TWO

IMPLEMENTATION OF THE PROJECT

The experimental project "Involving Private Medical Practitioners (PMP) in Family Planning Services in Urban Areas" was implemented by PIACT Bangladesh over a period of one year, beginning June, 1996. The major activities performed under the project during this period are presented below.

2.1. The Project Area

The project area is in mid-western Dhaka City, and represents five percent of the city's total population. The people living in the area belong to a mixed socio-economic group. The project area covers Zigatola, Rayer Bazar, Mohammadpur and surrounding areas.

2.2. Listing and Selecting PMPs for the Project

All of the qualified PMPs practicing in the project area were listed. A total of 172 PMPs, including 23 female PMPs were identified. Excluding specialized PMPs, about 155 doctors were sent an introductory letter describing the purpose and objective of the project. A consent form was also enclosed with the letter to know whether they are willing to participate in the program. The PMPs indicating interest were visited by PIACT staff explained the project activities. A total of 110 doctors joined the program, of which 96 (87%) continued throughout the project period. Those who continued with the project supported that the program would benefit the people; enrich their professional knowledge; and increase their earnings.

2.3. Curriculum Development

All of the qualified PMPs were medical graduates. Their FP knowledge was assessed through mystery client interviews and group discussions. The manuals on different contraceptives published by the Directorate of Family Planning, MCH-FP training curricula designed by NIPORT, contraceptive technology update and training curricula developed for PMP training by the Indian Medical Association (IMA) were consulted in developing the curricula for the orientation of PMPs. The draft curriculum was shared with the Directorate of FP, Mohammadpur Fertility Services and Training Center (MFSTC), Association for Voluntary Surgical Contraception (AVSC) International, National Institute of Population Research and Training (NIPORT), Concerned Women for Family Planning (CWFP), Community Health Care Project (CHCP) and Marie Stopes Clinic Society. The curriculum was finalized based on comments from all of these institutions. It was further modified based on the needs identified during the first orientation session. The main topics covered in the curriculum were as follows:

Topic 1 Trends in FP Prevalence and Selected MCH Indicators

- An overview of the FP-MCH trends in Bangladesh
- FP methods/services available in Bangladesh
- FP services available in the project area

Topic 2 Importance of FP Counseling and Quality of Care

- Discussion on the importance of counseling and follow-up of clients
- Increasing the ability to communicate with the clients (specially females)
- Rendering safe and infection-free FP services
- Arrangement of visual and auditory privacy in the chambers
- Improving service facilities in the chambers

Topic 3 Discussion on Condom, Oral Contraceptive (OC) and Menstrual Regulation (MR)

Condom:

- Advantages and disadvantages of condom

- Condom brands available through the government facilities and in the market
- Non-contraceptive use of condom

Oral contraceptive:

- Types of OC (low-dose and regular-dose)
- Contra indications of OC
- Checklist for screening an OC client
- How to take OC
- What to do if one/two pills are missed
- Post-partum use of OC during breastfeeding
- Common side effects of OC and their management
- Low-dose pill and its specific advantages and disadvantages

Menstrual Regulation (MR):

- Need for MR services
- Sources of MR services
- Restrictions to MR services

Topic 4 Discussion on: Injectable, Norplant, IUD and Sterilization

Injectable:

- Growth of injectable use in Bangladesh
- Contra indications for injectable
- Screening an injectable client (checklist)
- Composition and dosage of two injectable brands (DMPA, Noristerat)
- Side effects of injectable and their management
- Sources of referral for an injectable client

Norplant:

- Overview of Implant (Norplant) contraceptive
- Eligibility
- Contra indications
- Advantages
- Side effects

IUDs/Copper-T:

- Mode of action of IUD
- Copper-T 380A
- Copper-T 200B (currently most popular in practice)
- Clients best suited for IUD use
- Clients not recommended for IUDs
- Common side effects of IUDs and their management
- Sources of IUD services for the people living in the project area

Sterilization:

Brief description of male and female sterilization

Topic 5 Discussion on RTI and STD

- Definition of RTI and STD
- Classifications of RTI and STD

- Causes of RTI
 - STDs
 - Endogenous
 - Iatrogenic
- Signs and symptoms of RTI and STD
- Diagnosis of RTI and STD
 - Syndromic diagnosis
 - Conventional or laboratory diagnosis
- Treatment procedures
- Complications of RTI
 - Client
 - Partner
 - Children
- Drug Regimens
- Follow-up (importance)
- Prevalence of RTI/STD (female, male and neonate)
- Identification of the clients
- Need for partner management
- Need for RTI/STD services
- Integration of RTI care with FP services
- Service elements for RTI
- Infection prevention at places of employment

2.4. Orientation for the PMPs

Each PMP received three one-day orientations; during the third, fifth and seventh month of the project period. The first orientation was organized in four batches; the other two in three batches. An orientation on RTI was also conducted with female PMPs. The details about the orientations are presented below.

2.4.1. First Orientation Session: A total of 110 PMPs (including 23 female PMPs) attended in four batches for the first orientation session. The inaugural sessions were very brief and were arranged to introduce the PMPs to the project persons and to stress the importance of the program. The DG-FP showed a keen interest in the project and attended all four inaugural sessions. He encouraged the PMPs to accept the challenge and assured all possible assistance from the government side.

For a ready reference, the manuals of seven family planning methods published by the Directorate of Family Planning were given to each PMP. Other materials (i.e. lecture handouts, charts showing demographic and health indicators,) were also supplied to the PMPs.

2.4.2. First Follow-up Workshop (FFW): The 110 PMPs attending the first orientation session constituted the base upon which the project activities continued. These PMPs were invited to the second orientation session. Unlike the first orientation session where the focus was more on technical presentation, this follow-up workshop was designed to allow the PMPs to share. A technical session on RTI was also included in this workshop. In total, 83 PMPs (including 16 female PMPs) attended the first follow-up workshop.

2.4.3. Second Follow-up Workshop (SFW): The second follow-up workshop was held in three sessions. The session time was shortened to half a day. The objective of this workshop was similar to that of the first one to refresh the memories of the PMPs and allow them to share the experiences.

The invitees were all those PMPs who attended the first orientation and did not discontinue. In other words, any PMP failing to attend the first follow-up and willing to continue were also invited. The total

number of participants was 79. The number of PMPs participating in all the three orientations was 74, including 15 female PMPs.

2.4.4. Special Session on RTI/STD: As mentioned earlier, a technical session was held on RTI /STD in the first follow-up workshop. It was felt by the organizers and resource persons, that additional practical issues on RTIs/STDs should be discussed, specifically with the female PMPs. A total of 15 female PMPs participated in this session. These PMPs were the ones who had attended all three of the earlier sessions. The resource persons were chosen from among senior professionals in the field.

2.4.5. Attendance of PMPs in the Orientations: In general, the PMPs seemed interested and were punctual in attending the sessions. Besides the 14 PMPs who discontinued from the program for various reasons, there were 22 PMPs who attended the first orientation but could not join the two follow-up workshops. The following table shows the number of PMPs attending in the different orientations.

2.4.6. Resource Persons: A team of expert were designated as the core technical persons for conducting the orientations of the PMP program. These individuals conducted the technical sessions and shared their knowledge and experience with the PMPs.

2.4.7. Supplying Copies of Contraceptive Technology to PMPs: Each of the PMPs who attended the second follow-up workshop was given an original copy of the latest (1996) version of the contraceptive technology (Contraceptive Technology, 16th revised edition written by Hatcher R. A. et al.). The PMPs were requested to refer to the book to clarify any question or misconception with regards to contraceptives.

2.5. Project Monitoring and Follow-up

Each PMP was individually visited in his or her chamber at least once a month after the first orientation. Two field officers of PIACT were responsible for making these visits. The purpose of these visits was mainly to remind the PMPs about their responsibilities as discussed in the orientation sessions. In addition, field workers visited PMPs to invited them for follow-up workshops, distribution of posters, leaflets and stickers and hanging of signboards. During each of these visits, the field officers asked the PMPs whether they needed additional materials or whether they needed to share anything with PIACT staff about the project activities. They also enquired about the client record sheet and collected the completed ones. These activities were recorded by the field workers in a pre-designed format.

The project coordinator reviewed the activities of the field officers and guided them in the execution of their tasks. Thus, program management authority was able to keep abreast of the field situation.

2.6. Community Awareness Activities

In order to inform the people living in the project areas about the availability of FP services from the trained PMPs at the pharmacies several IEC activities were carried out in the project areas. These included:

- | | | | | |
|---|---|-------------|---------------|--------------|
| a) Hanging of signboards (containing the name of PMP and other relevant information) | <i>Table 1 Number of PMPs attended different orientation sessions</i> | | | |
| b) Distribution of a leaflet with the names and addresses of the trained PMPs in the locality | Description | Male | Female | Total |
| c) Distribution of a brochure describing project activities to the clients by PMPs | <i>First orientation session</i> | 90 | 20 | 110 |
| d) Placing of posters and stickers in the pharmacies and other public places | <i>First follow-up session</i> | 67 | 16 | 83 |
| e) Hanging of banners in the locality | <i>Second follow-up session</i> | 62 | 17 | 79 |
| f) Distribution of a newsletter project activities among the PMPs | <i>All three sessions</i> | 59 | 15 | 74 |
| g) Interpersonal communication with the community people by project personnel | <i>Special session on RTI/STD</i> | - | 15 | 15 |

- h) Dissemination of message that FP services are available to the couples through the existing NGO field workers
- a) ***Hanging of signboards at the pharmacies/chambers of the trained PMPs:*** A sign board (2'x 1'-4") was prepared for each PMP and erected at each chamber/pharmacy. Besides the name and address of the PMP, the sign board contained a message for the people "for any FP related problem, you can consult this doctor." The widely advertised Green Umbrella Logo of the government was printed in a corner of the sign board for drawing the attention of the people and to help understand at a glance about FP services.
- b) ***Distribution of a leaflet with the name and address of the participating PMPs printed on the back:*** A one-page leaflet was distributed among the potential clients of the area, mainly from the doctors' chamber/pharmacy. The names and addresses of the doctors who attended the orientation sessions were also listed.
- c) ***Distribution of a brochure on the project activities to the clients by PMPs:*** A four-color brochure on the project activities (with a photograph) was printed after the first orientation session and distributed to the clients by the PMPs.
- d) ***Placing posters and stickers in the pharmacies and other public places:*** A two-color poster (20"x15") showing a mother holding a healthy baby and a sketch depicting client-provider interaction in a PMP chamber at a pharmacy was printed and hung in the pharmacies and other public places. It contained a message similar to that of the signboard to assure message continuity. A total of 5,000 stickers (7.5"x2.75") were printed and pasted on the walls of all of the pharmacies and at suitable shops and other public places in the project area.
- e) ***Hanging of banners:*** Banners (3'x9') were erected at different visible locations of the project area for quick dissemination of the common messages about the program. It contained the message that many doctors in the area were trained in FP, and for any FP problem, the couples could visit the participating doctors.
- f) ***Distribution of a newsletter on the project:*** A newsletter named *PMP Barta* (i.e. PMP news) was published. It contained the news about the first orientation session. The names and addresses of all the doctors who participated in the program were included in the newsletter as a ready reference for all.
- g) ***Interpersonal communication:*** The PMPs were encouraged to raise the FP issue with their clients on their own initiative. The advantage of this mode of communication is that it is interactive. Moreover, no additional costs are involved. Thus, the approach is very much effective.
- h) ***Dissemination of the message to the couples through the existing NGO field workers:*** Discussions were held at a meeting with the representatives of the local NGOs involved with FP activities. The concept and complementary nature of the PMP project were explained to them and they were requested to inform their clients about the availability of FP services from the local PMPs. They were also requested to give special care to the clients referred by the PMPs. The NGO representatives agreed to extend their support toward the project for the greater interest of facilitating the couples for quality services. Throughout the intervention, these NGOs were kept informed about the project's activities. Some of the NGO program personnel acted as resource persons to the orientation sessions. Sufficient quantities of posters, leaflets, stickers and other IEC materials were also supplied to the NGOs for distribution.

2.7. Recording, Reporting and Dissemination

Recording: Every activity of the project was documentation. Wherever relevant, this data were shared with project management so that the program could be adjusted accordingly. This procedure was used particularly during the orientation sessions. Senior professional staff took note of the events and discussions in the sessions. Based on their observation, they planned and improved subsequent sessions.

Reporting: Periodic reports were submitted to Population Council on the progress of the project and also after major activities like the mystery client interviews and pre-intervention and post-intervention tests conducted with the PMPs.

Dissemination: A mid-term dissemination of the project findings was organized in April 1997 in a local hotel. This event was attended by policy makers, senior program managers, FP-MCH professionals, NGO representatives, donor representatives and the trained PMPs.

2.8. Establishment of Referral System

The trained PMPs were linked with the nearby GOB and NGO facilities for referral of clinical contraceptives, and also to refer clients presenting with complicated side effects. A referral form was developed for this purpose. To enhance the referral system, senior physicians were invited to participate in the orientation sessions as resource persons.

SECTION THREE

BACKGROUND INFORMATION OF THE PMPs

As previously mentioned, a total of 110 PMPs participated in the program. The baseline questionnaire was filled out by 103 PMPs. The following background information was collected from the baseline questionnaire survey. All of the PMPs were medical graduates. As shown in Table 2, over a quarter (28.2%) of them had received a post-graduation degree (Table 2).

More than a quarter (27.6%) of the post-graduate PMPs were specialists in community medicine and about one-third (30%) were obstetricians or gynecologists. About one-fifth (18%) of the PMPs, were female (Table 2).

Table 2 Distribution of PMPs according to sex, post graduation degree and type of specialty

Response	Percentage
Post graduation degree	
Had post graduation degree	28.2
No post graduation degree	71.8
Total	100.0
(N)	(103)
Specialty	
Obstetrician and gynecologist	30.0
Community medicine	27.6
Cardiologist	10.3
Chest specialist	7.0
Anesthesiologist	3.5
ENT (ear, nose and throat)	3.5
Virologist	3.5
Nephrologist	3.5
Nutritionist	3.5
Others	7.6
Total	100.0
(N)	(29)
Sex	
Male	81.6
Female	18.4
Total	100.0
(N)	(103)

Table 3 Distribution of PMPs by type of chamber, number of days they attend chambers per week , average number of patients treated during the previous week and category of patients coming to them for treatment

Category	Percentage
Type of chamber	
Chamber in others' pharmacy	84.2
Own chamber	8.0
Chamber in own pharmacy	3.9
Clinic	3.9
Total	100.0
(N)	(103)
Number of practicing day	
Three days	18.4
Four days	31.6
Five days	28.9
Six days	21.1
Total	100.0
(N)	(103)
Average number of patients	
Less than 5	23.7
6 - 10	36.8
11 - 15	14.5
16 - 20	10.5
More than 20	14.5
Total	100.0
(N)	(103)
Type of patient	
Male	42.7
Female	41.7
Children	11.7
Not stated	3.9
Total	100.0
(N)	(103)

The largest proportion of PMPs (84.2%) reported that they were sitting in the chamber of another party's pharmacy (Table 3). Nearly 61 percent of the PMPs practiced 4-5 days a week.

On average, 40 percent of the PMPs had treated over 10 clients during the past week in their private chambers. Male and female patients came in almost equal numbers to the PMPs for treatment (43% vs. 42%). Twelve percent of the patients were children (Table 3). Males rarely consulted the female doctors. Almost all of the PMPs (96.1%) reported that couples sought FP advice from them.

About 54 percent of the PMPs reported that couples came to them for advice on the use of coral contraceptives (OCs) and about one-third sought their advice in choosing an FP method. Forty-six percent of the PMPs reported that couples come for consultation on OC use. Fifteen percent of the PMPs reported that contraceptive users came to them for treatment of side effects. Fourteen percent

of the PMPs said that couples came to them to find out about IUD/injectable contraceptives and sterilization (Table 4).

Table 4 Distribution of PMPs by type of FP services usually sought by the clients

Category	Percentage
Consultation on suitable FP method	54.3
Consultation on OCs use	45.6
Treatment of contraceptive side effects	14.5
Consultation on birth spacing	4.9
Consultation on contraceptive use during breastfeeding	1.9
Consultation on safe period method	1.9
Menstrual regulation	1.9
Consultation on contraceptive failure	1.0
(N)	(99)
Note: Total exceeds due to rounding	

SECTION FOUR

ASSESSMENT OF PROGRAM EFFECTIVENESS

To assess the effectiveness of the program, three activities were carried out:

- A comparison of pre- and post-training knowledge and attitudes among the PMPs toward selected FP issues and RTI/STD
- Comparison of PMPs behavior toward FP clients as obtained through mystery client interviews done both before and after the orientation
- Interviewing the FP clients served by the PMPs to find out the quality of services provided by PMPs

4.1. Knowledge and Attitude Assessment

The knowledge and attitude surveys were conducted in the form of a self administered questionnaire, which was filled out by the PMPs during the orientation. The baseline survey was conducted during the first orientation session. The final follow-up survey was conducted at the end of the second follow-up workshop. To allow comparison, the same questionnaire was used both in the baseline and the follow-up. A brief questionnaire for the surveys was developed which contained multiple choice questions (MCQ) and True/False items.

Of the 110 PMPs attending the first orientation, the baseline questionnaires were completed by 103 PMPs. The final follow-up workshop was attended by 79 PMPs. Only seventy two PMPs attended all the three orientations. Thus, the comparison analysis included only 72 PMPs.

4.1.1. Quality of Care: Prior to the orientation, 55 percent of the PMPs reported that informed consent meant to provide clients detailed information about all of the available FP methods. This figure had risen to 88 percent after the third orientation (Table 5).

The knowledge level of PMPs on different aspects of counseling increased dramatically as a result of the orientation. For example, prior to the orientation, half (51%) of the PMPs reported that to inform clients about the side effects of the contraceptives was an element of counseling. This figure had risen to 78 percent at the end of the orientation (Table 6). Before the orientation, 70 percent of the PMPs said that they have to inform the client details about contraceptive that rose to 86 percent after the orientation.

4.1.2. Knowledge and Attitudes of PMPs with Regard to Individual Contraceptive Methods: Prior to the orientation only 36 percent of the PMPs could mention that low-dose oral pills contained less than 50 micrograms of estrogen hormone and high-dose oral pills contained more than 50 micrograms. After the orientation, over two-thirds (76%) of the PMPs were able to give correct answers (Table 7).

Table 5 Percent distribution of PMPs by their knowledge on the meaning of "Informed Choice"

Category	Percentage	
	Before orientation	After third orientation
Inform clients in details about all the available FP methods	54.8	87.5
Inform clients about the client's selected method	23.7	9.7
Inform clients about the side effects of the methods	12.3	2.8
Not stated	9.2	0.0
Total	100.0	100.0
(N)	(72)	(72)

Table 6 Distribution of PMPs by their knowledge on the different aspects of FP counseling

Issues to be discussed during counseling	Percentage	
	Before orientation	After third orientation
Details about contraceptive use	69.9	86.1
Potential side effects of each contraceptives	50.7	77.8
Contraindications of each contraceptives	46.6	62.5
Availability of contraceptives	28.8	52.8
Management of side effects	27.4	48.6
Advantage of each contraceptives	41.1	25.0
(N)	(72)	(72)

Note: Total exceeds due to rounding

Table 7 Distribution of PMPs by their knowledge of the differences between high- and low-dose oral contraceptives

Differences between high- and low-dose oral pills	Percentage	
	Before orientation	After third orientation
Low-dose pills contain less than 50 micro-gram of estrogen hormone and high-dose more than 50 micrograms.	35.6	76.4
High-dose pills contain higher quantity of estrogen hormone than low-dose pills.	21.9	18.1
High-dose pills contain lower quantity of estrogen hormone than low-dose pills.	21.9	2.8
Low-dose pills contain less than 75 micro-gram of estrogen hormone and high-dose more than 75 in micrograms.	4.1	0.0
Not stated	16.5	2.7
Total (N)	100.0 (72)	100.0 (72)

The knowledge of the PMPs on when to start OCPs (first day of menstruation) had increased significantly at the end of the orientation (Table 8). Knowledge among the PMPs about the contraindications of OCPs had increased sharply by the end of the orientation. For example, prior to the orientation, one-third (34%) of the PMPs knew that liver disease was a contraindication of OCPs, while after the orientation this number rose to two-thirds (64%). Moreover, three-quarters (76.2%) of the PMPs listed erroneous contraindications of OCPs use prior to the orientation. This figure had declined to 46 percent at the end of the orientation (Table 8).

The knowledge of PMPs about specific side effects of OC such as nausea and menstrual problems had increased significantly by the end of the orientation (Table 8).

Prior to the orientation, over one-third (33.3%) of the PMPs did not know what to advise to a client if she missed one pill. After the orientation, this figure dropped to 1.4 percent (Table 9).

Prior to the orientation, none of the PMPs knew what to do if the client missed her pill for two consecutive days. After the orientation, a large proportion (79%) of PMPs were able to give an appropriate response (Table 9).

Table 8 Distribution of PMPs by their knowledge on when to start taking oral contraceptive, major contra indications and major side effects of oral contraceptives pills

Category	Percentage	
	Before orientation	After third orientation
When to start OC pill		
On the first day of menstruation	4.1	95.8
After the menstruation	9.6	2.8
With in seven days of menstruation	83.5	0.0
Others	2.8	1.4
Total (N)	100.0 (72)	100.0 (72)
Major contra-indications of OCs		
<i>Multiple responses</i>		
Correct answers:		
Liver disease	34.2	63.9
Hypertension	70.0	51.5
Diabetes	32.9	47.2
Pregnancy	28.8	38.9
Heart disease	19.1	33.3
Migraine	8.2	25.0
embolism and thrombophlebitis	13.7	22.2
Cancer	44.1	19.5
History of thrombo-Jaundice	5.5	5.6
Any growth in the breast	11.0	2.8
Other	13.8	11.2
Incorrect answers:		
Not stated (N)	24.7 (72)	8.3 (72)
Major side effects of OC		
<i>Multiple responses</i>		
Nausea	64.3	100.0
Menstrual problems	35.6	60.8
Dizziness	39.7	45.9
Headache	41.1	33.3
Weight gain (N)	32.8 (72)	19.5 (72)

Table 9 Distribution of PMPs by their knowledge about what to do if one and two contraceptive pills are missed

What to do	Percentage	
	Before orientation	After third orientation
Missed one pill		
Take two pills the following day	49.3	94.4
Take the missed pill as soon as it is remembered	12.0	1.4
Take one pill the next morning and one pill the next night	2.7	1.4
Other	2.7	1.4
Don't know	33.3	1.4
Total	100.0	100.0
(N)	(72)	(72)
Missed two pills		
Take two pills together on the third and fourth days; use condom and continue pill as usual	0.0	79.1
Continue taking the pills and use a condom during the cycle	21.9	8.3
Discontinue the pill	43.8	1.4
Others	5.6	9.8
Not stated	28.7	1.4
Total	100.0	100.0
(N)	(72)	(72)

Table 10 Distribution of PMPs by their knowledge on the correct dose of Depo-provera (DMPA) and Noristerat (NET EN)

Dose	Percentage	
	Before orientation	After third orientation
Depo-provera		
Once every 3 months	57.5	87.4
Once every 2 months	5.5	5.6
2-month intervals for the first four doses; then 3-month intervals	9.6	4.2
Don't know	27.4	2.8
Total	100.0	100.0
(N)	(72)	(72)
Noristerat		
Once every 2 months	5.5	81.9
Once every 3 months	12.3	5.6
Once every 4 months	1.4	2.8
2-month intervals for the first four doses; then 3-month intervals	8.2	8.3
Don't know	72.6	1.4
Total	100.0	100.0
(N)	(72)	(72)

Prior to the orientation, 42 percent of the PMPs did not know how frequently Depo-provera injection should be taken. This figure, however, had decreased to 13 percent by the end of the orientation (Table 10).

Prior to the orientation, most of the PMPs (94%) did not know that Noristerat (Neten) injection should be taken every two months. This figure had decreased dramatically (18%) by the end of the orientation (Table 10).

Table 11 Distribution of PMPs by their knowledge on the most common problems arise due to injectable contraceptives and how to manage slight bleeding for an injectable contraceptive

Category	Percentage	
	Before orientation	After third orientation
Most common problems mentioned		
Amenorrhea	47.9	81.9
Inter-menstrual bleeding/spotting	50.7	79.2
Scanty bleeding during menses	45.2	56.9
Excessive bleeding during menses	27.4	52.8
Dizziness	43.8	12.5
Nausea	28.8	11.1
(N)	(72)	(72)
What to do for slight bleeding		
Counsel that this will be all right within a few days	70.0	97.2
Referred to a specialist immediately	9.6	0.0
Advise to try another method	8.2	0.0
Prescribe some medicine	0.0	1.4
Don't know	12.2	1.4
Total	100.0	100.0
(N)	(72)	(72)

Note: Total exceeds due to rounding

Table 11 shows that knowledge about side effects for the injectable contraceptive increased significantly as a result of orientation. For example, before the orientation, only about half (48%) of the PMPs reported that amenorrhea was a major side effect of the injectable contraceptive. This figure increased to 82 percent as a result of the orientation.

Prior to the orientation, PMPs were asked what they would advise an injectable client who was experiencing slight bleeding, nearly 70 percent reported that they would tell the client that the problem would disappear after a few days. This figure had increased to 97 percent by the end of the orientation (Table 11).

Before the orientation, only three percent of the PMPs knew that Copper-T 380A is effective for 8 years, while after the third orientation, most of the PMPs (93%) reported the correct duration of Copper-T 380A use (Table 12).

Before the orientation, only 14 percent of the PMPs knew that Copper-T 200B could effectively remain in situ for three years. After the orientation 86 percent of the PMPs were aware of this fact (Table 12).

Table 12 shows that the proportion of PMPs who were aware of the most common problems of IUD had increased significantly by the end of the orientation. For example, 45 percent of the PMPs mentioned that uterine cramps were one of the most common side effects of IUD. This figure increased to 89 percent after the orientation.

4.1.3. Knowledge of PMPs on Reproductive Tract Infection (RTI): It appeared that the knowledge among the PMPs about selected aspects of RTI was quite high before the orientation. In most cases, however, this knowledge still increased further as a result of the orientation (Table 13).

4.2. Mystery Client Interviews (MCIs)

4.2.1. Mystery Client Technique: Mystery client interview is a qualitative research technique to assess the actual behavior of service providers toward their clients. In assessing the behavior of the PMPs toward the FP clients, trained female field investigators (FIs) visited the PMPs' chambers posing as FP clients. Each presented a particular situation and asked the physician to write a prescription for her, giving the impression that she was ready to pay the fees. The FIs were thoroughly trained to respond to any related question which could be asked by the PMPs. The FIs were between the ages of 26 and 37 years. The minimum requirement of the FIs were bachelor's degree and several years of experience in field interviewing. Most of them were married. At the end of each mystery client interview, the FI immediately wrote down what she remembered about the discussion she had with the PMP. She also noted the overall physical condition of the chamber and any other observation related to the study. The entire effort was reviewed by senior professionals. Issues initially omitted were identified through discussion with the FIs, and were subsequently incorporated in the write-up.

4.2.2. The scenarios Used for MCI: Ten scenarios were developed on OCP, injectable and IUD for prospective users and clients facing complications in using FP methods. Two additional scenarios

Table 12 Distribution of PMPs by their knowledge on the most common side effects of IUD and duration of Copper-T 380A and Copper-T 200B use

Category	Percentage	
	Before orientation	After third orientation
Most common side effects		
Uterine cramps	45.2	88.9
Spotting	41.0	87.5
Heavy bleeding	45.5	59.7
Backache	56.2	31.9
Uterine perforation	49.3	16.7
PID	27.4	8.3
Infertility	8.2	1.4
Not stated	7.0	0.0
(N)	(72)	(72)
Duration of Copper-T 380A		
Less than 8 years	50.5	4.2
8 years	2.7	93.0
10 years	2.7	2.8
Don't know	44.1	0.0
Total	100.0	100.0
(N)	(72)	(72)
Duration of Copper-T 200B		
Less than 3 years	6.9	6.9
3 years	13.7	86.1
Over 3 years	26.3	2.8
Don't know	53.1	4.2
Total	100.0	100.0
(N)	(72)	(72)

Note: Total exceeds due to rounding

Table 13 Distribution of PMPs by their knowledge on different aspects of RTI

Knowledge of RTI	Category	Percentage	
		Before Orientation	After third Orientation
IUD insertion increases chance of RTI	True	71.2	59.7
Contraceptive pill users are prone to RTI	False	84.9	88.9
Norplant offers protection from chlamydial infection	False	72.6	79.2
Cervicitis can result from unhygienic insertion of IUD	True	90.4	94.4
(N)		(72)	(72)

Note: In first category total exceeds due to rounding

were developed without preference to a particular FP method. These scenarios were pre-tested as actual cases with PMPs outside the project area. The cases were:

1. **Scenario 1: Prospective OCP user (newly married):**
Statement: "Doctor, I am newly married. At this stage of our marriage, my husband and I do not want any children. I want to use pills. I seek your advice in this regard."
2. **Scenario 2: Prospective OCP user (having two children):**
Statement: "Doctor, I want to use the OCP, because I don't want to conceive within a year. I seek your advice in this regard."
3. **Scenario 1: Prospective injectable user (having one breastfeeding child):**
Statement: "Doctor, I want to take the injection because I don't want to conceive within a year. I seek your advice in this regard."
4. **Scenario 2: Prospective injectable user (having one non-breastfeeding child):**
Statement: "Doctor, I want the injection, because I don't want to conceive within a year. I seek your advice in this regard."
5. **Scenario 1: Side effect of OCP (spotting):**
Statement: "Doctor, I have been taking the pill for the last month, but am having getting problems. I started spotting within a few days after starting the pill. Please advise me on how to eliminate this problem."
6. **Scenario 2: Side effect of OCP (dizziness):**
Statement: "Doctor, I have been taking the pill for the past month. Since I began, I have suffered from continuous dizziness. Please give me some suggestions on how to get rid of this problem."
7. **Scenario 1: Side effect of injectable (excessive bleeding):**
Statement: "Doctor, I took the injection, but I am now having a problem. I am suffering from excessive bleeding. Please give some suggestions on how to get rid of this problem."
8. **Scenario 2: Side effect of injectable (amenorrhea):**
Statement: "Doctor, I took the injection, but I have a problem now. My menstruation has stopped. I am really concerned about this. Please help me."
9. **Scenario 1: Side effect of IUD (excessive bleeding):**
Statement: "Doctor, I had an IUD inserted. But now I have excessive bleeding during my menstruation. Please help me."
10. **Scenario 2: Side effect of IUD (lower abdominal pain):**
Statement: "Doctor, I had an IUD inserted. But for the past two days, I have been suffering from lower abdominal pain. Please help me."

4.2.3. Number of MCI: Before the orientation, a total of 64 mystery client interviews were conducted with the PMP using the 10 scenarios described above. During the last month of the project period, a total of 40 mystery client interviews were conducted with the same PMPs using the same scenarios. The number of interviews conducted for each scenario is presented in Table 14.

Four female FIs conducted the interviews. The whole team was guided by the senior researchers of PIACT. The FIs were thoroughly trained and after each day's interviews related issues were discussed with them.

4.2.4. Findings from the Interviews: Each of the mystery client interviews was unique in nature. Therefore, summarizing the findings would result in a degree of sacrifice in terms of the quality of the information. At the same time, it was necessary to examine the behavior of the PMPs in a given situation. The findings of the interviews have therefore been summarized in groups, separately, for the 10 scenarios.

Table 14 Distribution of the number of mystery client interviews before and after the orientation

Case	Number of PMPs	
	Before orientation	After
<i>Scenario 1</i>		
Prospective pill user (newly married)	7	4
<i>Scenario 2</i>		
Prospective pill user (having two children)	8	4
<i>Scenario 1</i>		
Prospective injectable user (having one breastfeeding child)	7	4
<i>Scenario 2</i>		
Prospective injectable user (having one non-breastfeeding child)	8	4
<i>Scenario 1</i>		
Side effect of oral pill (spotting)	6	4
<i>Scenario 2</i>		
Side effect of oral pill (dizziness)	5	4
<i>Scenario 1</i>		
Side effect of injectable (excessive bleeding)	5	4
<i>Scenario 2</i>		
Side effect of injectable(amenorrhea)	5	4
<i>Scenario 1</i>		
Side effect of IUD(excessive bleeding)	7	4
<i>Scenario 2</i>		
Side effect of IUD 2 (lower abdominal pain)	6	4
Total	64	40

Table 16 Use instructions of oral contraceptives mentioned by the PMPs

Use-instruction	Before orientation	After third orientation
When to start:		
First day of menstruation	3	7
Fifth day of menstruation	2	1
How to take:		
Every night/every day	2	4
Missed one pill:		
To take the missed pill, the next following day, as soon as it is remembered	2	3
To take two pills next night	2	2
Missed two pills:		
To stop taking pill until next menstruation	1	-
Missed three pills:		
To take 2 pills for three days continuously and husband will use condom then or abstain from intercourse	-	1
Suggested to see instructions on the pill packet	4	2
(N)	(15)	(8)

Note: Total exceeds due to rounding

4.2.4.1. Prospective pill users

Contraindication: The question PMPs asked the mystery clients most frequently had to do with the date of the last menstruation. This was done to assess the probability of pregnancy. Those clients who had children were asked whether they were breastfeeding child. This indicated that the PMPs knew that breastfeeding mothers should not take OC. These queries were made both before and after the orientation. Enquiry about other contraindications of OC, such as high blood

pressure, nausea and hyperacidity or gastric problems, were made by PMPs only after the orientation. This suggests that after the orientation, the PMPs knew more about the contraindications of OC and they tended to enquire more about the contraindications (Table

Table 15 PMP enquiry about the contraindications of oral contraceptives

Enquiries	Before orientation	After third orientation
Date of last menstrual cycle	9	8
Suffering from headache	1	2
Breast feeding	5	4
Diabetic	1	1
Suffering from high blood pressure	-	2
Suffering from dizziness	-	2
Suffering from hyperacidity/peptic ulcer	-	2
Suffering from lower abdominal pain	-	1
Suffering from nausea	-	1
Suffering from white discharge	-	1
(N)	(15)	(8)

Note: Total exceeds due to rounding

15).

Use instructions: Use instructions of OCP given by PMPs improved significantly after the orientation in terms of completeness and quality of information. For example, after the orientation, most of the PMPs mentioned that the first pill should be taken on the first day of menstruation which was not the case before the orientation. It was also observed that after the orientation, three PMPs provided instructions about what to do if a single pill was missed (Table 16).

Information about side effects: Prior to the orientation, the PMPs mentioned several OC side effects to the clients. In this regard, the PMPs had some misconceptions. For example, prior to the orientation, two of the PMPs mentioned that use of OC might cause[†] infertility. After the orientation, none provided any erroneous

information about OC side effect. After the orientation, however, the PMPs tended not to mention as many actual side effects of OC. This might indicate that after the orientation, the PMPs preferred not to mention the remote side effects and risk discouraging the clients from using OC (Table 17).

Pill brand prescribed: Recently, most of the pills available in the market are low-dose pill. Thus, the PMPs tended to prescribe low-dose pills both before and after the orientation. After the orientation, however, the PMPs prescribed largely the most recently introduced low-dose pills in the market. For example, Femicon, a low-dose pill introduced in the market by SMC, was prescribed by three out of the eight PMPs. This pill was not in the market before the orientations. Moreover, they did not know prior to the orientation, about Shukhi (a low-dose pill) recently introduced in the FP program. Ovostat, a standard-dose pill was mentioned by several PMPs both before and after the orientation. In fact, this brand of pill was found to be very familiar among the clients (Table 18).

4.2.4.2. Advice given for the side effects of oral contraceptives

Before the orientation, the PMPs gave a variety of suggestions to the clients, including taking nutritious food. In most cases, they advised the client to continue the pill or the pill brand without any fear. On the other hand, after the orientation though the clients were asked not to be afraid of the side effects, more than one-third (3 out of 8) of the clients reporting side effects of OC (Nordette-28) were advised to change the brand and one was asked to discontinue pill and use condom. This reflects an increase in the level of knowledge and confidence among the PMPs allowing them to suggest an alternate brand of OC or

19).

4.2.4.3. Misconceptions about oral contraceptives

Certain misconceptions about OC were found to be quite prevalent among the PMPs before the orientation. The PMPs informed the mystery clients about these when they sought advice for use of OCPs or when they sought advice for side effects of OC. A few of these misconceptions are listed below:

- It is better to substitute the pill from time to time with the condom
- After using the pill continuously for more than two years, husband should adopt another method
- The pill should not be taken by a breastfeeding mother until the child is one year old
- The pill can cause infertility
- After taking the pill continuously for six months, other method, such as the condom, should be used for two months. Because the pill contains hormones, its prolonged use on a continuous basis may cause problems

No such misconceptions about OCPs were found to prevail, however, after the orientation.

Table 17 Information about oral contraceptives side effects provided by the PMPs

Side effects	Before orientation	After third orientation
Dizziness	7	3
Spotting	1	-
Vomiting tendency	2	1
Excessive bleeding	1	-
Tastelessness	1	-
May develop jaundice	2	-
Breast milk gets reduced	2	3
Weight gain	1	-
High blood pressure	1	-
May develop infertility	2	-
Uterine ulcer	1	-
Did not mention	4	4
(N)	(15)	(8)

Note: Total exceeds due to rounding

Table 18 Pill brands prescribed by the PMPs

Oral Contraceptives Prescribed	Before orientation	After third orientation
Marvelon	4	-
Nordette-28	3	3
Norquest	1	-
Lyndiol	1	-
Ovostat	3	2
Ovacon	1	1
Femicon	-	3
Shukhi	-	1
None	1	-
(N)	(15)	(8)

Note: In one case, prior to the orientation, Carex condom was prescribed instead of pill. Total exceeds due to rounding

Table 19 Advice given to the mystery clients who went to the PMPs with side effects from oral contraceptive use

Advice/suggestions	Side effects			
	Spotting		Dizziness	
	Before orientation	After orientation	Before orientation	After orientation
Get an ultrasonogram	1	-	-	-
Take nutritious food	1	1	-	-
Remain tension free	1	3	-	1
Take pill regularly without any fear; and it will adjust over time	3	1	4	2
Stop taking the pill, consult with a doctor every three months; husband should use a condom	1	-	-	-
In case of no relief, return for a follow-up visit	2	2	1	2
Take more food	1	1	3	-
Take pill regularly and report after one week	1	-	-	-
Continue pill use unless advised otherwise by a doctor	1	-	-	-
Drink more water and take vegetables	1	1	1	-
Return for a follow-up visit	1	2	-	-
Return, so that PMP can refer for IUD insertion	1	-	-	-
Change the pill brand	1	2	1	1
Discontinue the pill until the problem subsides; use a condom in the interim period	-	1	-	-
Discontinue OC and instruct the husband to use a condom; for more safety to use double condom	-	-	1	-
Take injectable instead of taking OCP	-	-	-	1
(N)	(6)	(4)	(5)	(4)

4.2.4.4. Prospective injectable users

Methods suggested to the clients who asked for injectable: Before the orientation, the mystery clients went to 15 PMPs and expressed interest in receiving the injectable contraceptive. Among the 15 PMPs, only one PMP supported or prescribed this method. The remaining 14 PMPs discouraged the clients from taking injectable contraceptives and recommended the use of other method(s). OC was the most frequently recommended method followed by IUD (Table 20).

After the orientation, all eight of the PMPs approached for injectable contraceptives prescribed and referred for the method to FP clinics mostly to MFSTC. Five of them however, cautioned the clients against taking the method and suggested other methods such as IUD, pill and condom (Table 20).

Prior to the orientation, the PMPs did not support injectable contraceptive because of its side effects. Many of them, however, did not say exactly what they were. Some explained that they did not know much about the method but they had heard that it had a lot of side effects.

In fact, the PMPs straightway discouraged the clients against using injectable contraceptives and advised them to take other methods. The one PMP who did prescribe the injectable did not offer any information about the method. He simply said that he had heard that the injectable was a good method.

Table 20 Method suggested to the clients who asked for injectable contraceptives

Method suggested	Before orientation	After orientation
Injectable	1	8
Oral pill	12	2
IUD	7	3
Condom	3	2
Safe period	1	-
(N)	(15)	(8)

Note: Total exceeds due to rounding

After the orientation, although the majority of the PMPs preferred other methods over the injectable, they still provided information about the method. They mentioned different side effects of injectable contraception and in many cases asked the clients to rethink their decision about taking the injectable. All of them however, referred the clients to FP clinics to receive the method.

Specific comments made by the PMPs on the injectable contraceptive to dissuade the client from using it are given in the table below:

Before orientation

I do not consider Injectable contraceptive as a good method.

I do not support taking of injectable contraceptive.

Don't take injectable contraceptive. It has a lot of side effects. You have only one child, so you should not use injectable contraceptive.

These days many women use injectable contraceptive without knowing about it. Injectable contraceptive is injurious to health.

I recommended that you should not take Injectable contraceptive. You will face a lot of problems such as excessive bleeding during menstruation.

Injectable contraceptive has 22 kinds of side effects. I would not recommended that you take it.

I suggest that you don't take Injectable contraceptive, it has three kinds of side effects: scanty bleeding during menstruation, amenorrhea and spotting.

Injectable contraceptive has a lot of side effects. If you use injectable contraceptive for one year, you cannot conceive during the following year.

After third orientation

The benefit of injectable contraceptive is that it only needs to be taken every three months. But it has different side effects. For example, it can cause amenorrhea.

Injectable contraceptive is taken every three months. If you take injection, you may not have menstruation for 2-3 months and it also reduces breast milk.

Injectable contraceptive may cause many problems such as reduction in breast milk, excessive bleeding, weight gain, dizziness and increase in blood pressure.

In fact, injectable contraceptive is not a good method. It can cause several health problems. You may get amenorrhea, gain excessive weight and your breast milk could be reduced.

Please think for 1-2 days before you decide to take Injectable contraceptive.

Injectable contraceptive causes irregularity of menses, pelvic pain and nausea. But its advantage is that it only needs to be taken at 3-months intervals.

Injectable contraceptive primarily does not suit the body. It causes nausea, itching and irregular menstruation.

You should not take Injectable contraceptive at this age (23 years). It has a lot of side effects. For example, it causes amenorrhea, irregular menstruation or excessive bleeding. Sometimes it causes dizziness, nausea and itching. Its only advantage is that it is taken at an interval of 3 months. This does save you the trouble of taking a pill every day.

Injectable contraceptive causes irregularity in menstruation, nausea and excessive weight gain. However, if it adjusts with your body, its a bad method.

4.2.4.5. Advice given for the side effects of injectable contraceptives

Before the orientation, a total of ten mystery client interviews were conducted with the PMPs: five with the complaint of excessive bleeding and five with amenorrhea. All of the PMPs gave medication to the clients for their problems. Two PMPs advised the clients to discontinue the injectable contraceptive and to use OC. Two of the PMPs advised the clients to visit an FP clinic or a gynecologist for their problem and one PMP suggested a pregnancy test. The remaining five PMPs asked the clients to use the medication and assured them that the problems would go away. Some of them asked the clients to revisit them if the problems persisted.

After the orientation, eight PMPs were visited with side effects of injectable contraceptive (4 with excessive bleeding and 4 with amenorrhea). All of the PMPs prescribed medicine, but five of them discouraged the clients from continuing the method. Their concern was that injectable contraceptive had a lot of side effects. They preferred IUD or OCP. The remaining three clients were told that the problems were not serious and were assured that the problems would go away over time. These clients were advised to continue the method.

The specific comments made by the PMPs and the advice given to the clients by the PMPs about injectable contraceptives before and after the orientation are presented below:

Before orientation

Excessive bleeding

Injection is not supposed to cause this problem. If the problem continues during your next menstruation, I will look into it.

Take bed rest. Take ORS and the prescribed medicine.

In fact, I do not recommend the use of injectable contraceptive. You better discuss the use of the pill with your husband.

It would be better if you visit an FP clinic (mentioned MFSTC) and take their advice.

Use of injectable contraceptive causes this problem. I suggest that you to consult a gynecologist.

Amenorrhoea

Since you do not have any other health problems, you can continue with the method.

The problem will disappear if you take the Ovostat pill for three months.

I recommend that you drop the injectable contraceptive and use the pill. These days, many women use the injectable contraceptive, but it has a lot of side effects.

You should have a pregnancy test.

Don't worry. Take the prescribed medicine. You will be cured.

After third orientation

Excessive bleeding

I do not support the use of the injectable contraceptive. You should use pill or condom. The injectable contraceptive has a lot of problems. It causes amenorrhoea/ spotting/dizziness. You could also use IUD.

Many women cannot adjust with the use of the injectable contraceptive. You could use pill or IUD.

Sometimes this happens with the injectable contraceptive. It will gradually disappear.

Injectable contraceptives either cause amenorrhoea or spotting. I think you were given a date expired injection. It would be better if you dropped the injectable contraceptive.

Amenorrhoea

Sometimes injectable contraceptive causes amenorrhoea. You should continue the method, anyway.

Injectable contraceptives sometimes cause amenorrhoea or spotting. You need not be worried about it. Since this is your only problem, you should continue the method.

Injectable contraceptives may cause irregularity in menstruation or amenorrhoea. They also cause itching and dizziness. The advantage of the method is that it does not need to be taken every day. However, after the current dose is expired, you can take IUD.

Injectable contraceptive can cause menstrual irregularity. It even causes amenorrhoea. The advantage with the method is that it does not have to be taken every day. I suggest that you take IUD next month.

Overall, it seems that before the orientation, PMPs were less exposed to injectable contraceptive methods and their side effect management. After the third orientation, they knew more about the method and its side effects, and considered that the relative risk of using injectable contraceptives in terms of its side effects was higher than that of IUD or the oral pill. Thus, they advised the clients to discontinue the injectable method and adopt IUD or OCP.

4.2.4.6. Advice given for the side effects of IUD

The attitude of PMPs toward IUD was found to be positive both before and after the orientation. After the third orientation, the PMPs provided more information to the clients about IUD in terms of its duration, side effects, effectiveness and convenience, and specifically advised the clients not to remove it.

Both before and after the orientation, most of the PMPs consoled the clients that the problems they were suffering were only temporary and would go away over time. In case where the problems continued, the clients were asked to visit the FP clinic (particularly the clinics at which the IUD is inserted). In only a few cases, the PMPs advised the clients to remove the IUD. Overall, the quality of counseling about IUD use had improved after the orientation.

The specific suggestions given by the PMPs to the clients are given below:

Before the orientation

Excessive bleeding

This is not a serious problem. It may continue for 5 months only.

Initially, Copper-T may cause bleeding. You need not worry. Watch for three months. If it does not stop, you may visit the clinic from where you had the IUD inserted.

Copper-T may cause such problems in the initial few months. But it will disappear after five months. If the bleeding continues beyond five months you should visit an FP clinic.

There is nothing to worry about. It will be all right. This problem may continue for 4 months and will go away later. IUD is a good method.

Take the medicine. If it does not cure you, the IUD should be removed. IUD does not suit every woman.

It is not a serious problem. It is common with an IUD and gradually it will be all right. However, you are young and a mother of only one child. You should not have taken the IUD.

This bleeding may continue for the first five months. You need not be worried about it. Take the medicine and if the problems continue, you can visit an FP clinic.

After the orientation

Excessive bleeding

Some women initially suffer from such a problem. If the problem persists for more than 2-3 days, visit the place where you received the IUD and have it removed.

IUD is a good method. If bleeding does not go away within 2-3 days, you should visit an FP clinic (mentioned Marie Stopes Clinic).

IUD is a good and safe method. It takes sometime, however, for some women to adjust with it. If the problem persists during your next menstruation, visit me and I will refer you to a hospital. You should not remove the IUD.

IUD is a good method. It sometimes causes such problems initially. It will be all right. You should not remove the IUD.

Before Orientation

Pelvic pain

You should visit an FP clinic.

If the problem does not go away after taking the medicine, visit the clinic where you got it.

You are too young (22 years) to wear an IUD. You should take oral pill instead.

Take the medicine regularly and use a hot bag on the lower abdomen.

This is common with an IUD. You don't need to be worried about it. If the pain continues, visit the place where you took the IUD.

Take the medicine. I hope this will remedy your problem. If the pain does not go away, visit the place where you took the IUD.

After Orientation

Pelvic pain

IUD commonly causes such problems initially. It may also cause excessive bleeding. These symptoms go away after 4 months of use. You are wearing a foreign body. Initially, you may feel some discomfort.

Initially, this is common it may happen with an IUD. It may also cause excessive bleeding. Don't be worried. It will be all right. If possible, visit the clinic where you took the IUD.

Initially, an IUD may cause some problems. These, however, gradually go away. You can have a checkup from the clinic where you received the IUD, because sometimes an IUD can get displaced and cause such a problem.

IUD can initially cause such a problem. It may also cause bleeding. Don't worry. If you feel very uncomfortable, you can have a checkup at the clinic where you received the IUD. IUD is a good method.

4.3. Treatments of the Side Effects of Contraceptives

All of the PMPs prescribed medicine before and after the orientation for the treatment of the side effects reported by the mystery clients. Treating contraceptive side effects was one of the important components of the orientation. The medications prescribed by the PMPs before and after the orientation have been analyzed and presented here (Table 21).

Overall, there was significant improvement in the quality of prescribing medicine for treatment of contraceptive side effects. Some specific examples are provided below.

- **Treatment of spotting in low-dose OC users:** After the orientation, the PMPs started to prescribe standard-dose pills (Ovostat, Maya a higher dose of estrogen) to prevent spotting in case of low-dose OC users. No such evidence in treating spotting cases existed before the orientation. This was particularly a positive outcome.
- **Treatment of dizziness in OC users:** Dizziness is suspected to be mostly psychological in nature among OCP users. After the orientation, the PMPs began to prescribe tranquilizers and anxiolytic drugs and advise the clients to continue the pill. This is a clear successes of the orientation. But in the post-orientation period, however, one PMP advised the client to drop OC and take the injectable contraceptive. This was not an appropriate way to treat the dizziness problem.
- **Treatment of excessive menstrual bleeding in injectable users:** In the pre-orientation interviews, the PMPs frequently prescribed homeostatic drugs to stop bleeding. They also prescribed a lot of vitamins and iron preparations for their self-predicted nutritional deficiency in the clients. But in the post-orientation interviews, most of the PMPs avoided homeostatic drugs. With their recently acquired FP knowledge they suggested primarily haemotinic preparations or switching to another FP method (OCP).
- **Treatment of amenorrhea in injectable users:** In the pre-orientation interviews, the PMPs suggested various antibiotics and estrogen therapy for regulating menstruation. They also prescribed vitamins for injectable induced amenorrhea. After the orientation, the PMPs were much more precise in their prescriptions. After the orientation, they suggested pregnancy test. This was actually merited in some of the situations. Unlike before the orientations, the PMPs discontinued the use of massive and short-term estrogen therapy for menstrual regulation. The PMPs similarly, began to suggest tranquilizer drugs to prevent depression in cases of amenorrhea.

It was, however, observed that even after the orientation, the PMPs suggested anti-helminthic drugs or low-dose estrogen (primolut-N) without any logical ground.

- ***Treatment of excessive menstrual bleeding in IUD users:*** In the pre-orientation period the PMPs mainly suggested vitamins, iron and homeostatic drugs for excessive menstrual bleeding in IUD users. There was no attempt to evaluate clients condition in details (e.g. pelvic examinations to see cervical disease, ectopic pregnancy, PID etc.). After orientations, the PMPs dealt with the clients more systematically. They explored for any infection, ectopic pregnancy, assured the clients that her changes in menstrual bleeding are normal and will probably lessen over time. Moreover, they prescribed Ibuprofen for this purpose and refer to the center where she had it to re-evaluate, is a clearer success of the orientation.
- ***Treatment of lower abdominal pain in IUD users:*** During the pre-orientation period, the PMPs prescribed a number of antibiotics, non steroidal anti-inflammatory drugs (NSAIDs), etc. for lower abdominal pain in IUD users. After the third orientation, this tendency declined and PMPs proceeded more systematically (ruled out PID, attempted pelvic examination, checked for IUD displacement). In some respects, however, findings are not definitive. This suggests the need for further refresher training/orientation.

Table 21 Medicines prescribed by the PMPs for treatment of side effects for the different contraceptives before and after the orientation

Serial Number	Name of method	Presenting complaints	Suggestion before orientation	Suggestion after orientation	Comments
1.	OC Nordette-28	Spotting	Syrup B Complex Syrup Antacid Tablet Multivit	Tablet Anoroxyll Capsule Iron Tablet Multivit Plus	PMP prescribed homeostatic drug (Anoroxyll) in post-orientation advice. Iron was also given. PMPs became more precise after the orientations.
2.	OC Nordette-28	Spotting	Tablet Anoroxyll Tablet Belcopan Tablet Denxit Syrup Beconex	Capsule Pecap OC. Ovostat	Marked improvement in knowledge of the PMP. To prevent spotting, the PMP changed the low-dose pill (Nordette-28) to a standard-dose pill (Ovostat).
3.	OC Nordette-28	Spotting	Capsule Feofol	Tablet Anoroxyll Tablet Calcium. Lactate Tablet Supravit-M Tablet Folic Acid OC. Maya	Marked improvement in knowledge of the PMP who substituted standard-dose pill for low-dose pill to eliminate the spotting.
4.	OC Nordette-28	Spotting	Capsule Feofol Tablet Multivit Tablet Almex-400 Tablet Primolut-N	Tablet Primolut-N	The PMP discontinued the unnecessary medications like Almex (which is anti-helminthic). Primolut-N was given correctly as before.
5.	OC Nordette-28	Dizziness	Tablet Folfetab OC. Marvelon OC. Norquest	Continue Nordette-28 Tablet Folic Acid Tablet Aristovit- B	Dizziness alone is not sufficient cause to change the brand of contraceptive pill. Before the orientation, PMP did this. After the orientation, PMP advised the clients to continue the same pill and gave some other medications to boost the morale of the clients.
6.	OC Nordette-28	Dizziness	Tablet Stemetil Tablet Feofol	Injection Depo-Provera Tablet Multivit Plus.	Though the switch over to injectable is not preferred,, the PMPs did try to get rid of the problem in a logical way.
7.	OC Nordette-28	Dizziness	Condom (Panther)	Tablet Marvelon Tablet Evalin	Here, the PMP tried similar low-dose pill and gave a psychotropic drug to boost the client psychologically. This which is better than advice given prior to the orientation.
8.	OC Nordette-28	Dizziness	Tablet Vergon Capsule Feofol	Continue previous OC (Nordette)	Balanced suggestion by the PMP after orientation is marked. Increase in confidence of the PMP is observed.
9.	Injectable	Excessive bleeding	Injection Anoroxyll Tablet Anoroxyll	Capsule Ferospan	After the orientation, the PMP learned that excessive bleeding is self limiting/transient for injectable.
10.	Injectable	Excessive bleeding	Tablet Methergin Tablet Aristovit-M ORS	Capsule Feofol Tablet Aristovit-M Capsule Tyclil	After the orientation, the PMPs rejected tablet methergin, which could be harmful in this situation.
11.	Injectable	Excessive bleeding	Capsule Feridex/Feofol Tablet Methospan Tablet Multivit	Tablet Anoroxyll Capsule Fepus	Pre and post advice are more or less similar. Here we see no improvement after orientation.
12.	Injectable	Excessive bleeding	Injection. Calcium with vitamin C Tablet Caltate Tablet Usina	Capsule Fepus Switch over to OC (Nordette 28)	During orientations, the PMPs learned more about the FP methods. This is reflected in their initiatives to switch over to other methods. Although the switch over are not always completely logical.

13.	Injectable	Amenorrhea	Capsule Cephalaxin Tablet Ibuprofen	Tablet Clozam	For injectable induced amenorrhea ,there is no logical reason to prescribe antibiotic. Before the orientation, the PMPs prescribed antibiotics. After the orientation, they suggested tranquilizer drugs calm the client and advised them to wait for recovery.
14.	Injectable	Amenorrhea	Ovostat	Advice urine for pregnancy test	Suggestion after orientations is more precise.
15.	Injectable	Amenorrhea	Capsule Feridex Tablet Aristovit B	Tablet Alben Tablet Primolut-N Tablet Ritmet/Animate	Use of Primolut-N (hormone) is not justified.
16.	Injectable	Amenorrhea	Tablet Gynocoseed	Capsule Feofol Capsule Supravit-M	After orientations, PMPs avoided hormonal drugs.
17.	IUD	Excessive menstrual bleeding	Capsule Feofol Capsule Beconex Tablet Ceevit	Tablet Anoroxyl Tablet Methergin Tablet Nospa	The PMP tried homeostatic drug as an emergency after the orientations. However, this was not logical.
18.	IUD	Excessive menstrual bleeding	Tablet Multivit Plus	Tablet Primolut-N Tablet Butapen	More precise hormonal medications were suggested after the orientations.
19.	IUD	Excessive menstrual bleeding	Tablet Methergin Tablet Solvit-B	Capsule Amoxycilline Tablet Nospa Tablet Cosium Capsule Feofol etc.	Little improvement is observed in quality of suggestion after the orientations.
20.	IUD	Exclusive menstrual bleeding	Tablet Ferocit	Capsule Feofol Tablet Keolax	Little improvement is observed in quality of suggestion after the orientations.
21.	IUD	Lower abdominal pain	Capsule Amoxycillin Tablet Butapen Tablet Vit-B	Tablet Butapen Tablet Genac	Little improvement is observed after the orientations. However, antibiotic was avoided.
22.	IUD	Lower abdominal pain	Tablet Ficlox Tablet Butapen	Tablet Butapen Tablet Nospa	Little improvement is observed in the suggestion. Antibiotic is avoided.
23.	IUD	Lower abdominal pain	Tablet Ciprocin Tablet Xynofen	Tablet Napa	Little improvement is observed in the prescriptions after the orientations.
24.	IUD	Lower abdominal pain	Tablet Amoxicillin Tablet Nospa Tablet Anaplex Tablet Servidoxyne Tablet Spasmonil Tablet Multivit	Tablet JP Derox Capsule Doxicap	No improvement is observed in the prescriptions after the orientations.

Note: The information was gathered from the prescriptions of the PMPs given to the mystery clients.

4.4. Information from Client Record Sheets and Client Interviews

The trained PMPs were requested to record information about the clients they would advise for FP. The majority of the PMPs (70%) kept records of the clients to whom they provided FP services/advice. Over a period of nine months records of 332 clients were collected from the PMPs (Table 22). From those record sheets, 100 were chosen randomly. These clients were interviewed to collect information on what FP services they had received from the PMPs, how much they paid in fees, and their level of satisfaction with the services of the PMPs. Out of 100 clients, 87 clients were successfully interviewed.

4.4.1. Information from Client Record Sheets: Table 22 shows that a large majority (87%) of the clients were advised to use a specific method of contraception. It may be noted that six percent of the clients were advised to undergo menstrual regulation.

The PMPs advised the clients most frequently (57.3%) to use OC, followed by condom. Nearly 12 percent of the clients were advised to accept IUD (Table 23).

Among those clients who were advised to use OC, nearly a half (46.1%) were not given the name of a specific brand. Among the brands, Shukhi and Nordette-28 were suggested most frequently (Table 23).

Among those who were advised to use condom, over three-quarters (78.3%) were not given a specific brand name. Among the suggested brands, Panther and Carex were found to be most popular (Table 23).

4.4.2. Information from Client Interviews: From among the 332 clients, a total of 87 clients were interviewed in the home. Ninety percent of the clients were female and the clients selected for the interview were all female. Only 13 percent of the PMPs clients were illiterate. Nearly 30 percent of the clients had higher secondary or more education (Table 24).

A large majority (70%) of the clients were housewives. A substantial percentage (17%) were engaged in service (Table 24). Nearly 38 percent of the clients were living in their own house. The average monthly income of the clients' family was Tk. 10,008. Over a quarter of the clients' families had monthly incomes exceeding Tk. 10,000 (Table 24).

Table 22 Distribution of clients by the types of FP services received from the PMPs

Type of services	Percentage
Advised to take a specific method of contraceptive	86.6
Advised for MR	6.0
Counseled for FP	4.2
Advised to continue the FP methods the clients were using	1.8
Advised on the side effects of FP method the clients were suffering from	0.9
Referred to clinic/hospital	2.4
Others	2.4
(N)	(332)

Note: Total exceeds due to rounding

Table 23 Distribution of clients by suggested methods and brand of contraceptives

Category	Percentage
FP methods suggested	
Oral Contraceptive	57.3
Condom	24.0
IUD	11.5
Injection	4.9
Norplant	3.1
Tubectomy	2.8
Vasectomy	1.4
(N)	(288)
Suggested brand of oral pill	
Shukhi	15.2
Nordette-28	15.2
Marvelon	6.7
Ovostat	6.7
Ovacon	4.9
Maya	1.2
Femicon	3.6
Did not suggest any specific brand	46.5
Total	100.0
(N)	(165)
Suggested brand of condom	
Panther	7.3
Carex	5.8
Raja	4.4
Sensation	2.9
Did not suggest any specific brand	76.7
Others	2.9
Total	100.0
(N)	(69)

Note: A Total of 44 PMPs did not suggest a specific methods contraceptive method. In first category total exceeds due to rounding

Table 24 Distribution of clients by their level of education, occupation, ownership of house and monthly income of their families

Category	Percentage
Level of education	
Illiterate	12.8
Less than primary	19.5
6-10 years of schooling	25.3
Secondary School Certificate	11.5
Higher Secondary School Certificate	14.9
Graduates	16.0
Total	100.0
(N)	(87)
Occupation	
Housewife	70.2
Service	17.2
Business	8.0
Others	4.6
Total	100.0
(N)	(87)
Ownership of house	
Rented house	59.8
Own house	37.9
Not stated	2.3
Total	100.0
(N)	(87)
Monthly income (Tk.)	
Less than 3,000	13.8
3,001 - 5,000	14.9
5,001 - 10,000	23.6
More than 10,000	34.5
Can't say	13.2
Total	100.0
(N)	(87)

One-third of the patients reported that they had visited PMPs only for the purpose of seeking advise about FP methods. Most of the remaining clients said that they had mainly visited the PMPs for their own treatment or for the treatment of their children (Table 25).

A large majority of the clients (81.6%) reported that they had discussion with the doctors about FP (Table 25). Over a quarter of the clients reported that they had paid the PMP a fee for consultation on FP methods use only. The remaining 72 percent did not pay a separate fee for FP advice (Table 25). Of those clients who paid the PMPs fees for FP consultation, the majority (60%) paid less than Tk. 50. A few of them (5%) paid more than Tk. 100 (Table 25).

Nearly 90 percent of the clients reported that they were satisfied with the consultation they had with the PMPs on FP (Table 25). According to the clients, the criterion on which they based satisfaction was whether or not felt that the PMPs had given them good advice. About one-third (31.4%) said that the PMPs told them about the benefits of FP which they found very useful (Table 25).

Table 25 Distribution of clients by their primary purpose of visit, amount paid and level of satisfaction and IEC materials seen

Category	Percentage
Main purpose of visit	
For own treatment	45.8
To seek advice on FP methods	33.3
For treatment of children	16.7
Others	4.2
Total	100.0
(N)	(87)
Whether discussed about FP	
Discussed	81.6
Did not discuss	16.1
Not stated	2.3
Total	100.0
(N)	(87)
Whether paid fees	
Paid solely for FP consultancy	28.2
Did not pay an extra charge for FP consultancy	71.8
Total	100.0
(N)	(71)
Amount paid (in Tk.)	
Less than 50	60.0
51 - 100	20.0
101 - 200	5.0
Not stated	15.0
Total	100.0
(N)	(20)
Whether satisfied	
Very satisfied	8.4
Satisfied	77.5
Somewhat satisfied	12.7
Not satisfied	1.4
Total	100.0
(N)	(71)
Reasons for satisfaction	
Doctor was good and gave good advice.	44.3
Doctor told about the benefits of FP which was very useful	31.4
Doctor described the different contraceptive methods and helped in selecting a suitable method	18.6
Selected appropriate method and	15.7
Doctor provided treatment for contraceptive side effects.	7.1
Total	100.0
(N)	(71)
IEC materials seen	
Poster	52.9
Sticker	35.6
Leaflet	16.1
(N)	(87)

The clients were asked whether they had seen any of IEC materials. Over half of the clients (53%) reported that they had seen the poster and over one-third (36%) had seen the sticker (Table 25). The majority of the clients reported that they had seen the poster/sticker/leaflet in the chamber of the PMP. About one-fifth of the clients said that they had seen the poster on a wall in some public place.

About three-quarters of the clients reported that they were using a contraceptive method at the time of the consultancy (Table 26). Among those clients who were currently using contraceptives, the majority (55.4%) were using OCP and over a quarter (27.7%) were using condom (Table 26).

Table 26 Distribution of clients according to whether they were currently using contraceptives and type of contraceptives

Category	Percentage
Status of contraceptive use	
Currently using	74.7
Not currently using	25.3
Total	100.0
(N)	(87)
Type of contraceptive	
Pill	55.4
Condom	27.7
Tubectomy	6.2
IUD	4.6
Norplant	4.6
Others	1.5
Total	100.0
(N)	(65)

SECTION FIVE

DISCUSSIONS, LESSONS LEARNED AND RECOMMENDATIONS

5.1. Discussions

The project "Involvement of Private Medical Practitioners in Family Planning Services in Urban Areas" was undertaken to solicit the interest of the private medical practitioners (PMPs) in, establish a large number of FP information/service centers within a short period of time, attract private investment in the FP sector, improve the overall standard of FP services and ultimately reduce the increasing financial pressure on the government in the FP sector.

Prior to the orientation, the knowledge level of the PMPs on FP methods was limited. Knowledge increased significantly as a result of the orientations. The mystery client interviews indicated that after the orientation, the PMPs provided more choice to the clients with regards to FP methods. They also provided appropriate information about contraceptive side effects and spent more time discussing the contraindications. It was also observed that the quality of prescription offered by the PMPs had improved significantly after the orientation. There is still, however, need for improvement in this regard.

It was observed that the PMPs had a generally negative attitude toward the injectable contraceptive and did not change much as a result of the intervention. Findings suggest that with the increase of knowledge among the PMPs (about the different contraceptive methods), they tended to suggest method switching more frequently. It would be necessary to provide the PMPs with information on the risk and benefits of switching methods frequently.

In fact, to ensure high quality of services from the PMPs it would be appropriate to conduct mystery client interviews at a regular interval (say, every six months) to assess the quality of advice, services and treatment provided, and accordingly provide them with needed information. In addition, a refresher training for the trained PMPs after one-year period would be useful.

During the second and third orientation sessions, the PMPs showed interest in creating facilities in their chambers where they could provide clinical contraceptive services-- particularly injectable contraceptives and sterilization. The female doctors were also interested in providing IUD services. Such facilities should be created to expand the available options in the private sector. If it were implemented, the PMPs would need to undergo practical training on clinical contraception. This would also need equipment and a system of obtaining the clinical contraceptives. Finally, they would need to be linked with the existing GOB and NGO facilities for referral and consultation.

The clients' feedback about the PMP project was quite encouraging. A large majority of the clients were satisfied with the services of PMPs and over a quarter (28%) said that they had paid fees to the PMPs for FP consultation. Of those who paid, the majority paid less than Tk. 50. Nearly three-quarters of the clients were currently using contraceptives.

Trained PMPs were linked with nearby GOB/NGO facilities so that they could refer their clients for clinical contraceptives and complicated side effects. To enhance the referral system, senior physicians were invited to participate in the orientation sessions as resource persons. Through the mystery client interviews it was observed that several PMPs referred the clients to Mohammadpur Fertility Services and Training Center (MFSTC) even prior to the orientation and after the orientation they referred the clients frequently to MFSTC and Marie Stopes Clinic. In fact, these are the two FP clinics in the project areas which provide a wide range of FP and RTI treatment services.

The PMPs are medical graduates. Their course curriculum includes reproductive physiology and FP issues. They lack, however, knowledge about contraindications and management for side effects of specific contraceptives, and are not continually updated about contraceptive issues. Thus, the curriculum for the orientation was designed from these perspectives. Three days allowed adequate time to orient them about these issues. The unique feature of this pilot project was that the three one day orientations sessions were not given at the same time. Instead, they were given on three different occasions with a time interval of around two months. This seemed to contribute to the positive outcome of the orientation. The study found this method to be particularly effective in improving and

retaining the knowledge of the PMPs about FP, RTIs, and STD and ensure their commitment to providing the services.

5.2. Lessons Learned

A number of lessons were learned from the pilot project. These were as follows:

- PMPs were interested in increasing their involvement in FP service delivery. It was learnt that, PMPs participation can be ensured in the program if they are selected properly and approached by the senior program staff.
- It was learnt that a very few clients approached the PMPs especially for FP services before the orientation. After the orientations, many clients directly sought FP services from the PMPs.
- This program also learnt that, involvement of PMPs to rendering FP services is feasible. Since, before the orientation, the PMPs did not initiate discussion about FP methods with the clients. But, after the orientation, they began to do so.
- It was possible to inform the community people through IEC to seek FP services from PMPs.
- It was possible to develop a referral system between the PMPs and the government/NGO service centers.
- PMPs were willing to render clinical contraceptive services from their chambers.
- The program was not successful in changing the negative attitudes of the PMPs with regard to injectable contraceptives.
- It was possible to maintain register of FP clients by the PMPs.
- The design for a three-day orientation, held on three different days with an interval of two months was found to be most effective in improving and retaining the knowledge about FP methods, complication, side effect management and RTI/STD. Three-day orientation held on three different days was encouraged the PMP to provide FP services.

5.3. Recommendations

Based on the orientation, the following recommendations have been made:

- Considering that the PMPs are medical graduates, are interested and have the unique opportunity to be involved in FP service delivery, the PMP project should gradually be expanded to all urban areas of Bangladesh. This would address three of the major challenges faced by the country's FP program: quality of care, privatization and sustainability.
- In order to assure high-quality advice and services from the PMPs and maintain their interest, the PMPs should be regularly updated on contraceptives, particularly with regard to the critical issues of side effect management.
- In view of the interest and facilities available with the PMPs, the selected PMPs should be trained to render clinical contraceptive services-- particularly injectables and IUD insertion. All PMPs should also be trained for syndromic management of RTI/STD.
- The study highly recommended the scheduling of orientation sessions at two month intervals for any subsequent replications.

PART B

**INVOLVING NON-QUALIFIED PRIVATE MEDICAL PRACTITIONERS IN
FAMILY PLANNING SERVICES IN URBAN AREAS**

SECTION ONE

DESCRIPTION OF THE PROJECT

1.1. Background

In the rural areas over 100,000 non-qualified medical practitioners are providing medical care services. As with the PMPs in the urban areas, an experimental study was conducted with 58 rural medical practitioners (RMPs) in Komalgarj Thana of Moulvibazar District. Most of the RMPs practice in the pharmacies of the village markets.

Like PMPs, RMPs were given orientations on contraceptive methods, management of contraceptive side effects, management of RTIs/STDs and referral of FP clients to the health centers.

1.2. Objectives

The overall objective of this operations research project was to explore the feasibility of involving the RMPs in providing selected FP services on a commercial basis (with special emphasis on counseling and side effect management). The specific objectives were to:

- Ascertain the interest among RMPs through their participation in project activities;
- Assess knowledge retention imparted to the RMPs in the training/workshops;
- Assess the extent of FP services (in terms of prescribing FP methods, counseling and side effect management) provided by the RMPs after the orientation.
- Assess the level of satisfaction of the clients receiving FP services from the RMPs;
- Establish a referral system between the RMPs and the existing FP service facilities (e.g. Union Welfare Center and Thana Health Complex).

1.3. Implementation of the Project

The RMPs were given a three-part orientation with an interval of two months between sessions. The training curriculum and materials used in the PMP project (described on pages 5-9) was revised and used in the training for RMPs. The resource persons used were trainers from the clinical services and training project of the Directorate of FP, AVSC International, relevant FP officials from district and thana.

The first orientation session was held over a two-day period and attended by 58 RMPs. It was organized in two batches. The second and third orientations sessions were one day each and were attended by 52 and 50 RMPs respectively. After the first orientation, signboards (containing the name of the RMP and the message that he had received training on FP) was hung in front of the pharmacies/chambers of the trained RMPs. A leaflet containing information of the project activities and the names and addresses of all trained RMPs was distributed to the clients. Field officers placed poster and stickers in the pharmacies and other public places informing public about the project.

The trained RMPs were linked with the nearby health facilities for referral of clinical contraceptives, and also to refer clients presenting with complicated side effects. Referral forms were developed and provided to the RMPs for this purpose. To enhance the referral system, the concerned officials from the health centers were used as resource persons in the training. The RMPs kept records of the clients to whom they provided FP services and whom they referred. Afterwards, a client survey was conducted based on these records.

For comparison purposes, the knowledge of the RMPs on selected aspects of FP and RTI/STDs was assessed before orientations. This was done through the use of a pre-structured questionnaire. The same process was repeated after the third orientation session. Mystery client interviews were conducted, similar to those conducted in the PMP project with a sample of RMPs before and after the orientations. The study findings are presented in the following sections.

SECTION TWO

SELECTED BASIC CHARACTERISTICS OF RMPs

2.1. Age Distribution

The average age of the RMPs was 38.6 years. Eighteen percent of the RMPs were under 30 years old and more than one-third (35%) were 30-39 years old (Table 1).

2.2. Educational level

A large majority (83.3%) of the RMPs had at least passed the Secondary School Certificate examination and a sizable proportion (5%) were graduates (Table 1).

2.3. Practicing Facilities

The majority (58.3%) of the RMPs practiced in a pharmacy in addition to selling medicine. Thirteen percent of the RMPs reported practicing in their chambers at home. Another 15 percent said that they practiced in their chambers in the market place but did not sell medicine (Table 1).

2.4. Practicing Time

The majority (62%) of the RMPs reported that they were engaged in full-time practice. Over a quarter (26.7%) said that they practiced in the afternoon only; and five percent said that they only practiced in the morning (Table 1).

2.5. Patient Flow

The median number of patients served by the RMPs per week was 70. Thirty eight percent of the RMPs reported that, on average, they served 51 to 100 patients per week. About one-fifth (18.4%) of the RMPs reported that they provided services to more than 100 patients per week (Table 1).

2.6. Consultation Fee

Forty two percent of the RMPs said that they did not charge their clients a fee. Their effort, they explained, was compensated by the profit they made from selling medicine. About one-third (32%) of the practitioners said that they had a fee of Tk. 10. Only a few (3.3%) of the RMPs charged Tk. 30 (Table 1).

Table 1 Age distribution, educational level, practicing facilities, timing, patient flow per week and consultation fee of the RMPs

Category	Percentage
Age distribution	
Less than 30	18.3
30-39	35.0
40-49	18.3
More than 49	11.7
Not stated	16.7
Total	100.0
(N)	(58)
Mean age	38.6
Educational level	
Less than S. S. C.	10.0
S. S. C.	65.0
H. S. C.	13.3
B A	5.0
Not stated	6.7
Total	100.0
(N)	(58)
Facility type	
Pharmacy	58.3
Only chamber (in the market)	15.0
Chamber at home	13.3
Practice in tea garden	6.7
Not stated	6.7
Total	100.0
(N)	(58)
Practicing time	
Full-time	61.6
Only in the afternoon	26.7
Only in the morning	5.0
Not stated	6.7
Total	100.0
(N)	(58)
Weekly patient flow	
Less than 20	10.1
20-50	26.6
51-100	38.3
More than 100	18.4
Not stated	6.7
Total	100.0
(N)	(58)
Median	70
Consultation fee	
No fee	41.7
10	31.7
15	8.3
20	8.3
30	3.3
Not stated	6.7
Total	100.0
(N)	(58)
Average	7.6

SECTION THREE

ASSESSMENT OF EFFECTIVENESS OF THE PROJECT

3.1. Knowledge among RMPs About Oral Contraceptive

When to start taking oral contraceptives:

Before the orientation, 59 percent of the RMPs stated that OC should be started from the first day of menstruation. After the third orientation, almost all (98%) gave this response (Table 2).

Table 2 Distribution of RMPs by their knowledge on when to start oral contraceptive

When to start	Percentage	
	Before orientation	After third orientation
On the first day of menstruation	58.6	98.0
Within 7 days of the onset of menstruation	31.2	2.0
Within 8 to 13 days of the onset of menstruation	3.4	0.0
On the second day of menstruation	3.4	0.0
Others	3.4	0.0
Total	100.0	100.0
(N)	(58)	(50)

Major contraindications of oral contraceptives: Table 3 shows that the knowledge of RMPs about various contraindications of OC had increased by the end of the third orientation. Before the orientations, about 38 percent of the RMPs said that high blood pressure was a major contraindication of OC. After the third orientation, the proportion of RMPs mentioning high blood pressure as a contraindication of OC rose to 50 percent. Before the orientations, 16 percent of the RMPs reported that unmarried women should not use OC. After the third orientation, 58 percent of the RMPs gave this response. Before the orientations, one-third of the RMPs gave erroneous contraindications of OC. This figure dropped significantly after the third orientation (Table 3).

Benefits of taking iron tablets: The knowledge about the benefits of taking iron tablets increased substantially after the third orientation. Interestingly, misconceptions about the benefits of taking iron tablets also increased as a result of orientations. During the training, it was discussed that menses occur while the women takes the row of iron tablets. It was explained that if the row of iron tablets is slipped, and the white tablets are continued, menses will not occur. It seems that this message was misconstrued by some of the RMPs to mean that the iron tablet helps to induce the menses (Table 4).

Table 3 Distribution of RMPs by their knowledge about the major contraindications of oral contraceptives

Reported contraindications	Percentage	
	Before orientation	After third orientation
Correct Answers		
Unmarried	15.5	58.0
High blood pressure	37.7	50.0
Pregnancy	22.4	30.0
Diabetes	15.5	10.0
Jaundice	1.7	12.0
Varicose veins	1.7	10.0
Breast cancer/uterine cancer, etc.	5.1	8.6
Breastfeeding mothers	1.7	4.0
Headache/migraine	1.7	2.0
Incorrect Answers		
Weak women	18.7	10.0
Excessive menstrual bleeding	1.7	0.0
Client having anemia	1.7	0.0
Hormone problem	1.7	0.0
Others(widow, adolescent, etc.)	8.5	18.0
Not stated	0.0	2.0
(N)	(58)	(50)

Note: Total exceeds due to rounding

Table 4 Distribution of RMPs according to their knowledge about the benefits of the iron tablets

Benefits of the iron tablets	Percentage	
	Before orientation	After third orientation
Correct Answers		
Correct anemia	67.2	72.0
Increases flow	12.1	18.0
Incorrect Answers		
Make fatty/Weight gain	17.2	24.0
Regulate menstruation	6.8	14.0
Delay childbirth	3.4	0.0
Not stated	10.3	4.0
(N)	(58)	(50)

Note: Total exceeds due to rounding

Major side effects of oral contraceptives: The knowledge about the major side effects of OC increased to a large extent after the third orientation. Before the orientation, about 66 percent of the RMPs reported nausea/vomiting as a major side effect of OC. After the third orientation, all of the RMPs gave this answer. Before the orientation, only 12 percent of the RMPs mentioned spotting as a side effect of OC. After the third orientation, about one-third of the RMPs reported spotting as a side effect of OC (Table 5).

Treatment of amenorrhea: Before the orientation, only a few of the RMPs knew of a treatment for amenorrhea. This knowledge increased very significantly as a result of the orientations. After the third orientation, 60 percent of the RMPs reported that they would advise their clients to continue the oral pill if they had amenorrhea. They also informed the clients that their menses would resume if they continued the oral pill. Before the orientation, 57 percent of the RMPs said they did not know what to advise the amenorrhic clients. Often, they would refer the amenorrhic clients to the health center. After orientations, however, all but six percent of the RMPs knew how to counsel their amenorrhic clients. It was also observed that before the orientation, more than one-third of the RMPs gave incorrect answers about the treatment of amenorrhea. This figure declined significantly after the third orientation (Table 6).

Treatment of spotting: After the third orientation, most of the RMPs knew what to advise the pill clients in case of spotting. Prior to the orientation, less than a quarter of the RMPs knew the treatment. Before the orientation, around 41 percent said that they would refer the clients with spotting to the health center for advise. Apart from this, about a quarter of the RMPs had erroneous ideas about the treatment of spotting. They suggested antibiotics and homeostatic drugs. This practice had declined significantly by the end of the third orientation. This is a positive outcome of the orientation because the antibiotics and homeostatic drugs which were being prescribed were harmful for the clients' health (Table 7).

Advice on missing pills: Before the orientation, a large majority of the RMPs knew what to advise their clients if a single oral pill was missed. After the third orientation, this knowledge increased further. Very few of the RMPs could correctly advise their clients on what they should do if two pills were missed. After the third orientation, 40 percent were able to advise

Table 5 Major side effects of oral contraceptives

Major side effects of oral contraceptive	Percentage	
	Before orientation	After third orientation
Nausea/vomiting	65.5	100.0
Vertigo	63.8	64.0
Spotting	12.0	32.0
Headache	20.7	30.0
Lower abdominal pain	10.3	12.0
Weakness/burning sensation in the extremities	22.3	6.0
High blood pressure	8.4	6.0
Excessive bleeding	17.1	4.0
Others	17.0	24.0
Not stated	13.8	4.0
(N)	(58)	(50)

Note: Total exceeds due to rounding

Table 6 Treatment of amenorrhea as suggested by RMPs

Treatment of amenorrhea	Percentage	
	Before orientation	After third orientation
Correct Answers		
Suggest to continue oral pill	5.2	60.0
Test for pregnancy	3.4	26.0
Offer counseling/assurance	0.0	18.0
Suggest to wait for next menstruation	6.8	0.0
Incorrect Answers		
Improved diet & iron tablet	14.7	0.0
Suggest to stop OC	8.6	0.0
Injection menstrogen/tablet		
Coumorite/tablet Ovacon	8.5	0.0
Suggest for MR	5.1	0.0
Others	0.0	2.0
Don't know (Refer to FWC/THC)	57.0	6.0
Not stated	15.5	10.0
(N)	(58)	(50)

Note: Total exceeds due to rounding

Table 7 Treatment of spotting as suggested by RMPs

Treatment of spotting	Percentage	
	Before orientation	After third orientation
Correct Answers		
Assurance that this is normal for 3 months	22.3	98.0
Suggest high-dose pill	0.0	4.0
Don't know	41.2	2.0
Incorrect Answers		
Anoroxyl, Ergotamine Meleate and Methaspan	11.9	4.0
Antibiotic	8.5	2.0
Not stated	34.5	16.0
(N)	(58)	(50)

Note: Total exceeds due to rounding

their clients in this case. Before the orientation, a large majority of the RMPs gave erroneous answers in this respect. This figure declined significantly after the third orientation (Table 8).

3.2. Knowledge among RMPs About Injectables Contraceptive

Contraindications of injectable: The knowledge of RMPs increased significantly as a result of the orientations. Prior to the orientation, only ten percent of the RMPs knew that pregnancy is a contraindication of injectable contraceptive. That fact was mentioned by 40 percent of the RMPs after the orientation. Before the orientation, around 29 percent did not know about any contraindications of the injectable. This figure declined to six percent as a result of the orientations. Even after third orientation, however, a significant number of the RMPs mentioned erroneous contraindications (one-child mother, women above 45 years, breastfeeding mother, etc.) of the injectable (Table 9).

Table 8 Advice of RMPs if one and two pills are missed

Advice of RMPs	Percentage	
	Before orientation	After third orientation
Missed one pill		
Correct Answers		
Take 2 pills next day	70.6	88.0
Take 2 pills in the next day and use condoms	15.5	20.0
Take 2 pills in the next day and continue regular pill	0.0	2.0
Incorrect Answers		
Stop taking rest of the pills	1.7	0.0
Take rest of the pills without taking the missed one etc.	1.7	0.0
Start new packet of pill	1.7	0.0
Others	3.4	0.0
Not stated	10.3	2.0
Missed two pills		
Correct Answers		
Two pills together on next two days with using condom and continue pill as usual	1.7	40.0
Don't Know (Refer to doctors /FP clinic)	3.4	0.0
Incorrect Answers		
Three pills third day	13.8	14.0
Discontinue the pills	39.5	2.0
Wait until next menstruation	8.6	0.0
Others	1.7	10.0
Not stated	24.1	4.0
(N)	(58)	(50)

Note: Total exceeds due to rounding

Table 9 Contraindications of injectable contraceptives reported by the RMPs

Contraindications	Percentage	
	Before orientation	After third orientation
Correct Answers		
Pregnancy	10.3	40.0
Unmarried women/widow	15.5	38.0
High blood pressure	24.1	26.0
Women having no children	5.2	26.0
'B'-Virus/jaundice/ liver problem	1.7	14.0
Cervical cancer/ breast cancer	0.0	10.0
Irregular menstruation	3.4	4.0
Newly married couples	0.0	4.0
Lower abdominal pain	0.0	4.0
Diabetes	10.3	0.0
Others	12.0	14.0
Incorrect Answers		
One-child mother	3.4	6.0
Tuberculosis	0.0	6.0
Breastfeeding mother	0.0	4.0
Varicose veins	0.0	2.0
Women over 45	10.3	0.0
Others	20.6	10.0
Not stated	29.3	6.0
(N)	(58)	(50)

Note: Total exceeds due to rounding

Major side effects of injectable: Knowledge about the major side effects of injectable contraceptives increased to a large extent after the third orientation. For instance, excessive bleeding was mentioned by ten percent of the RMPs before the orientation. This figure increased to 46 percent after the third orientation. Before the orientation, half of the RMPs could not mention a single side effect of the injectable. This figure declined to 18 percent as a result of the orientation (Table 10).

Table 10 Major side effects of injectable contraceptives

Major side effects of injectable contraceptives	Percentage	
	Before orientation	After third orientation
Spotting	5.1	48.0
Excessive menstrual bleeding	10.3	46.0
Amenorrhea	25.9	42.0
Obesity	5.1	20.0
Lower abdominal pain	1.7	20.0
Headache	32.8	18.0
Abscess	1.7	8.0
Irregular menses	10.3	6.0
High blood pressure	1.7	6.0
Nausea	13.8	4.0
Restlessness	8.5	4.0
Others	15.3	6.0
Not stated	50.0	18.0
(N)	(58)	(50)

Table 11 Advice given in case of excessive bleeding due to injectable contraceptive

Advice for excessive bleeding	Percentage	
	Before orientation	After third orientation
Correct Answers		
Refer to THC/FWA/H&FWC/FWV/Doctor/Hospital	51.7	52.0
OCP for 21 days/C-5 for 10-21 days/Standard-dose pills for 10 days	0.0	44.0
Incorrect Answers		
Iron tablet	3.4	4.0
Injection Anoroxyl	15.4	4.0
Antibiotic	5.1	0.0
Others	22.1	14.0
Not stated	29.3	8.0
(N)	(58)	(50)

Note: Total exceeds due to rounding

Advice/treatment to be given in case of excessive bleeding:

Prior to the orientation, about half of the RMPs (52%) were able to give correct responses regarding what they would advise or what treatment they would give an injectable client if she was suffering from excessive bleeding. After the third orientation, almost all of the (96%) could provide correct answer. Before the orientation, about 46 percent provided incorrect responses and another 29.3 percent could provide no response in this respect. This figure declined to 22 percent and eight percent, respectively, by the end of the third orientation (Table 11).

Advice/treatment to be given for amenorrhea:

The knowledge of the RMPs about treatment or advice to be given to an injectable client suffering from amenorrhea increased tremendously. After the third orientation, 90 percent of the RMPs stated that they would assure the client that amenorrhea was not harmful for health. This had been mentioned only by ten percent of the RMPs before the orientation. Before the orientation, about half (48.3%) of the RMPs did not know

what to advise an amenorrhic client. This figure declined to 12 percent after the third orientation (Table 12).

Table 12 Advice given in case of amenorrhea due to injection

Advice for amenorrhea	Percentage	
	Before orientation	After third orientation
Correct Answers		
Assurance (Amenorrhea will not make harm your health)	10.3	90.0
Test for pregnancy	0.0	26.0
Refer to health complex/medical officer/FP doctor/FP clinic	34.5	4.0
Incorrect Answers		
Use pill with injection	5.2	4.0
Use condom	1.7	4.0
Iron tablets	3.4	2.0
Injection menstrogen	1.7	0.0
Others	5.1	0.0
Not stated	48.3	12.0
(N)	(58)	(50)

3.3. Knowledge of RMPs About IUD

Contraindications of IUD: Before the orientation, only a small percentage of the RMPs could name a contraindication of IUD. After the third orientation, this figure increased very significantly. Specifically, PID mentioned by 62 percent of the RMPs. Before the orientation, over half of the RMPs (55.2%) were unaware of the contraindications of IUD. This figure declined to ten percent by the end of the third orientation (Table 13).

Major side effects of IUD: Knowledge about the major side effects of IUD increased very significantly after the third orientation. Lower abdominal pain as a side effect of IUD was mentioned by about 21 percent of the RMPs prior to the orientation. After the third orientation, this figure increased to 50 percent.

Table 14 Major side effects of IUD

Major side effects	Percentage	
	Before orientation	After third orientation
Lower abdominal pain/ cramps	20.5	50.0
Excessive bleeding	13.8	42.0
Leucorrhoea	3.4	16.0
Spotting	0.0	12.0
Cramps & pain in uterus	0.0	10.0
Uterine infection	5.1	6.0
Uterine perforation	0.0	6.0
Vertigo/headache	3.4	4.0
Missing thread	0.0	4.0
Irregular menstruation	8.5	0.0
Others	13.6	14.0
Not stated	68.9	34.0
(N)	(58)	(50)

Note: Total exceeds due to rounding

Similarly, excessive bleeding was mentioned as a side effect of IUD by 42 percent of the RMPs after the third orientation. This figure was mentioned by only 14 percent before the orientation. Before the orientation, a large majority (69%) of the RMPs could not name a side effect of IUD. This figure declined to 14 percent as a result of the orientations (Table 14).

Advice/treatment to be given in case of excessive bleeding of IUD user:

Prior to the orientation, 43 percent of the RMPs knew what to advise or what treatment to offer an IUD user suffering from excessive bleeding. This figure increased to 88 percent after the third orientation. Before the orientation, over half (53.4%) of the RMPs said that they did not know what treatment or advice to offer an IUD client for bleeding. This figure dropped to 32 percent after the third orientation (Table 15). Moreover, incorrect responses declined significantly after the third orientation.

Table 13 Contraindications of IUD

Contraindications	Percentage	
	Before orientation	After third orientation
Correct Answers		
Patients suffering from PID, Uterine infection, leucorrhoea, RTI/STD,	13.6	62.0
Pregnancy	5.2	14.0
Unmarried women	5.2	14.0
Newly married/before giving birth	0.0	12.0
Excessive bleeding	1.7	4.0
Patients suffering from heart diseases	1.7	4.0
Widow	0.0	4.0
Incorrect Answers		
Mother of 1-2 children	3.4	0.0
After MR/abortion	5.1	6.0
Asthma	5.1	2.0
Others	10.3	14.0
Not stated	55.2	10.0
(N)	(58)	(50)

Table 15 Advice/treatment given in case of excessive bleeding of IUD users

Advice/treatment for IUD users	Percentage	
	Before orientation	After third orientation
Correct Answers		
Refer to FP clinic/FWV/ doctor/hospital/THC	37.4	56.0
Offer assurance/counseling	0.0	30.0
Advise to take medicine prescribed by qualified doctor	5.1	2.0
Incorrect Answers		
Prescribe iron/folic acid/ vitamin	5.1	2.0
Methaspan/anoroxyl	1.7	2.0
Antibiotic	1.7	2.0
Other contraceptive methods	6.8	2.0
Not stated	53.4	32.0
(N)	(58)	(50)

Note: Total exceeds due to rounding

Advice/treatment to be given for lower abdominal pain: The knowledge of RMPs about the treatment or advice to offer a client in the case of lower abdominal pain improved significantly as a result of the orientation. Before the orientation, 60.3 percent of the RMPs had no knowledge in this regard. This figure decreased by about half after the third orientation. However, after the third orientation, 30 percent of the RMPs still did not know what treatment or advice to offer an IUD client with complaints of lower abdominal pain. On the other side, incorrect answers were significantly decreased after the third orientation (Table 16).

Names of RTI/STDs mentioned by RMPs: The RMPs were asked to name three RTI/STDs. Prior to the orientation, the most frequently mentioned RTI/STDs were gonorrhea (8.6%), syphilis (6.9%) and moniliasis (6.8%). After the third orientation, knowledge about these RTI/STDs had increased: gonorrhea (52%) and syphilis (48%). Before the orientation, none of the RMPs mentioned AIDS. After the third orientation, 14 percent mentioned AIDS. Before the orientation, 81 percent of the RMPs were unable to mention three RTI/STDs. This figure declined significantly as a result of the orientation. Still, 46 percent of the RMPs were unable to mention the names of three RTI/STDs. It is also observed that the incorrect answers given before the orientation were significantly decreased after the third orientation (Table 17).

Advice/treatment to be given in case of burning sensation during urination: The

Table 18 Advice/treatment to be given in case of burning sensation during urination

Advice/treatment	Percentage	
	Before orientation	After third orientation
Correct Answers		
Drink more water, cold soft drink	29.3	64.0
Cotrimoxazol	8.6	32.0
Antibiotic (no name mentioned)	22.4	24.0
Urine examination	5.1	8.0
Capsule Doxacyllin	1.7	8.0
Lemon juice, Green coconut water	5.1	4.0
General treatment	6.8	2.0
Refer to doctor/THC/hospital	3.4	2.0
Incorrect Answers		
Syrup Alcally	6.8	4.0
Tablet Metronidazol	0.0	2.0
Others	1.7	0.0
Not stated	48.3	16.0
(N)	(58)	(50)

Note: Total exceeds due to rounding

Table 16 Advice/treatment given in case of lower abdominal pain for IUD users

Advice/treatment	Percentage	
	Before orientation	After third orientation
Correct Answers		
Ibropen 400mg/inflam 400mg	5.2	28.0
Refer to doctor/FWV/FP center/hospital/THC	22.3	20.0
Offer assurance/counseling	0.0	20.0
Diclofen	0.0	2.0
Analgesic tablet	1.7	0.0
Incorrect Answers		
Hysomide/tablet Butapen	8.5	4.0
Hartman solution	1.7	0.0
Others	13.6	8.0
Not stated	60.3	30.0
(N)	(58)	(50)

Note: Total exceeds due to rounding

Table 17 Names of RTI/STDs as recalled by RMPs

Names of RTI/STDs	Percentage	
	Before orientation	After third orientation
Correct Answers		
Gonorrhea	8.6	52.0
Syphilis	6.8	48.0
AIDS	0.0	14.0
Leucorrhoea	3.4	10.0
Trichomoniasis	3.4	8.0
Vaginal candidiasis/Moniliasis	6.8	0.0
Sulphingitis	1.7	0.0
Incorrect Answers		
Tuberculosis	1.7	2.0
Infection	1.7	0.0
Leprosy	1.7	0.0
Uterine cancer	1.7	0.0
Diarrhea	1.7	0.0
Others	5.1	5.1
Not stated	81.0	46.0
(N)	(58)	(50)

Note: Total exceeds due to rounding

knowledge of the RMPs about the treatment/advice to offer a client if she/he complains a of burning sensation during urination improved significantly as a result of the intervention. Before the orientation, 29 percent of the RMPs said they would advise a client with such a problem to drink more water. This figure increased to 64 percent after the third orientation. Prior to the orientation, about half (48.3%) of the RMPs did not know what to advise their clients in this respect. This figure dropped to 16 percent as a result of the intervention (Table 18).

3.4. Views of RMPs About Oral Contraceptive

Before Orientation

In many cases, previous generation pills have side effects.

Low-priced pills can cause excessive bleeding during menstruation or may cause amenorrhea. Thus, one should not take a low-priced pill.

Using an OCP for a long time can cause vaginal infection. It is better to change pill brands from time to time.

It takes some time for your body to adjust to the pill. Worrying is futile. The advantage of taking the pill is that one can buy it from any shop.

After third Orientation

One should not take the row of iron tablets. If iron tablets are not taken, menses will not occur. This is beneficial for health and keeps the face beautiful.

OCP is better than any method. Although each method has some side effects, those for OCP are less.

Use of OCP reduces breast milk.

OCP use can initially cause side effects such as spotting. Spotting can be treated by using one cycle of Ovostat (standard dose).

OCP is the best method. It has fewer side effects and is readily available.

3.5. Views About Injectable Contraceptives

Before Orientation

The advantage of injectable use is that it does not have to be taken every day.

Injection causes amenorrhea, itching and sometimes excessive bleeding. For these reasons, many women discontinue injectable contraceptive. Thus, one should have injection only after blood examination.

If an injectable user suffers from excessive bleeding, she can remedy this by taking 21 oral pills.

Injectable is a good method. Although it initially causes problems, it does gradually adjust with the body.

After third Orientation

Injectable contraceptives can cause excessive bleeding which gradually goes away. One needs not worry about it. If the problem is acute, one should discontinue the method.

Injectable is better than the pill because it does not to be taken every day. It is taken every 2-3 months.

Injectable contraceptives some-times cause excessive bleeding, dizziness, and lower abdominal pain. Over time, however, these symptoms go away. In most cases, injectable causes amenorrhea.

Excessive bleeding is a side effect of the injectable contraceptive. This can be cure by taking one packet of Nordette-28.

The injectable contraceptive has several side effects. In many cases, it causes excessive bleeding or amenorrhea. Thus, it is better not to use this method.

3.6. Views About IUD

Before Orientation

Among all of the FP methods, IUD is the best. Once it is taken, it is effective for several years.

If a woman gives birth to one or more children through normal delivery, she can wear the IUD, without any problems. This is because, the process of normal delivery makes the uterus big enough to house the Copper T.

IUD is a good method. If there are problems, it should be removed.

After Third Orientation

Among all the FP method, IUD is the best. Its great advantage is that it is a long-acting method. If IUD causes any serious problems or if one desires to have children, it can be removed.

If the IUD causes uterine problem resulting in lower abdominal pain, it should be removed.

The majority of IUD users do not face any problems. The advantage with the IUD is that if it does not suit the user it can be removed.

The IUD can cause lower abdominal pain during the first four months. Because the Copper T is a foreign body, it can cause uneasiness and some other problems until it is adjusted with the body. Once it is adjusted, it will cause no further problems. IUD is a good method.

3.7. Mystery Client Interviews

Mystery client interview techniques have been described in section 4.2.1. on page 39 of this report. A total of six scenarios were developed for prospective OCP, injectable and IUD users. The scenarios along with three others, for side effects, are described below.

1. Prospective FP User: Newly Married

Statement: "Doctor, I have recently gotten married. At this stage, my husband and I do not want any children. I want to use an FP method. I seek your advice in this regard."

2. Prospective FP User: One-Child Mother

Statement: "Doctor, I have one-year-old child. My husband and I do not want any more children yet. I want to use an FP method. I seek your advice in this regard."

3. Prospective FP User: Two-Child Mother

Statement: "Doctor, I have two children. Now my husband and I do not want any more children right now. I want to use an FP method. I seek your advice in this regard."

4. Side effect of Oral Contraceptive: Spotting

Statement: "Doctor, I am taking the pill. But I am suffering from spotting. Please tell me how to get rid of this problem."

5. Side effect of Injectable Contraceptive: Excessive Menstrual Bleeding

Statement: "Doctor, I took the injection, but now I am suffering from excessive menstrual bleeding. Please tell me how to get rid of this problem."

6. Side effect of IUD: Lower Abdominal Pain

Statement: "Doctor, I have an IUD. Now I have excessive bleeding during my menstruation. Please help me."

Collection of Data: A total of 30 mystery client interviews were conducted with the six scenarios both before and after the orientation. Five interviews were conducted for each scenarios. Two female interviewers conducted the interviews. They were thoroughly trained for the purpose.

Findings from the Interviews: The findings of the mystery client interviews for each group of scenarios have been summarized. This was a difficult task because each interview was unique in nature.

Prospective FP Users: After the orientation, the RMPs were able to provide a wider range of FP method options compared to what they had offered prior to the orientation. None of the RMPs suggested the use of condom or Norplant to the mystery clients prior to the orientation. After the third orientation, many suggested these methods. IUD was also suggested more frequently after the third orientation. Injection and ligation were least favored after the orientation but they gave more emphasis to IUD and Norplant as a result of the intervention. OCP was equally favored both before and after the third orientation. Women having one or two children were told about clinical contraception after the third orientation. IUD and Norplant were most frequently suggested. Norplant was not suggested before the orientation. In case of a one-child mother, none of the RMPs had suggested the IUD before the orientation. After the third orientation, of the five mystery clients one-child mothers, three were advised to adopt the IUD (Table 19).

Pill brand suggested: Of the 15 prospective FP users OCP were prescribed to 12 clients. After the third orientation, most of the clients (10 out of 12) were advised to take a low-dose pill. Before the orientation, the pill brands suggested were largely standard-dose. This is despite the fact that the low-dose pills, Ovacon and Nordette-28 had been known to the RMPs all along.

Table 19 Methods suggested by the RMPs to the prospective FP clients

Category	Orientation	Methods						Total
		Oral Pill	Condom	Norplant	Injection	IUD	Tubectomy	
Newly married	Before	5	-	-	-	-	-	5
	After	5	2	-	-	-	-	7
Mother of one child	Before	5	-	-	1	-	-	5
	After	4	1	2	1	3	-	11
Mother of two child	Before	2	-	-	1	2	2	7
	After	3	-	3	-	3	1	10
Total	Before	12	0	0	2	2	2	
	After	12	3	5	1	6	1	

Note: Total exceeds due to rounding

Advice given to pill users for spotting: After the third orientation, all of the mystery clients with spotting were advised not to get worry to continue taking the pills, and that the problem will disappear over time. Before the orientation, this advice was given by only one RMP. Before the orientation, the majority of the mystery clients were advised to change the brand pill they were using. One client was asked to use condom (Table 20).

Table 20 Advice given to the mystery clients who went to the RMPs with side effect (spotting) due to OC

Advice	Side effect (spotting)	
	Before orientation	After third orientation
Do not get worried, the problems will disappear over the time. Pill should be continued.	1	5
To take more vegetables, fish, milk, egg and fruits.	3	1
Because of the spotting, you may get weak. Take an egg every day if you can afford it.	1	-
Since you are a newlywed couple, your husband can use a condom for the time being. Pill use does give rise to side effects. Condom does not.	1	-
To change the pill brand.	3	-
To take the prescribed medicine; in case of no relief, take another FP method in consultation with husband.	1	1
Medicine prescribed.	-	2
To take a cycle of Ovostat.	-	1
(N)	(5)	(5)

Note: Total exceeds due to rounding

Advice given to injectable user for excessive bleeding: After the third orientation, all of the RMPs advised the injectable clients with excessive bleeding not to worry; that it would decrease over time. This advice was given by two RMPs before the orientation. Besides this, the suggestion pattern remained more or less the same. After the third orientation, however, two of the clients were advised to get a checkup at a health center (Table 21).

Table 21 Advice given to the mystery clients who went to the RMPs with a side effect of the injectable contraceptive (excessive bleeding)

Advice	Side effect (excessive bleeding)	
	Before orientation	After third orientation
Not to be worried for excessive bleeding; it is one of the side effects of injectable contraceptive and will be decrease over time.	2	5
To take the prescribed medicine; in case of no relief, switch to another method after consulting with an experienced FP doctor.	2	2
Switch from injectable method.	1	1
If the bleeding does not decrease after taking the prescribed medicine, (and if she again faces the problem in her next menstruation) she should stop taking the injectable method.	1	-
To switch to pill (Ovostat/Nordette-28) if she does not get better after taking the prescribed medicine.	1	2
Bleeding will decrease if she takes oral pills (Ovostat) for 21 consecutive days and two iron tablets per day after a meal.	1	1
Advised for check-up in hospital/health complex	-	2
To take nutritious food	-	2
(N)	(5)	(5)

Note: Total exceeds due to rounding

Advice given to IUD clients for lower abdominal pain: After the third orientation, all of the clients with lower abdominal pain were asked to visit the health center, where the IUD had been inserted, to make sure that the IUD was in place. Most of them were also informed that lower abdominal pain and excessive bleeding were two of the major side effects of IUD, and nothing to worry about; they would disappear within 2-4 months. Such counseling had only been given only by one RMP prior to the orientation. Before the orientation, the majority of the clients were advised to remove the IUD. It is important to note that before the orientation, one client was advised to remove the IUD by herself by pulling the IUD string (Table 22).

Table 22 Advice given to the mystery clients who went to the RMPs with an IUD side effect (lower abdominal pain)

Advice	Side effect (lower abdominal pain)	
	Before orientation	After third orientation
To go to the hospital or to the health center where she had the IUD inserted it make sure the IUD was in place.	1	5
Lower abdominal pain and excessive bleeding are the primary side effects of injectable contraceptive. This will go away within 2-4 months. Don't worry.	-	4
The client should check (by herself) whether or not the IUD string was in place. If the pain was because of a uterine problem, her IUD should be removed.	-	1
To have the IUD removed by a lady doctor or in a hospital if the pain does not disappear.	1	-
To switch to Ovacon (pill) after removing the IUD.	1	-
If the prescribed medicine (tablet Hysomide) does not minimize the pain, an antibiotic (tablet Moxacillin) should be taken.	1	-
The uterus is probably infected/the IUD string went inside the uterus, so the IUD should be removed.	1	2
Not to worry. If the prescribed medicine does not cure the pain, she might have a uterine infection, she should contact a lady doctor	2	-
If she has excessive pain, she can remove the IUD by pulling the IUD string, herself.	1	-
(N)	(5)	(5)

Note: Total exceeds due to rounding

3.8. Client Records

Each RMPs was asked to keep a record of the clients to whom they advised FP methods, to whom they provided FP services, who they treated for FP method side effects and who they referred to the health worker or health center. They were provided with a pre-designed form to keep such records. This record form was supplied to the 58 RMPs who attended the first orientation. A total of 44 RMPs (76%) kept the records. In total, they recorded 750 clients (on average 17 clients each), to whom they provided some kind of FP service-- either at the pharmacy or at the client's home over a period of about five months.

Among the clients to whom they provided FP services, 60.5 percent of them were female. The occupation of the majority of the female patients was housewife (60.3%) and a substantial proportion were tea garden laborers (17.4%) and daily laborers (12.2%). Among the male clients, about 45 percent were farmer/agriculture laborers and a substantial proportion were daily laborers (13.7%) (Table 23).

3.9. Referral of Clients

A total of 61 clients were referred by 17 RMPs to health centers or health worker (FWA/FWV). One RMP referred 22 (36.1%) cases. The large majority (82%) of the cases were referred to the THC (Table 24).

The RMPs referred the clients mainly for two clinical methods, Norplant (41%) and injectable (27.9%). Ten percent of the clients were referred for sterilization. The RMPs referred 8.2 percent of the cases for irregular bleeding and 13.1 percent of the cases for MR (Table 24).

The major services provided and recorded by the RMPs included recommending use of temporary methods (26.7%), recommending use of OCP (14.4%) and general discussion on FP methods (30.2%). Other services included: referring to the health center for clinical contraceptives or other services (10.7%), recommending permanent methods (7%) and treatment/advice for side effects (9.2%) (Table 25).

3.10. Client Survey

Out of 570 clients, 125 (22%) clients were randomly selected and 104 cases (83.2%) were successfully interviewed. Of the 104 respondents, 29 (27.9%) were male and 75 (72.1%) were female.

The average age of the female respondents was 32 years and that of the male respondents was 39.4 years. On average, the clients had 3.4 children. The majority of the female respondents were housewives and 21.3 percent were tea garden laborers. The major occupations among the males were agriculture (24.1%) and laborer. The majority (67.3%) of the respondents were from the lower socio-economic class (Table 26).

Table 23 Percent distribution of female and male clients by their occupation

Occupation	Female clients	Male clients
Housewife	60.3	0
Tea garden laborer	17.4	2.2
Farmer/agriculture laborer	0	44.9
Daily laborer	12.2	13.7
Others (teacher, service, business, driver etc.)	2.9	17.7
Not stated	7.2	22.5
Total	100.0	100.0
(N)	(345)	(225)

Table 24 Type of health centers to which the clients were referred and reasons for referral

Type of health center/worker	Percentage
Thana Health Complex	82.0
Health and Family Welfare Center	11.5
FWA	6.6
Total	100.0
(N)	(61)
Reasons for referral	
Norplant	41.0
Injectable	27.9
Sterilization	9.8
Irregular per vaginal bleeding	8.2
Menstrual regulation	13.1
Total	100.0
(N)	(61)

Table 25 Distribution of clients by the services rendered by the RMPs

Services rendered	Percentage
General discussion on FP	30.2
Recommended for temporary methods	26.7
Recommended oral contraceptive	14.4
Referred to health center/health worker for clinical contraception	10.7
Provided treatment/advice for side effects	9.2
Recommended permanent methods	7.0
Recommended MR	2.1
Not stated	2.0
Total	100.0
(N)	(570)

The majority (67.3%) of the respondents reported that when a family member got sick they went to the RMPs. Over half (51.0%) also said that they went to the health center or a qualified private medical practitioners (14.4%) (Table 26).

Slightly over 43 percent of the respondents said that they were currently using a FP method. Of them, the majority (56.7%) of the FP users reported that they were currently using OCP and 13.3 percent were using the injectable method. A significant proportion of the clients (13.4%) had been sterilized (Table 26). More than three-fourths of the clients said that they are satisfied with the services provided by the RMPs (Table 26).

The following information was also taken from the records kept by the RMPs. The discussions held with the patient about FP included the following:

- The convenience or and inconvenience of IUD and its duration.
- The benefits and risks of taking OCP and recommendation of pill use.
- The client was taking OCP and was suffering from dizziness. Thus, the RMP advised the client to undergo sterilization. Because the client was too frightened to do this. She was advised to take the injectable contraceptive.
- The client was told that the injectable is a good method and it does not cause any major side effects. Thus, the client was advised to adopt injectable contraceptives.
- The client wanted to avoid pregnancy for the time being. Thus, the discussion included information about the various FP methods available.
- The client was having some difficulty in using OCP. Thus, the RMP advised the client to change the brand of pill she was using.
- The client was taking OCP in combination with a medicine for some disease. In the opinion of the client, OCP was reducing the effectiveness of the other medicine she was taking. The RMP explained to her that this could not be the case.
- The RMP discussed the risks and benefits of the different modern contraceptive methods available contraception and advised the client to take OCP or injection.
- The RMP advised against frequent pregnancy and asked the client to use the injectable contraceptive.
- The client came to discuss MR/D&C.
- The client had an IUD and she wanted to remove it to have a child. She asked for the suggestion of the RMP. The RMP referred the client to the health center.
- In the opinion of the RMP, temporary methods were not suitable for the client. Thus, the RMP advised the client to choose a permanent method.

A large majority of the clients (81.6%) were happy with the services/advice of the RMPs.

Those who said that they were not happy with the services/advice of the RMP mentioned the following reasons:

- The clients had taken OCP pill at the advice of the RMPs but they were suffering from side effects.
- The clients had asked for a long-acting method (Norplant) but since they had few children (less than three), they were not referred for a long-acting method.

Table 26: Economic status, person consulted at the time of sickness, satisfaction level and current method of contraceptive use of clients

Category	Percentage
Economic status	
Upper	2.9
Middle	13.5
Lower middle	16.3
Lower	67.3
Total	100.0
(N)	(104)
Where to go	
Multiple response	
Village doctor	67.3
Qualified doctor	14.4
Health center	51.0
(N)	(104)
Level of satisfaction	
Very satisfied	2.8
Satisfied	78.8
Somewhat satisfied	2.9
Not at all satisfied	15.5
Total	100.0
(N)	(104)
Methods of contraception	
Oral contraceptive	56.7
Sterilization	13.4
Injectable contraceptive	13.3
IUD	1.9
Condom	6.7
Total	100.0
(N)	(45)

- The RMPs had recommended tubectomy, but they were too frightened to undergo the procedure.

The majority (64%) of the respondents said that the availability of FP services at the pharmacy level would benefit them.

The respondents said that they would benefit for the following reasons:

- They could get the contraceptive supplies any time from the pharmacy.
- They could generally find the physician at the pharmacy.
- They get good service and high-quality contraceptives from the pharmacy.
- The pharmacy is the first place to go in the event of a problem; the physician at the pharmacy had always listened carefully to their problems and takes proper care.
- The pharmacy is nearby and easily accessible.
- The physician at the pharmacy is known to them and trusted to take proper care.

The clients who said that availability of FP services at the pharmacies would not benefit them gave the following reasons:

- FP services are available from the FP fieldworkers free of cost.
- One has to pay for FP services at the pharmacy.
- FP methods are costly at the pharmacy.
- FP services are available free of cost from the health center.
- There are qualified doctors at the health center and better facilities are available there.
- The physicians at the pharmacy do not give adequate attention to the clients.

3.1.1. Treatment of Contraceptive Side Effects by RMPs

Pseudo-clients presented their pre-selected side effect scenarios to the RMPs. Before and after the orientations, all of the RMPs prescribed medicine for treatment of all of the side effects reported by the pseudo-clients. Treatment of contraceptive side effects was one of the most emphasized important components of the orientation. The medications prescribed by the RMPs before and after the orientation have been analyzed and presented below.

Overall, the quality of contraceptive side effect management improved significantly among the study RMPs. The irrational use of antibiotic and hazardous use of homeostatic drugs were significantly reduced as a result of the intervention. Some specific examples in this regard have been provided below. Detailed information is presented in Tables 30 and 31.

- ***Treatment of spotting in low-dose OCP users:*** Spotting is a common complaint among low-dose OCP users for the initial 3 to 6 months. After the third orientation, almost all of the RMPs stopped irrational treatment for low dose OCP use related spotting. Prior to the orientation, the RMPs prescribed antibiotics (Fimoxyl, Tycil-Amoxycillin), homeostatic drugs (Methergin, Anoroxyl), and anti-spasmodic drugs (Spanil-Hyoscine N-butyl bromide). After the orientation, they began to prescribe standard dose OCP (Ovacon, Ovostat) for the management of spotting. The RMPs were not knowledgeable about the fact that reassurance can be offered as a treatment. Before the orientation, they invariably advised the clients to discontinue OCP use for spotting. The concept of counseling was non-existent among the RMPs. This factor improved significantly after the orientation. The common practice of prescribing homeostatic drug (Methergin and Anoroxyl) and use of antibiotic stopped except in a few isolated cases.
- ***Treatment of excessive menstrual bleeding among injectable users:*** Some women experience excessive menstrual bleeding during the initial 6-12 months of injectable use. A pseudo-client with this scenario consulted with some of the RMPs both before and after the orientation. After the orientation, almost all of the RMPs offered inconsistent and illogical advice for excessive menstrual bleeding due to injectable use. Prior to the orientation, they preferred to prescribe antibiotics (Moxacil, Hicosil - Amoxycillin, Floxin - Ciprofloxacin, Cepox - Cephalexin); homeostatic drugs (Methergin, Anoroxyl); and anti-spasmodic drugs (Hysomide, Hyocine - Hyocine N-butyl bromide). After the orientation, however, they began to prescribe low-dose combined OCP (Shukhi and Nordette-28), and (in some cases, standard-dose OCP (Ovostat, Ovacon, or Maya) although brands were not always indicated). They also prescribed Ibuprofen (Inflam), iron, and reassurance and referred the clients to the health care facilities. The common practices of prescribing

homeostatic drugs (Methergin and Anoroxy) and use of antibiotic was reduced significantly except in a few cases.

- ***Treatment of low abdominal pain among IUD users:*** Women sometimes complain of lower abdominal pain due IUD use. This needed a thorough checkup to assess for PID, missing IUD or ectopic pregnancy. These procedures require an abdominal and pelvic examination and sometime radiological investigation, all of which are beyond the scope of the RMPs. The success of the program was that while all of the RMPs prescribed medicines (antispasmodic, antibiotic-amoxycillin, multivitamin, etc.) for this problem before the orientation, they rarely did so after the orientation. For this type of problem, they began to refer the clients to an appropriate health care facility (H&FWC and THC). Although antispasmodics have no practical application in this situation, the practice of using them was not entirely eliminated, after the orientation.

Table 27 Medicines prescribed by the RMPs for the treatments of different side effects of different contraceptives before the orientation

Case No.	Method name	Problem	Treatment (medicine)	Specialist's comments on the logic of the medications
1.	OC Nordette-28	Spotting	Tablet Methargin Capsule Fimoxy OCP Ovostat	Tablet. Methargin is used for homeostatic purpose, Fimoxy for anti-ineffective action. Both prescriptions are erroneous. Spotting is due to lack of estrogen, so Ovostat (standard dose) is an appropriate choice.
2.	OC Nordette-28	Spotting	Tablet Anaroxyl OCP Marvelon	Tablet. Anaroxyl is used for homeostatic purposes and is not appropriate in this case. OCP Marvelon is essentially the same as OCP Nordette-28. There but may be a moral boost in that pill has been changed, but the treatment is not appropriate.
3.	OC Nordette-28	Spotting	Tablet Methorspan OCP Ovostat	Tablet. Methorspan is for homeostatic purpose. Spotting in low-dose pill is due to the lack of estrogen, so use of OC Ovostat, which is a standard-dose pill is logical.
4.	OC Marvelon	Spotting	Capsule Tycil 250 mg Tablet Spanil	No reason to use Tycil (Amoxycillin) and Spanil (hyoscine N-butyl bromide) for this symptom.
5.	OC Ovostat	Spotting	Tablet Anaroxyl	Anaroxyl is not the proper medication for this symptom..
6.	Injectable	Excessive bleeding during menstruation	Tablet Floxin 500 mg Tablet Hyoscine	No reason to prescribe Floxin (ciprofloxacin) or Hyoscine for this symptom.
7.	Injectable	Excessive bleeding during menstruation	Tablet Moxacil Tablet Anaroxyl	No logic behind prescribing the Moxacil (Amoxycillin) and Anaroxyl for this symptom..
8.	Injectable	Excessive bleeding during menstruation	Capsule Hicosil Tablet Anaroxyl	Antibiotic (Hicosil) and homeostatic drugs are not recommended for this symptom.
9.	Injectable	Excessive bleeding during menstruation	Cepox Tablet Anaroxyl Tablet Methorspan OCP Ovostat	To minimize the symptom, the prescription of standard-dose OCP can be used. But a low-dose pill would be more appropriate. The Antibiotic (Cephalexin), and the homeostatic drug (anaroxyl, mehtorspan) are not merited in this case and could be hazardous.
10.	Injectable	Excessive bleeding during menstruation	Tablet Anaroxyl Tablet Hysomide	These drugs are not appropriately prescribed and could cause complications.
11.	IUD	Lower abdominal pain	Tablet Hysomide Oposovit-M OCP Ovacon	Tablet Hysomide is not appropriately prescribed. Other medications also are inappropriate.
12.	IUD	Lower abdominal pain	Capsule Moxacil Tablet Hysomide	Tablet. Hysomide prescribed here is not appropriate. Antibiotic (Amoxycillin) is prescribed without the basis of a checkup.
13.	IUD	Lower abdominal pain	Tablet Butapen	There is no rationale to prescribe such an anti-spasmodic drug.
14.	IUD	Lower abdominal pain	Tablet Hysomide Tablet Apa Tablet Femitab	Analgesics (Apa) could provide symptomatic relief, but other drugs are not appropriate.
15.	IUD	Lower abdominal pain	Tablet Hysomide (Refer Komalganj Health Complex)	Appropriate prescription. Referral to the higher service center. But hysomide is not the appropriate drug.

Source: Prescription of Mystery clients

Table 28 Medicines prescribed by the RMPs for the treatments of side effects of contraceptives after the third orientation

Case No.	Method name	Problem	Treatment (medicine)	Specialist's comments on the logic of the medications
1	OC Ovostat	Spotting	OC Shukhi	The treatment suggested by the RMP is not appropriate. Changing from standard-dose to low-dose pill may not improve the condition. In fact, it could aggravate the situation.
2	OC Nordette-28	Spotting	Capsule Fimoxyl Tablet Methergin	An antibiotic (amoxycillin) will not effect this symptoms. Moreover, homeostatic drug (Methergin) does not work in non-gravid uterus, rather it could be harmful.
3	OC Nordette-28	Spotting	Tablet Methergin Tablet Infram	Here is also inappropriate use of Methergin. The anti inflammatory drug (Infram) will also have no effect on the symptom.
4	OC Nordette-28	Spotting	OC Ovostat Tablet Infram 400 mg	Here, the RMP has chosen the right one and suggested to take standard dose OCP from low-dose pill. The added treatment they have given (NSAID) does not have any role to improve the condition.
5	OC Nordette-28	Spotting	OC Ovacon/Ovostat	This treatment is completely appropriate and will definitely improve the clients' condition.
6	Injectable	Excessive bleeding during menstruation	OC Ovostat Tablet Iron	Although standard-dose OCP (Ovostat) is not appropriate for excessive bleeding after having a DMPA, the RMP chose the right one. Tablet iron is also recommendable at this stage.
7	Injectable	Excessive bleeding during menstruation	Tablet Infram Tablet Methergin	It is advisable to provide (NASID) inflam for the treatment of excessive bleeding due to DMPA but providing tablet methergin is not appropriate to stop bleeding.
8	Injectable	Excessive bleeding during menstruation	OC Nordette-28	Providing a low-dose OCP (Nordette-28) is the appropriate treatment for excessive bleeding due to DMPA injection.
9	Injectable	Excessive bleeding during menstruation	OC Shukhi/OC Ovacon/ OC Maya Tablet Cloxin Tablet Anaroxyl Tablet Hysomide/Butapen Tablet Infram	Only the low-dose OCP (Shukhi) is appropriate treatment. Standard-dose OCP (Ovacon, Maya) can be taken in some instances, but doxacillin, the homeostatic drug (Anaroxyl), the anti spasmodic drugs (Hysomide, Butapen) are not appropriate.
10	Injectable	Excessive bleeding during menstruation	Injection. Anoroxyl Capsule Moxacil	The homeostatic drug (Anoroxyl) and the antibiotic will have no effect on the symptom.
11	IUD	Lower abdominal pain	Tablet Diclofen 50 mg	In some instances, NSAID drug diclofenac (Diclofenac sodium) can have an anti inflammatory effect. The best drug, however, is ibuprofen.
12	IUD	Lower abdominal pain	No medicine given Referred to THC for checking	Logically, this referral system can play a great role in this situation. The RMP now understands when and where to refer their complicated cases.
13	IUD	Lower abdominal pain	Tablet Nospa Tablet Spasmonil	These anti spasmodic drugs (Nospa, Spasmonil) will not have any effect on the situation.
14	IUD	Lower abdominal pain	No medicine given Referred to THC for checking	This is appropriate because it is not the RMPs's jurisdiction to examine. This client needs a careful, thorough vaginal examination and investigations by a qualified physician.
15	IUD	Lower abdominal pain	Tablet Hysomide	Inappropriate use of anti spasmodic (Hysomide) drug.

Source: Prescription of Mystery clients

SECTION FOUR

LESSONS LEARNED AND RECOMMENDATIONS

4.1 Lessons Learned

A number of lessons were learned from the pilot project of involving the RMPs in FP service delivery. These were as follows:

- RMPs were interested in becoming involve in FP service delivery. It was learnt that quality counseling on FP methods can be given by the RMPs.
- It was learnt that the majority of the RMPs were engaged in full-time practice in pharmacies in addition to selling medicine.
- A large proportion of the RMPs did not charge a fee, since they make profit from the sale of medicine to the clients.
- It was learnt that due to inadequate knowledge about family planning RMP provides less options for FP method before the orientation. After the orientation, RMPs provided a wider range of FP method options.
- RMPs would be an ideal referral source for the government health centers for clinical contraceptives.
- Maintaining register for FP client by the RMP is possible.
- The design for a three-day orientation held in three sessions with an interval of two months between sessions was found to be effective in the development of interest among the RMPs about FP.
- Through the use of IEC activities it was possible to inform the community members about and motivate them to seek FP services from the RMPs.

4.2. Recommendations

- Considering the fact, that RMPs provide health care services to a large majority of the rural population and that they have interest in getting involved in FP service delivery. The program should gradually be expanded to all rural areas of Bangladesh.
- In order to update the knowledge of the RMPs about FP methods and RTI/STD management, the RMPs should be provided with relevant and necessary information in this regard on a regular basis. Also refresher training should be arranged for them at regular intervals of two years.
- RMPs provide injections to their clients in the treatment of different diseases. Thus, they should be capable of administering injectable contraceptives. Therefore, considering the fact that 60 percent of the clients who received FP service from them were female, this situation would serve as outstanding opportunity to promote the use of injectable contraceptives.