Strengthening STD Services for Men in an Urban Clinic Based Program

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This study is a collaborative project with Marie Stopes Clinic Society
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Preface

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

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

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

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

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

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

Kim Streatfield
Project Director

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CONTENTS

LIST OF TABLES		vi
ABBREVIATIONS		vii
ACKNOWLEDGMENTS		ix
EXECUTIVE SUMMARY		xi
CHAPTER 1	**INTRODUCTION**	1
1 1	Prologue	1
1 2	Background	2
1 3	Objectives	4
CHAPTER 2	**METHOD AND INTERVENTION**	5
2 1	Hypotheses	5
2 2	Methodological Design	5
	2 2 1 Needs Assessment	5
	2 2 2 Intervention	6
	a) Management Information System	7
	b) IEC Intervention	8
	c) Training	9
	2 2 3 Evaluation Phase	10
2 3	Limitations of the study	10
CHAPTER 3	**BASELINE STUDY AND CLIENT PROFILE**	11
3 1	Introduction	11
	3 1 1 Field Based Marketing and IEC Activities	11
	3 1 2 Clinical Services	12
	3 1 3 Client and Clinic Interaction	15
3 2	Findings	17
	3 2 1 Client Profile	17
	3 2 2 Presentation of Chief Complaints	23
	3 2 3 History of Exposure	25
	3 2 4 Partner Management	29
	3 2 5 Counseling Profile	30
	3 2 6 Impact of the study	30
CHAPTER 4	**EPILOGUE**	33
4 1	Discussion and Conclusion	33
4 2	Policy Recommendation	37
REFERENCE		39
APPENDIX 1		I
APPENDIX 2		II
APPENDIX 3		III

d

LIST OF TABLES

Table 1	Types of Clients and Services during the Study Period	18
Table 2	Age Distribution of Clients by Diagnostic Group	19
Table 3	Level of Education by Types of Clients	20
Table 4	Occupation by Types of Clients	21
Table 5	Marital Status of the Types of Clients	22
Table 6	Sources of Information by Types of Clients	22
Table 7	Chief Complaint Versus Types of Clients	23
Table 8	Local Examination	24
Table 9	Previous Treatment History	25
Table 10	Types of Exposure by Clients	26
Table 11	Types of Exposure by Diagnostic Group	26
Table 12	Length of time since Last Exposure	28
Table 13	Length of time since Last Exposure by Diagnostic Group	28
Table 14	Partner Management	29
Table 15	Counseling Profile	30
Table 16	Types of Clients in Quarterly Distribution	30
Table 17	Diagnostic Groups in Quarterly Distribution	31
Table 18	Sources of Information in Quarterly Distribution	31

ABBREVIATIONS

CSW	Commercial Sex Worker
DFID	Department For International Development
FC	Field Coordinator
FGD	Focus Group Discussion
FP	Family Planning
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
MIS	Management Information System
MR	Menstrual Regulation
MSC	Marie Stopes Clinic
MSCS	Marie Stopes Clinic Society
MSI	Marie Stopes International
ODA	Overseas Development Assistance
OT	Operation Theater
PC	Population Council
PHC	Primary Health Care
PID	Pelvic Inflammatory Disease
RPR	Rapid Plasma Reagin
RTI	Reproductive Tract Infection
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TPHA	Treponema Pallidium Hemagglutination Test
UTI	Urinary Tract Infection
VDRL	Venereal Disease Research Laboratory
WHO	World Health Organization

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The study is very much indebted to the Marie Stopes Clinic Society, for taking the collaborative stance throughout the study, especially Dr Yasmin H Ahmed, the Country Director of Marie Stopes Clinic Society, Dhaka, Bangladesh Dr Khair, the clinic doctor of MSC, deserves a special thanks for his help, in refining the form, through which data collection of the study was done We are grateful to all the field coordinators, counselors, clinic managers and many other staffs of MSC who has helped us enormously in data collection and improving service delivery

The supportive attitude of all staff of Population Council towards sex and sexuality, inspired the study in taking this shape Heartfelt thanks to Dr P Kim Streatfield the Country Representative, Population Council, Dhaka, for his continuous support and advice to the research team

The quantitative analysis of the study depended much on the expertise of Dr Alan Noel Gray, Program Associate, Population Council, Dhaka We owe Dr Gray for his expert hand on the SPSS analysis

We express our heartfelt gratitude as research team to Nancy Piet-Pelon, Consultant, Population Council, Dhaka, who continuously helped us throughout the research In the development of IEC, Nancy had a major role to play In designing the training and decision making and negotiation for smooth operation and intervention of the research, her consultative role and advice was necessary and plausible The final draft and editing of the papers always had her thoughtful and creative touch

Translating the Management Information System into a computer based program was achieved through the programmer Badal Chandra Dhar, ICDDR,B The study is also indebted to Mr Dhar for his effort and expertise in developing the MIS program in a very short time He developed a 'user friendly' system which made timely data entry possible

The assistance of Ismat Bhuiya, Research Officer, Population Council, Dhaka in developing the questionnaire for the needs assessment and her sincere effort in helping the team in the needs assessment is acknowledged A special thanks to Md Mostak Ahmed, the person who did the entire data entry of the study and assisting in various aspects of the study

For the development of the three IEC, the research team owes special thanks to Mr Asem Ansari of ICDDR,B and Md Sabih-ul Alam, of Communicants not only for their artistic skills but for their effort in giving a concept the shape of an educational and communicable artwork

The administrative support of Population Council, Dhaka, was very congenial for the smooth operation of the research and effective technical assistance deserves acknowledgment

To all the male patients who attended the MSC clinics during the nine month period, if you would not have provided the information we could never come up with such conclusions We salute you all

AUTHORS

Executive Summary

While Reproductive Tract Infections (RTIs) have infected individuals for centuries it is only with the shift to a reproductive health agenda that their diagnosis and treatment has gained attention at the national level in Bangladesh In order to reduce the spread of sexually transmitted RTIs, it is essential that individuals at risk understand the modes of transmission, the signs and symptoms, and the consequences of untreated infection Identifying and treating partners of infected individuals is an absolutely essential aspect of appropriate clinical services

This study was conducted in three phases Both qualitative and quantitative methods were used to obtain information The purpose of the first phase of the study was to obtain baseline information on the male Sexually Transmitted Diseases (STD) services by MSC The objectives of the second and third phase were to provide interventions on the specific needs identified from the baseline, and evaluate the intervention outcome Along with clinical diagnosis the study information includes the results of in-depth interviews of the clients' sexual history partners, condom use, and treatment patterns

Male patients attending two STD clinics in Dhaka are the subjects of this research The health records of every patient includes kinds of complaints, previous medical history, clinical diagnosis, sexual history and partner management The study encompasses building awareness and education on STDs/RTIs in the field, health education and counseling at the clinic, and diagnosis and treatment The study includes the total number of clients who visited both the clinics for services over a period of 9 months, July, 1996 to March, 1997, 1467 came for 1689 different services and visited the clinic 1859 times

The study reveals that out of 1689 services given, 11 percent were STD clients The percentage of the STD clients are higher among the age group of 20-29 Most of the STD clients have no schooling, however, one tenth is graduate and above One fourth of the total clients are coming for services related to other sexual health problems of which almost all are coming with psycho-sexual disorders About one-fourth of the total client flow have a sexual exposure history other than their regular partner and only very insignificant numbers of those use condoms An overall observation of the clinical services is that the services have increased by almost 200 percent during the last six months of the nine month the study period

The study results put us in a position to better understand the obstacles to programming integrated STD services They further help us with knowledge on clients' perceptions of STDs, the language they use to describe conditions, and the importance they ascribe to appropriate treatment and behaviour modification

Two important achievements of the study were, the development of a computer based MIS for record keeping, monitoring, measuring performance and quality of care of a clinical STD service provision Secondly, the development of three IEC materials for male STD intervention was one of the major outcomes of the project The IEC is designed to help providers

communicate with the clients and as an aid to awareness of sexual responsibility for oneself, partner/s and children

Organizations undertaking a clinical STD intervention can consider the following

- An effective male STD intervention will have to target all age groups, service categories and education levels

- Personal contact appears to be a positive approach for reaching men seeking STD services although the role of media was not fully explored

- Exposure history should not be a singular screening criteria because clients tend to conceal this information Extensive training of the providers is needed to elicit complete client information

- Male STD intervention should be coupled with general and other sexual health services as 50 percent of the STD diagnosis came from these two client categories

- The perception that men, because they are symptomatic speak more easily about STDs is erroneous

- Providing STD services to men therefore requires a two pronged approach
    a) Efforts have to be given on awareness and educating men,
    b) Providers need training, backup and psychological support to deal with the issues of sexuality and STDs

There remains a culture of silence even among men on issues of sexual health and well being Efforts have to be made to empower men to talk about sex and sexuality concerning their own self

CHAPTER 1
INTRODUCTION

1 1 PROLOGUE

Reproductive Tract Infections (RTIs) and Sexually Transmitted Diseases (STDs) can have a detrimental effect on the reproductive health and well-being of both men and women STDs account for 15 percent of the total disease burden worldwide (WHO) Both short and long term sequelae of untreated RTI/STDs can cause profound biomedical, social and economic impact on individuals and communities **Gonorrhea** and **chlamydia** cause morbidity, like discharge and urethritis, and also infect the upper reproductive tract and result in pelvic inflammatory disease (PID) PID can cause infertility, by scarring the fallopian tubes, or ectopic pregnancy Untreated gonococcal and chlamydia infections in pregnant women may cause miscarriage neonatal pneumonia, or ophthalmia neonatorum **Syphilitic** infections can cause serious birth defects, mental retardation and other problems for the newborn **Bacterial vaginosis**, the most common RTI, can cause premature delivery and low birth weight infants

The magnitude of the problem of RTI/STDs is a growing public health concern in Bangladesh Data from recent studies indicate a high prevalence of 68 percent in a rural population of symptomatic women (Wasserheit, 1989), a 56 percent prevalence of RTIs was established in another rural setting among self-selected women who attended a health camp (Hussain et al , 1996), and 60 percent of women of reproductive age attending an urban clinic (Chowdhury et al , 1995) These figures are a cause for concern and highlight several outstanding issues

Among the most compelling of these issues is that men have not been the focus of research on RTI/STD prevalence The studies cited above have focused on women who are contacted through family planning or health services The need to learn more about men, in relation to RTIs, is apparent

In Bangladesh, the social impact of RTIs often affects women Women can be exposed to the risk of RTIs, particularly those which are sexually transmitted, unknowingly Infections are often left untreated due to stigma and cultural taboos associated with RTIs, lack of awareness of the risks of untreated infections, and inaccessibility of appropriate services Women who suffer from complications like infertility, miscarriage or still birth, can be socially ostracized While both men and women can be infected, it is often the man whose sexual behavior puts his partner's health at risk

Men apparently engage in behavior which puts both their partners and themselves at risk The thriving commercial sex industry in Bangladesh is an indirect indicator of the presence of high risk behavior A situation analysis of sexual behavior in Dhaka City revealed a high prevalence of risky practices among various population groups (Hashmi, 1995) Premarital and extramarital sex, as well as sex with CSWs is prevalent Most men who have sex with CSWs do not use condoms This implies that men who engage in high risk sexual practice do not

perceive their risk of contracting an STD, or else that risk is not as compelling as temporary pleasure

Cultural and social values limit the power of women to negotiate sexual behavior with their partners Therefore, providing treatment for a woman or advising her on safe sex is not sufficient to reduce her risk of exposure It is imperative that an RTI/STD control program target men educating them about their risks and responsibilities Though HIV/AIDS is not yet known to be widespread in Bangladesh, the prevalence of RTIs and identified risky sexual behavior are factors which could hasten its transmission

The Population Council in Bangladesh (PC) collaborated with the Marie Stopes Clinic Society (MSCS) on this intervention research The rationale which supports the intervention is that an effective RTI/STD control program is essential to interrupt the disease transmission cycle This interruption can be achieved most directly through the successful clinical management of the infection in both partners Partners need to receive simultaneous treatment and counseling to adopt safe sex behaviors Without the combination of clinical intervention and behavioral change, clients will be re-infected

While repeat infections have other negative consequences, by far the most important is the risk to the health of the client and his or her partner As we have stressed, those risks include permanent impairment of reproductive capacity, poor pregnancy outcomes, and mortal risks through exposure to incurable disease (HIV) For service delivery, there are also several negative consequences in terms of 1) increased health care costs, 2) negative perception of the clinical service programs, and, 3) lowering the health status of the client Positive results from clinical treatment and counseling can increase client satisfaction and play a critical role in increasing service utilization

1 2 BACKGROUND

MSCS is a non-governmental organization which provides comprehensive reproductive health care in urban settings It is affiliated with Marie Stopes International (MSI) a worldwide organization dedicated to providing reproductive health services of the highest quality to women throughout the world One of the principles of the organization is to establish services which are sustainable, though non-profit Clients are expected to pay At the same time, MSC tries to create an environment which is client-centered and attractive -- often a contrast to public services Essentially, MSC fits into a niche in most countries between the public services and private practitioners MSC effectively serves the lower economic strata of the society who are willing to pay for services but still have limited resources

In Bangladesh, MSCS has been established since 1988 It has 7 urban clinics nationwide Donor funding for the development of clinics is from DFID (formerly ODA) MSC has 2 clinics in Dhaka, both in busy commercial areas These are connected to the community through field coordinators who are responsible for marketing the clinical services among selected groups In the clinics there are services for women and men The services for women include full range

of family planning methods, ante-natal and post-natal care, MR, immunization, treatment of minor gynecological problems, and limited pathological tests MSC usually charges for service on an ability-to-pay system

In 1995, MSC incorporated RTI screening services into their women's clinic Approximately 44 percent of the women attending the clinic used the RTI services, about one third were diagnosed with an RTI on the basis of syndromic diagnosis This high prevalence led to a management decision to start services for men The stated purpose was to provide services for the male partners of infected women who were clients of MSC Initially, the management developed referral cards for partners which were given to each woman client diagnosed with an STD

The intervention research started when the first male clinic (Clinic 1) had been operating for 18 months during the afternoon hours only The male clinic in the second location (Clinic 2) [1] started in May 1996, simultaneously with the research These clinics are on main roads in densely populated areas in the midst of commercial centers and transportation centers, close to students' resident halls and garment factories Both are very easy to locate for potential clients

During the research period, MSC with encouragement from their donor DFID has altered their service focus At the start of the intervention, they were involved in MSI services for women and had just begun services for their male partners While continuing to serve this population, they have recently started services for CSWs, shifted to include serving "the poorest of the poor" who cannot pay for services, and increased their services to men Each of these shifts has taken management time and energy to re-focus

The additional client flow is a direct response of increased services for men However, MSC was yet to reach the male clients they anticipated (partners of clients with STD related complaints) Rather, most of the men who attend the male clinic have general health complaints and are not partners of the MSC women clients

MSC clinics and field work system afforded an excellent location for this research As one of the first clinical organizations to start male programs, MSC was interested in trying approaches to IEC for clients and training for their workers which had not been used in the past The management gave their own time, and the time of their service providers and field coordinators, to this program The field coordinators attended a PC developed workshop on sexual health, were the primary disseminators of the IEC leaflet developed for men, as well as the users of flipchart on sexual health At the clinic, the client record forms were developed in cooperation with the service providers IEC for clinic-based use was developed cooperatively for use by the providers

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[1] Clinic 1 The clinic situated in Elephant Road
Clinic 2 The clinic situated in Mohakhali (Rasulbag)

The clinic has been using the WHO syndromic approach for case management in addition to some laboratory testing Specific intervention was done during client consultations and counseling in the clinic setting

1 3 OBJECTIVES

The general objectives of this intervention research are

To develop a model of STD service delivery by strengthening the existing MSC service delivery system, creating demand in the target population, and, adopting various modes of partner management within a clinic-based service delivery system

Specific objectives

a To assess the gaps in the current STD service delivery system of MSC (Dhaka)

b To determine what proportion of clients attending the clinic avail of STD services and develop a profile of these clients

c To strengthen STD diagnosis, treatment, counseling, partner management and follow up for all STD clients attending MSC clinics (Dhaka)

d To ensure men, in the target population of MSC have access to information on STD related issues and services and to determine what is the source of information for clients attending the clinic for STD services

e Developing IEC material to educate men and build awareness among men on sexual health and RTI/STDs that are culturally appropriate for the community

f Developing a computer based MIS to ensure efficient program management for STD clinical service delivery

e To define and develop a feasible partner management strategy

An action research is an interaction between the beneficiaries and the providers, as accommodation of a 'flexible reaction to progressive results of the study' The interventions were always tailored according to the feedback from the beneficiaries and interactions with the target population

CHAPTER 2
METHOD AND INTERVENTION

The hypotheses of the study were based on various assumptions and results of previous studies In Lusaka, Zambia, at an urban health care center, researchers randomly allocated 302 male STD patients and 94 female STD patients to receive or not receive individual counseling combined with written information to sex partners (i e , contact slips) They aimed to determine whether or not this intervention improved partner management Men in the intervention group brought more partners from the last three months to the clinic than those in the control group (1 8 vs 1 2, $p < 0\ 001$), while women in both groups brought the same number of partners (0 7) In the intervention group, more partners of the men received treatment based on contact slips than partners of the women (1 6 vs 0 4) Overall findings show that individual counseling of men improved STD partner notification (Faxelid, et al , 1996)

2 1 HYPOTHESES

The study attempted all its intervention and data collection focusing on the following two hypotheses

1) If STD awareness among men in the general population is increased and comprehensive quality STD services are made available, men will seek care for STD related problems
2) For a proportion of male clients who visit a clinic, their visit will result in treatment of the man's partner

2 2 METHODOLOGICAL DESIGN

This study was conducted in three phases The purpose of the first phase of the study was to obtain baseline information on the Male STD services by MSC The objectives of the second and third phase were to provide interventions on the specific needs identified from the baseline, and evaluate the intervention outcome

2 2 1 Needs Assessment Phase

The objective of the first phase was to assess the current STD service delivery system through situation analysis and needs assessment of MSC male clinics and also parts of the female sources which are related to partner management The situation analysis and needs assessment of the existing STD services was conducted over a one month period The process of this assessment consisted of several steps

- A review of the existing STD service delivery in the male clinic was conducted through questionnaire and in-depth interview of the various staff engaged in service provision The services providers interviewed included managers of the two clinics, 1 male doctor, 2 female doctors, 2 male counselor, 2 female counselor, 2 nurses and 9 field coordinators

- A review of clinic records, service statistics and record keeping in the male clinic, observation of the clinic facilities (e g clinic setup, quality of care waiting time, auditory and visual privacy for examination and counseling room, client provider interaction, display of STD related IEC)

- Checklists were developed and used for these purposes Interviews with the clients focused on awareness of STDs, available services, and client satisfaction Focus group discussions were conducted with samples of the target population in order to assess the information needs for STD-related IEC Interviews were conducted at the clinics at convenient times for providers

- Partner management aspects of the female clinic were assessed through in depth interviews of the service providers, as well as clinic records and analysis of the current service statistics Questionnaire and checklists were developed and used for these purposes

- Exit client interviews were conducted for both male and female clients through an open ended questionnaire at the clinic premises A total of 11 exit client interviews were conducted selecting only those who were willing to participate The in-depth interviews with the exit clients were focused on awareness on STD, available services, quality of care (time given to them, clinic timing, waiting time, information given to them, questions asked to them, providers' behavior) and client satisfaction

- Three focus group discussions (FGD) were conducted with samples of the target population (students CSW) and field coordinators in order to assess the information needs for STD related IEC and service provision FGD with the target population was conducted at the clinic premises FGD with CSWs was conducted at a park The focus group on CSWs were conducted to understand the pattern of their male clients 'behaviour and practice

The results of the preliminary review were shared with MSC management and clinic staff On the basis of these findings necessary strategies were developed and suggested to MSC for implementation

2 2 2 Intervention Phase

In order to reduce the spread of sexually transmitted RTIs, it is essential that individuals at risk understand the modes of transmission, the signs and symptoms, and the consequences of untreated infection The study had to improve the ability of the service and information providers to better communicate with the client on the very delicate and personal matter of an individual's sexual behaviour and sexual activity

The study contained a number of interventions to improve the skills of providers for efficient and empathetic service delivery A total of six months time was allocated for interventions focused towards improved service provision The interventions were

A Developing a Management Information System (MIS)
B Developing IEC Materials
C Providing training

A Management Information System

The first intervention was the development of a workable MIS The record keeping system was developed to accomplish many purposes

- a profile of STD clients
- a method of partner records and information
- information needs of the clinical and administrative staff
- tracking the information needed by donors

The first step was developing a health record form as an entry point to an information database The health record of every patient includes kinds of complaints, previous medical history, clinical diagnosis, sexual history and partner management The following groups of items were included

- Client's personal details
- Client's presenting complaints
- Contraceptive use
- Clinical examination
- Past history of treatment
- Sexual behaviour
- Provisional diagnosis
- Lab tests and results
- Treatment
- Partner management

The draft form was then tested with the doctor in the clinic The examination part of the form was revised to minimize the time the service provider spent on completing the records The doctor can keep records by ticking the appropriate responses

Data Management and Analysis A Foxpro database program was specifically developed to record the data on each client Information on all patients visiting the clinic between September, 1996 until March 1997 was entered in the database The MIS program is now a resource for any clinic interested in clinical STD services

The client profiles were entered into the computer through the Foxpro database program Data were searched for any inconsistency and cleaning was done in the Foxpro program Data was then transferred into SPSS Analysis was done through SPSS The qualitative data were extracted and described in a narrative way

B IEC Intervention

Promotional and clinic based client oriented IEC materials were developed, field tested and finalized During the study period, the research team developed three IEC materials The general guidelines for effective patient education in STDs are respect and concern for the patient's safety, patient-centered education, opportunity to address cognitive, affective, and psychomotor learning domains, use of adult learning principles, and use of visual, auditory, and interpersonal channels of communication The process of patient education involves making an assessment, establishing priorities, identifying long- and short-term objectives, identifying barriers to learning, assessing the learning environment, and evaluating client progress The most effective evaluation techniques of patient education are those that measure actual behavioral change (Ghee, et al , 1996) Three IEC materials were developed to increase awareness and education on STD and sexual health among men

A brochure named "***Apni ki Jhukir Shammukhin?***" (Are You at Risk?) was developed and sold at two taka per copy by the FCs Another approach to selling these brochures was through small news stalls and through booksellers (those who sell pornographic magazines) It was also kept at the clinic premises free-of-cost for clients to pick up

Two other flip-charts on sexual health and clinical management of STDs named "***Jauno Shasthya Ebong Aamra'*** (Sexual Health and Us) and "***Jauno Bahito Rog***" (Sexually Transmitted Diseases) were also developed, field tested and used in the field situation Staff (FCs, Counselor, etc) were given specific training on IEC and counseling

Staff were given orientation on STDs and the purpose of this intervention Specific training of relevant staff was also conducted on client interaction, record keeping and clinical procedures for diagnosis and management of STDs

A Case on Need for Information by Adolescents

A 18 year old garment worker lives with his other friends in a bachelor mess around a market place, works 8-12 hours every day He heard about MSC clinic from a field coordinator and knows that the clinic deals with sexually transmitted disease *'Jouno rog'* He came to the clinic with the problems of nocturnal emission and weakness (*Shopnodosh, ebong durbalata*) Previously his nocturnal emission occurred only with certain dreams But now-a-days it happens without seeing/dreaming anything and also in the daytime It occurs 4 5 times a week, whereas previously it only occurred at 7-10 days interval

The client thought nocturnal emission was a disease or weakness This perception he gathered from a *'Kabiraj'*, who gave him medicine and said that this problem will go away But his condition did not improve The provider then asked the client, if he had any bad habit (*Kono kharap obbhash ache)?* (implying elicit exposure history) The client informed that he had no history of exposure The provider complemented him as a 'Good boy' and explained to him that nocturnal emission is not a disease

The provider examined and did not find any discharge or ulcer on the penis He gave him some multi-vitamin for weakness The client was not convinced with the advice as he commented, *'Let's see what happens' (Dekhi ki hoy)*

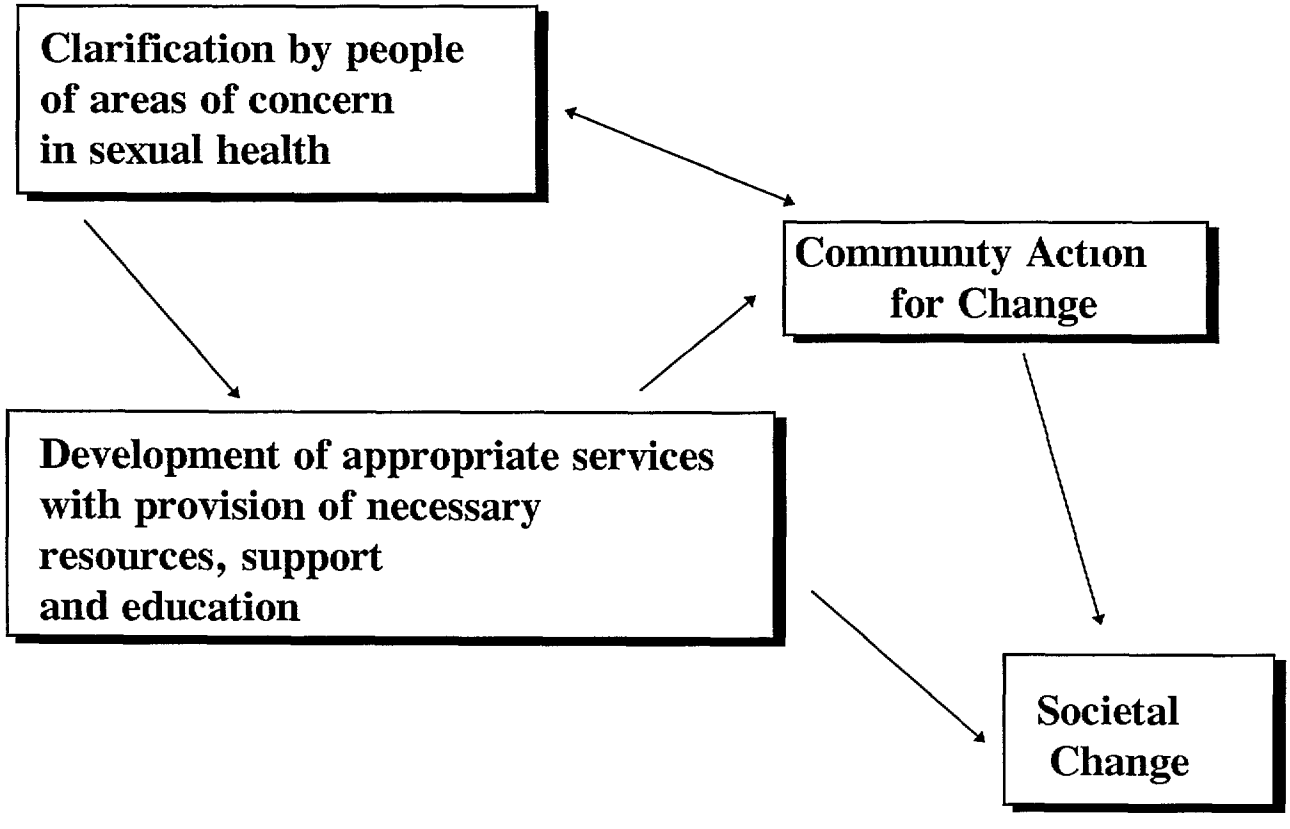
The flipcharts were developed as an aid to the FCs and the counselors to initiate a discussion with their target population's sexual health concerns, problems, information and management of STIs/RTIs It was recommended to keep the audience small and the same age if the aid was used in a group A day long training was arranged for the service providers for the administration of the flipchart

C Training

Prior to training on IEC the research team conducted a 5 day long workshop entitled **Understanding and Communication on Sexual Health** as a first step towards skill development of the service providers The broad areas covered in this workshop were concepts and components of sexual health, factors affecting sexual health, common sexual health problems, communication on sexual health issues Selection of the topics was based on the needs identified during the baseline review During the workshop in addition to providing the participants with theoretical background on sexual health, PC focused on the practical problems observed in the field The curriculum of the training/workshop is given in Appendix 1

We also found that the community had questions and concerns on sexual health and hence there was a great need for a proper IEC The conceptual model for the training can be described by the following flowchart

Flowchart



The training was a new experience for PC as well as MSC A review on the basic knowledge of the service providers of the male STD intervention was conducted The most important information revealed from this review was, (1) that staff, especially the field staff and the male counselors, needed clearer understanding of sexuality, sexual and reproductive health issues, and sexual and reproductive health problems of their working community, (2) they also needed to overcome their shyness/ personal/ attitudinal barriers, and, (3) they needed to improve their communications skills in order to sensitize men about STDs and the consequences of these

The expectations of the participants were synthesized and compiled under the topics of knowledge, communications, and skills The synthesis of the participants' expectations is given in Appendix 2

2 2 3 Evaluation Phase

At the end of the second phase the components of the intervention process--MIS, training IEC, field activities, and STD management and treatment-- were evaluated and the outcome compiled and analyzed The evaluation process was done like the initial assessment phase The changes were measured and compared Based on the evaluation, specific recommendations were made to the MSC to refine the male STD services with particular emphasis on partner management This process took one month

2 3 LIMITATIONS OF THE STUDY

This is not a generalizable data set The data of this study represent all urban male clients those who came to the clinic for services over the 9 month period

The study had number of limitations Although the IEC materials were the first ever developed in the country in Bangla, use of this in the field by some of the FCs and one counselor was minimal The time was very short to see the effects of IEC activities

It was very difficult to see what effect the partner management strategies had because few partners come to the clinic and many of the partners are asymptomatic

CHAPTER 3
BASELINE STUDY AND CLIENT PROFILE

3 1 INTRODUCTION

The objective of the first phase was to assess the pre-intervention STD service delivery system of MSC These findings are based on observations, as well as service provider and exit client interviews and focus group discussions

3 1 1 Field-Based Marketing and IEC Activities

MSC has a cadre of field coordinators working with different target populations in different parts of Dhaka city (i e garments workers, slum dwellers, shopkeepers in the market area, transport workers, pharmacists, male mess dwellers, vendors, students, pimps and CSWs) The primary target population is the urban poor The field coordinators visit their designated target populations and distributing advertising leaflets with a short introduction to the clinic, services available and price list They also hang banners in front of the garment factories and give incentives to the potential referrers (e g coaster, wall clock, bearing the MSC logo) These activities are designed to increase the client flow of the clinic

The field coordinators did not have any specialized training to do this marketing in the field of STDs They found it difficult to communicate with the people Lack of proper terminology, knowledge and skill development resulted in reproductive health, sexual health, or *bektigoto* (personal) health dimension used interchangeably This created confusion in the community There was also confusion between *bektigoto rog* (personal disease) and *jouno rog* (sexually transmitted disease) The field coordinators had little opportunity to work with special groups in public settings because of gender segregation and age division Thus they limit their information to public relations for the clinic services In the factory setting, time constraints do not allow any in-depth discussion The FCs have to hurry through their information Consequently before a discussion on reproductive health preconditioning of target population is minimal Instead they are obliged to do a direct and disease-focused discussion

IEC For the male clinic the available printed IEC material is the general advertising brochure There is also a price list of services The field coordinators remarked on the lack of proper IEC materials They have to depend on their personal knowledge and communication skills The expressed need for training on STD among the field coordinators was remarkable The field coordinators need better understanding and information on the signs, symptoms, complications and treatment procedures of STDs Even though they might know the name of the diseases, they have no in-depth knowledge Moreover they need communication skills

MSCS is a foreign funded local NGO However, there was a tendency among the field staff to market it as a foreign organization which can create a different expectation (i e foreign doctor, foreign medicine) in the client population

3 1 2 Clinical Services

Location Both the clinics are well located They are situated on main roads and are very easy to find At the entrance, the sign board for the female clinic is well displayed However services for men are not significantly displayed Neither the waiting room, the reception nor counselor's room have identification Clients go to the manager first to ask for directions, as she is the only person who can be seen

Clinic Hours Male clinics were kept open for three hours every day at a specified time in Clinic 1 and Clinic 2 In Clinic 1, the male clinic opening hours were from 14 30 hrs to 17 30 hrs while the female clinic remained open from 8 30 hrs to 21 00 hrs In Clinic 2 the male clinic was open from 18 00 hrs to 21 00 hrs against the female clinic 14 30 hrs till 21 00 hrs The timing of the clinic was not suitable or sufficient to the shopkeepers as well as to the general population

Waiting Area The waiting room for men is comfortable and is adequately furnished No IEC materials were displayed in the men's waiting area Even the doctor's room was not decorated with any kind of IEC materials especially on STD/sexual health

In female clinics the waiting area is adequately furnished but during peak hours it cannot accommodate all the clients, especially in Clinic 1 The waiting area for females (Clinic 1) is well decorated with various types of IEC material including a TV and a VCP IEC focuses mainly on FP and PHC issues The female waiting area has properly placed toilet and drinking water facilities for the clients

Counseling Area The counseling area for male clients is located just outside the doctor's consultation room There was minimal auditory and visual privacy Sometimes more than one client was found waiting in this place, especially in Clinic 1 It was difficult for the counselor to do any kind of personalized counseling in such a setup In female clinics there is a separate area for counseling but auditory and visual privacy was not maintained

Consultation Room The consultation room is well placed It has all the necessary equipment and good visual privacy However auditory privacy is not possible In both male clinics, clients waiting in front of the counselor can overhear the conversation between the doctor and clients

Service Delivery Clients come to the male clinic either by referral or on their own On entering they are registered by the male counselor who fills in the current registration cum health form He asks about the purpose of visit, personal details and obtains information on present complaint as well as sexual history As there is no mechanism for providing this

information to the doctor, clients have to repeat the history Detailed medical, sexual history, high risk behavior and examination is performed by the doctor There is a gap in information exchange regarding a client between the doctor and the counselor before and after consultation

In the male clinics, staff actively discourage general patients from coming This was done in the field as well as in the clinics by informing clients that this clinic serves clients with gonorrhea/syphilis This may have a negative impact on the clients and stigmatize the clinic at this early stage of its development People may not come because they may fear being branded as STD patients

The female clinic has a wider constellation of services Though the clinic is predominantly a reproductive health care clinic, general health and child health services are also provided

Counseling In the male clinic the counselor did a minimum of counseling for RTI/STD clients The counselor does the job of a receptionist with very limited time for counseling Similarly a gap also existed for post-diagnostic counseling As a result counseling could not be tailored according to the need of the clients Counselors did not use any kind of IEC materials There was no flip-chart, brochure, and demonstration of condom In the female clinic the scenario was the same

Number of Providers The male clinic runs with only two providers the male doctor and the counselor There was only one male doctor working in both the clinics In clinic 2, a counselor is not yet appointed The doctor himself does all the work of a counselor temporarily As the client load was low, this arrangement worked satisfactorily During the baseline survey, the two clinics had five male field coordinators, a female field coordinator and the two counselors also work as field coordinators part-time

In the female clinic of clinic 2 in each shift there was one medical officer, two nurses, one counselor and one receptionist (only morning) The female medical officer had to provide out patient services as well as work in the operation theater (OT) During the observation period, the doctor had to move back and forth between the OT and consultation room This not only prolonged waiting time but also reduced time provided to each client For clients with RTI/STDs considerable time is required to condition the clients to elicit history and explain her case It interferes with proper case management if the provider is pulled in too many ways Providers feel that there should one person exclusively assigned for counseling

Service Statistics· Within the eight and half months, since inception till before the initiation of the project (October 15, 1995 until June 1996), the male clinic had 633 clients in total Out of them 79 came for STD services, 112 clients came for services related to psycho-sexual disorder, and the rest were general and other clients

Technical Competence of Providers

Male Clinic The medical officer is well trained in genito-urinary medicine The clinic is attended by a large number of male clients with psycho-sexual problems As this is a new area for the providers, they are not trained on this issue During the observation process gaps were noted in eliciting clinical history pertaining to sexual problems However, obtaining this information is most difficult and needs skillful communication with the client

Female Clinic The female clinicians are technically very competent They are very thorough in their history taking and client examination within the given time limit However clinicians skills varied on syndromic diagnosis There is no mechanism through which clinicians can share information or consult on a particular case (within female clinic and between female and male clinic) The clinicians felt that for the RTI clients they are unable to do risk assessment or counseling on risk behavior adequately due to time constraints In addition they feel they do not have the necessary skills on counseling or communicating on issues relating to sexuality and sexual behavior

Clinical Diagnosis The diagnosis is based on syndromic management guideline (WHO) Laboratory testing is only used for syphilis screening The current practice to screen syphilis through an RPR test is not adequate A RPR reactive client needs a TPHA test for confirmation Only a qualitative method of RPR or VDRL is not ideal, a two year follow up of a reactive client is necessary This is not maintained in the clinic The interpretation of VDRL/ RPR test needs reviewing and advising the client for quantitative follow-up tests up to two years to see treatment compliance and occurrence of re-infection

Need for Understanding Laboratory Results - A Case Study

A 23 year old man came with the complaint of syphilis He was VDRL reactive and TPHA test positive He had a history of sexual exposure with a housewife 3 4 times He had no ulcer or discharge from his penis but had burning sensation and frequent micturation His disease was diagnosed by an MBBS physician, was treated by benzathine penicillin *(12 lacs injection)* everyday for 10 days He also received two injections from another clinic and got cured

Recently he found out that his blood is VDRL positive Now he wants to make the test result negative because he has given one hundred thousand taka for an overseas job If he goes there being positive for syphilis he will be sent back to Bangladesh and he is going to lose at least two hundred thousand taka Nobody told the client that his VDRL test will always remain positive even after he is cured The client's reaction, after learning this was, *'Only Allah can cure me'*

Laboratory Test The laboratory of MSC is developed solely according to their need Some of the general precautions to be maintained in the clinic are absent in the laboratory (especially in Clinic 2)

3 1 3 Client and Clinic Interaction

CLINIC

As the client load was small, the doctor felt he has ample time to spend with each patient Within the existing clinic hours a maximum number of 10 clients can be seen properly Little conditioning was done prior taking the sexual history and examination Sometimes, the provider was not comfortable in eliciting history related to sexual behavior (e g asking questions like, "*Do you have any bad habits?*" can give different connotations to different clients) Often the history is incomplete and not sequential He also gives little information to the client about his disease

Counseling was not tailored to meet the needs of the clients During the interaction clients opinion was seldom sought and very few questions were invited from the clients The process of partner management and behavioral change (condom use) was not stressed enough and there was minimum consistency in providing information

PARTNER MANAGEMENT

At present medications are prescribed for both the partners and referral cards are given to the clients There were mixed reactions regarding the referral card Some clinicians feel that if clinicians explain the card properly and if couple counseling could be done, partner referral may be successful MSC has been providing registration cards to the clients For the client, a blue card (size 6'' and 4 5'') was used, a white card same size for the partner, a pink card same size for a garment worker, a light blue size 3 5" and 2 5" for a CSW and a white card same size for referral However, the staff felt the color and size of the card was not a problem

Male clients are not keen to send their partners to the female clinic No information is kept as to how many referral cards are given and how many of them returned In this regard there is little linkage between the male and female clinic Staff felt that male clinic hours should be the same as that of the female clinic This will probably enhance better linkage

The clinicians tend to leave the issue of partner management and referral until the very end of the consultation process Sometimes it is left to the nurse to give the card to the client, which was often done with minimum counseling

SERVICE CHARGE

Consultation and lab charges are low It is well accepted by the clients and within the financial reach of the poor strata of the society

CONSTELLATION OF SERVICES

Being a male reproductive health clinic rather than a mere STD clinic, clients may present different complaints while coming for reproductive health matters The FCs and all other providers are advertising the clinic as a STD clinic and have been screening clients in the

field However, it was found that clients may not present their sexual complaint at the first instance

SUPERVISION AND MONITORING

The clinic manager is responsible for day to day supervision of the clinic activities The marketing supervisors supervise the field activities of FCs The central office supervises and monitors through field visits and service statistics Client satisfaction is supposed to be assessed through exit client interview checklist (during the observation process it was not in use) However there is no mechanism yet in place for directly monitoring the clinical service and performance of the clinicians

RECORD KEEPING

The current record keeping system of MSC was prepared on an *adhoc* basis It has very few options for recording client profile, their health seeking patterns, disease profile, partner management, sexual behavior and prognosis Detailed RTI screening information is obtained during the first visit but for subsequent visits no mechanism is available for keeping detailed reproductive health information for either male or female clients

MALE CLIENTS' PERCEPTION

According to the male clients the doctor is very friendly with them Clients are normally satisfied with the nice clean environment of the clinic They have never experienced doctors giving so much time to the patients to understand their problems, taking time to listen to the patients Also they are quite happy with the time given to them by the doctor and the counselor which is rare in other clinics or doctors' chambers (this may be due to the light client flow) They have made satisfactory remarks about the warm and friendly behaviour and patient hearing As people find the services of MSC much better than any other clinic they are quite dumb-founded when asked for any suggestion to improve the services

A Case of a Satisfied Client

He was aged 30, came from Tejgaon truck terminal He heard about MSC from a group discussion that was done by the staff He had symptoms of STD and gave a history of repeated penicillin shots

During exit interview the client appreciated the MSC environment, the behavior of the provider and the counselor waiting area and services charges He was happy that the provider asked him everything about the disease and examined in details, and gave him enough time for conversation This was the first time he saw a condom, learned how and why to use it Previously, he never used a condom during intercourse although he had history of multiple exposure He was a satisfied client He thought that truck drivers are people who cannot go home whenever the wish and need to have sex when they have an opportunity As a result, they are always exposed to STDs Regarding the charges at MSC, he said that "They are taking only 20 taka for VDRL test whereas elsewhere it is 150 taka" He felt that, regular group discussion on STD would be effective

However, client satisfaction about the service delivery varies Some complained of long waiting time, perception of the doctors as paramedics and unsatisfactory clinical service provision The short clinic timing (three hours per day in each clinic) is very limited for the clients to find time to visit the doctor Especially, the timing of Clinic 1 (from 2 30 to 5 30 p m) is not convenient for the male clients Either it has to be before or after the working hours of the male clients, which is normally 9 00 a m to 5 00 p m

A couple of clients were unhappy as their chief complaint was weakness and powerlessness and the doctor just said that the illness is mainly psycho-sexual Improved counseling and client hearing is needed to cater to this group of people A number of clients were not able to tell their exposure history as probing is limited They normally wait for the doctor or the counselor to somehow understand their problems as talking about sexual inadequacy is quite difficult Clients are quite keen to know about the reasons and remedies for sexual diseases or problems Those who have ever been affected, or suspect they have sexual inadequacy, are very eager to know about remedial services

REFERRAL AND FOLLOW-UP

The clinic is referring to outside facilities, laboratory and consultation services are given referral in complicated cases Compliance is entirely client dependent The clinic does not have any mechanism to collect the feedback from the referral sites Though referral is suggested to the client it is the choice of the provider, as there is no policy on referral sites from MSC

The clinic has provision for encouraging follow up clients by making the follow up consultation free and mentioning the follow up visits date Time limit for follow up visit is not always mentioned to the client It is encouraging to note that most of the clients referred for laboratory test do come back for follow-up However, there is no follow up system for RPR/VDRL positive cases

3 2 FINDINGS

3 2 1 Client Profile

Before going into the findings and analysis, two sets of operational definitions are required The clients are divided into three categories according to the services they have come for and the way they are diagnosed

Operational Definitions

Type of Client

a) STD clients	Those who have come for STD screening and consultation with a combination of other services, which could be pathology, general health

b) Other sexual health clients — Those who have come with complaints concerning sexual health but do not think they have any STDs This category of clients could also come for other services

c) Other clients — Those who have come for any other services other than sexual health (i e general health, contraception, immunization, pathology)

Type of Conditions

a) STD related conditions — Clients diagnosed as having signs and symptoms of STDs, some even after pathological tests

b) Psycho sexual health — Clients diagnoses as having no sexual diseases but having some psychological or physiological phenomenon which makes them feel sexually disordered

c) Other diagnosis — Clients diagnosed with any other diseases

Table 1

Types of Clients and Services during the Study Period

Clinic	STD clients	Other sexual health	Other clients	Total
Services including follow-up				
Elephant Road	116	195	631	942
Mohakhali	97	249	571	917
Total	**213**	**444**	**1202**	**1859**
Services excluding follow-up[a]				
Elephant Road	91	190	569	850
Mohakhali	76	242	521	839
Total	**167**	**432**	**1090**	**1689**
Number of clients				
Elephant Road	83	179	451	713
Mohakhali	73	235	446	754
Total	**156**	**414**	**897**	**1467**

[a] Includes repeat visits of clients for new services

The above table (Table 1), presents the number of clients coming to the clinics during the study period, (July 1996 to March 1997) This table is the reference point for all other figures that will be shown in this presentation to identify the difference between the clients, services provided and the number of visits

Out of the total 1467 clients, 11 percent were STD clients, 28 percent were 'other sexual health' clients and 61 percent were other clients Both the clinics had almost identical distributions of client flow

Age distribution

The age distribution of clients is based on the actual number of clients who visited the clinics within the nine month period

The proportion of clients who had STD diagnosis is highest for age group 25-29 Out of the total STD related diagnosis about one third came from this age group (32 1 per cent) The second highest STD services was provided to the age group of 20-24 years (24 percent of the total STD diagnosis) One other important observation is that, among the 'Psycho-sexual disorder' category, the age group of 20-29 was highest (66 percent)

Table 2

Age Distribution of Clients by Diagnostic Group

Age Groups	STD related conditions %	Psycho-sexual disorder %	Other Diagnoses %	**Total**	
				%	N
Less than 13	0 0	0 0	1 1	0 7	11
13-19	17 1	9 8	16 1	14 6	214
20-24	23 3	32 1	26 7	27 9	410
25-29	32 1	33 7	25 5	28 6	420
30-34	11 2	14 4	11 8	12 2	179
35-44	9 2	5 7	10 4	8 9	130
45-54	5 4	0 5	3 5	3 1	45
55 and over	0 0	0 5	2 6	1 6	23
Not stated	1 7	3 3	2 2	2 4	35
Total	100% N=240	100% N=368	100% N=815	100 %	1,467

❖ *Of 1,467 clients, diagnosis was missing for 44 clients*

It is important to note that Table 2 refers to diagnostic group after the first consultation There were 240 STD-related conditions among the clients, compared with 156 new clients who had come for consultation about STDs (Table 1, third panel) By inference, a substantial proportion of clients diagnosed with STD-related conditions had come seeking treatment for other conditions

This finding implies that, an STD service provision should be accompanied with general and other sexual health services We will refer to this important observation subsequently However, our findings agree with the results of a report of WHO, that says, the highest

rates for notifiable STDs are usually seen in the 20 to 24 year old group, followed by the 15-19 and 25-29 year olds The overall morbidity rate of STDs is higher for men The report emphasizes that prevention and control of STDs in youth should be done within a positive sex educational framework (WHO, 1989)

Education

The outstanding feature of Table 3 is the generally high education level of the clients (22 4 percent clients are with higher secondary education or above) There is a higher proportion of STD diagnosis among those with no education (24 4 %), while those with secondary or higher secondary education have a larger proportion with psycho-sexual disorder

Table 3

Level of Education by Types of Clients

Education	STD related conditions %	Psycho-sexual disorder %	Others %	Total	
				%	N
No Schooling	17 0	6 2	12 3	11 4	168
Primary	25 0	19 8	25 9	23 8	350
Secondary	43 0	47 3	39 1	42 3	620
Higher Secondary	9 2	15 8	11 3	12 1	177
Graduate and Above	5 8	10 9	11 4	10 4	152
Total	100% N=240	100% N=368	100% N=815	100 %	1,467

❖ *Of 1,467 clients, diagnosis was missing for 44 clients*

The proportion of diagnosed STD cases are higher among the education category of no schooling, the second highest proportion of diagnosed STD cases are among the secondary and primary education groups

Occupation

This selected dataset refers only to those men who have come to a clinic seeking health care provision and client flow is dependent on the focus of advertisement and marketing of such services in selective population

The highest proportions of STD diagnoses come from the service (28 percent), garment worker (25 percent) and business (15 percent) categories However, the highest incidence of STD related conditions were diagnosed amongst the occupation category of transport workers (28 percent) When considering STD intervention, the program should be very careful about branding types and natures of professions as high risk population STD/HIV service provision tends to categorize high risk population in some occupational categories Risk factor in sexual health is an individual behavioral aspect which could not be generalizable according to the social, cultural or economic status of a person

Table 4 Occupation by Types of Clients					
Occupation	STD related conditions	Psycho-sexual disorder	Others	Total	
	%	%	%	%	N
Service	28 0	17 4	20 7	21 0	307
Garment Worker	24 7	37 2	35 8	34 1	500
Business	14 6	10 9	9 1	10 4	153
Transport Worker	12 5	7 9	5 4	7 4	107
Student	4 2	11 4	9 8	9 3	136
Factory Worker	1 8	4 0	3 2	3 3	49
Shopkeeper	1 2	2 2	1 5	1 7	25
Others	13 0	9 0	14 5	12 8	187
Total	100% N=239	100% N=368	100% N=813	100 %	1,464

❖ *Of 1,464 clients, diagnoses was not found for 44 clients*

Note No occupation was recorded for 3 clients

Marital status

There are actually no significant differences between the proportions of STD related condition according to marital status in Table 5 However, those who are married and living with spouse are significantly less likely to be diagnosed as 'psycho- sexual disorder' clients

Anxiety of Sexual Performance of a Married Man

A 32 year old man, graduate, living with his wife and two children, came with complaints of, "weakness, sexual weakness, nocturnal emission Sometimes he cannot stay long enough during sexual intercourse (*Durbalata, dhatu durbalata shopnodosh hoy majhe majhe beshi khon thakte pari na)*" His wife was also concerned about his condition and asked, "what happened to you?" (*Tomar ki hoisay?)*

He had history of exposure with a CSW several times 10 years back During that time he got an ulcer on the penis and was treated by a physician He said since then one of his testes is gradually becoming small the other one is normal The atrophic process started after he got infected for the first time He is afraid, feels guilty and confused about his sexual performance On examination, the provider found him healthy

In Harare, Zimbabwe, community physicians conducted a case control study of all adult male outpatients aged 16-50 to identify social and behavioral risk factors for STDs There were 83 STD cases and 37 controls STDs were not associated with marital status, wife's place of residence, education level, or employment (Gwati, et al , 1995) Though the

socio-cultural construct of Zimbabwe may allow more multiple partnership than Bangladesh, even then the findings of this study shows that the there is no significance associated with STDs and marital status

Table 5

Marital Status of the Types of Clients

Marital status	STD related conditions	Psycho-sexual disorder	Others	Total
Married and living with spouse (%)	19 6	19 0	59 0	100 % (463)
Married and not living with spouse (%)	16 0	32 0	50 0	100 % (206)
Never Married or not stated (%)	14 5	26 8	55 0	100 % (798)
Total Number	240	368	815	1,467

❖ *Of 1,467 clients, diagnosis was not found for 44 clients*

Note There are 14 separated/divorced men who are included with the 'Never married or not stated' category It is not worthwhile showing such small numbers separately

Source of information

MSC adopted various mechanisms to disseminate the information about the existence of these clinics The strategy has been shifting through their modes of IEC from a focus on the information of the existence of the MSC clinic to increasing the knowledge level of the target population on STDs and risk factors attached to it, and the prevention, treatment and partner management aspect of STDs Table 5 shows, what kind of information sources attracted the client for various type of service provision

Table 6

Sources of Information by Types of Clients

Information Source	STD related condition %	Psycho-sexual disorder %	Other diagnoses %	**Total**	
				%	N
Field coordinator	41 7	52 7	46 7	47 4	696
Personal contact	50 8	33 1	40 6	40 3	591
Media	3 3	8 7	6 0	6 5	95
Doctor/pharmacist	3 8	5 2	6 1	5 4	79
No information	0 4	0 3	0 5	0 4	6
Total	100% N=240	100% N=368	100% N=815	100%	1,467

❖ *Of 1,467 clients, diagnoses was not found for 44 clients*

Among all clients the two main sources of information were the clinics' FCs and personal contact About half of the STD related diagnosis cases came for the first time on the basis of information about the clinic gained from personal contact, that is, friends, relatives, referrals and clients

3 2 2 Presentation of Chief Complaints

Clients coming to the clinic for service provision are normally asked about their complaints for which they have come for treatment The study has also taken into account the fact that people seeking STD related services will be hesitant to speak about their complaints In the form developed for MIS, provision was made for any client to present a combination of upto 5 complaints Table 7 shows how the different types of clients present their complaints to the clinic doctor

Table 7

Chief Complaint Versus Type of Client

Chief Complaints	STD related conditions %	Psycho-sexual disorder %	Other Diagnoses %	**Total**	
				%	N
Urinary Problem	52 5	11 5	6 2	14 6	263
Nocturnal Emission	4 0	18 4	2 0	6 7	120
Premature Ejaculation	2 2	19 0	1 4	6 2	111
Itching	3 3	0 6	6 1	5 6	101
Infertility	0 4	4 8	0 5	1 7	30
Swelling	1 8	0 4	1 1	1 0	19
Ulcer	3 3	0 0	0 5	0 9	17
Impotence	0 0	1 7	0 2	0 5	10
Urethral Discharge	0 4	0 2	0 0	0 1	2
Others	32 2	43 3	81 9	62 5	1,122
Total complaints	276	478	982	1,795	
Total no of services	256	379	996	1,689	
Mean no of complaints	1 08	1 26	0 98	1 06	

Multiple Responses

❖ *Of 1,795 complaints, 59 had no diagnoses*

Most of the STD clients presented urinary problem as their chief complaint (The rubric 'Urinary problem' refers to ***Prosrabe jalapora, Kit kit kore kamrano, Prosrabe sukar jai, Prosraber age pore dhatu jai***)

Among the 'Psycho-sexual health' clients about one out of every four client presents nocturnal emission and premature ejaculation as a problem and 6 percent nominate infertility By contrast, 36 percent of 'STD Clients' nominate urinary problem as a chief

complaint and complaints of nocturnal emission and premature ejaculation are very small in number (4 and 2) Urinary problem, nocturnal emission and premature ejaculation were the complaints most frequently nominated, comprising 15 percent, 7 percent and 6 percent of the total complaints

There are some studies which focus on men presenting psycho-sexual symptoms to the doctors Many of these sexual problems are associated with anxieties about sexuality and sexual power These psycho-sexual problems can be the majority of the patients attending on the STD clinic (Rahman, et al , 1997)

Out of the clients presenting themselves as seeking STD related services local examination was done for 90 percent clients Also for 58 percent of clients coming for 'Other sexual health' and 25 percent 'Other clients', local examination was done This affirms that substantial number of clients coming for services other than STD related services are found to be diagnosed as having STD related conditions

Need For Sex Education

A 22 year university student expressed his problems in the following way "I feel uneasy in relation to sexuality Sometimes I feel weak The size of my penis I guess is too small Semen comes out through urethra if there is constipation Sometime there is burning sensation during micturation' The provider asked him, do you have any bad habits? *(Kono kharap obbhash ache)* The client said, I use to masturbate long time ago *(Onek aage hat martam)*

He read a number of medical books but could not find out the normal size and thickness of a penis He was anxious about the size of his penis and potency He feels less sexual excitation compared to 4-5 years back and experienced premature ejaculation Several times he tried to have sex with CSWs but every time he failed to penetrate Recently he got a girl friend When he meets with his girl friend he becomes excited and experiences something coming out through the urethra

He could not share this experience with anybody He wanted to come to the clinic several times for advice but did not have enough will power before that day He refused a local examination and was desperate to have some kind of biomedical investigation By probing him and through local examination, the provider assured him that he has normal virility

Table 8

Local Examination

Local Examination	STD clients %	Other sexual health %	Other clients %	Total Number
Ulcer	8 6	1 2	2 2	22
Urethral discharge	42 4	0 0	0 0	64
Morning gleet	31 8	0 0	0 0	48
Scrotum swelling	0 0	1 2	2 9	11
Local examination done[a]				
- number	151	250	274	675
- percent of clients	90%	58%	25%	40%
	N=167	N=432	N=1,090	N=1,467

❖ *Diagnoses was not found for 44 clients*

Though 64 clients were found to have urethral discharge under local examination, only one of them had mentioned urethral discharge as a complaint This could mean that the concept of discharge as a complaint is not in the common perception of the clients or else most of the discharge complaints are camouflaged as nocturnal emission or premature ejaculation

Treatment History

Many, before they came in for treatment had already sought treatment somewhere else About 36 percent of the total STD clients came to the clinic after receiving treatment from elsewhere, 22 percent of the 'Other sexual health' clients and 28 percent of 'Other clients' received other treatment before coming to MSC

Table 9

Previous Treatment History

Treatment History		STD related conditions %	Psycho-sexual disorder %	Other diagnoses %	**Total** %	**Total** N
Treatment received for present problem?	Yes	35 9	22 0	28 0	27 2	460
	No	57 5	71 3	47 6	54 6	922
	No inf ♦	6 6	6 7	24 4	18 2	305
Total		100 % N=167	100 % N=432	100 % N=1,088	100 %	1,689

♦ *'No information' includes 'not applicable'*

❖ *Of 1689 clients, treatment history is missing for 2 clients*

The above table agrees with the study of Kanbargi and Kanbargi (1996), which states that, thirty percent patients visiting medical institutes for STD services had been treated at least once before for an STD The findings of this study shows a slightly higher proportion However, the data did not include what kind of treatment the clients had sought before to identify some trend of client flow pattern among urban STD patients

3 2 3 History of Exposure

Exposure histories were obtained for 1,279 client visits, or 69 percent Excluding follow-up cases, the proportion was 75 percent of client services, including patients returning for new services However, there were 458 client services where a positive exposure history was recorded Of these, 379 said they did not have exposure within the last three months

Table 10 Types Of Exposure by Clients					
Type of Exposure	STD clients %	Other sexual health %	Other clients %	**Total**	
				%	N
CSW	68 9	25 5	8 0	18 5	312
CSW, Girl Friend (both)	0 6	1 1	0 4	0 6	11
Girl Friend	3 0	10 2	4 2	5 6	95
Male	0 0	0 2	0 3	0 2	4
No Exposure	3 6	3 7	1 3	2 2	36
No Exposure Recorded	23 9	59 2	85 8	72 9	1,231
Total	100 % N=167	100 % N=432	100 % N=1090	100 %	1,689

There is slightly more specificity to exposure histories involving CSWs when the type of client is replaced with the diagnostic group This is because many STD diagnoses are for clients other than those who presented for STDs

Table 11 Types Of Exposure by Diagnostic Group					
Type of Exposure	STD related conditions %	Psycho-sexual disorder %	Other diagnoses %	**Total**	
				%	N
CSW	50 4	24 3	8 1	18 5	312
CSW, Girl Friend (both)	0 0	1 3	0 6	0 6	11
Girl Friend	5 1	11 1	3 7	5 6	95
Male	1 1	0 0	0 1	0 2	4
No Exposure	4 3	3 4	1 2	2 1	36
No Exposure Recorded	39 1	59 9	86 2	72 9	1,231
Total	100 % N=256	100 % N=379	100 % N=996	100 %	1,689

❖ *Of 1689 clients, diagnoses is missing for 58 clients*

A few studies in Bangladesh revealed that people have multiple sexual partners and most of these partners are CSWs As people do not have the information about the protective role of condom against STD, the use of condom is low (Naved, et al , 1996, Hossain, et al , 1996 and Sharma, et al , 1997, Felsenstein, et al , 1997) A study on male clients attending the outdoor of STD clinic which shows that there is evidence of practicing oral, anal and vaginal sex The partners were mainly CSWs but also friends of both sexes were described as situational and opportunistic (Khan, 1996)

Men having sex with men is not discussed Bangladesh but many studies revealed that it exists in the society The prevalence in some studies is about 5-10 percent (Sharma, et al , 1996, Hossain, et al , 1996) Research indicates that a boy's first sexual intercourse in this population was either with a prostitute or an older woman in the community The patients reported prostitutes as the main source of STD infection, followed by friends and relatives A small percentage of men reported having sex with men (Kanbargi, et al, 1996) This study shows, according to response of the clients only one percent have had sex with men Our assumption is that, this is only the tip of an iceberg

Eliciting Sexual History is Difficult

A unmarried young man, aged 21 years, with 5 years of schooling, lives in a mess with his friends He works in a factory for 8-12 hours everyday, and do not have much leisure time Most of his free time he spends with his male friends The client was interviewed at the end of a clinical consultation

He stated that "Physically I am weak, I have constipation and semen passes through penis before and after urination and defecation" (*Dhurbalata kashsa prossraber agae pore dhatu jay)* Previously he had frequent nocturnal emission but now it is not occurring any more so he felt that he has became weak The client has also visited an other MBBS doctor in his village and he has also said the same thing He had also been to a '*Kabiraj* and took a popularly advertise alternative medicine *(Bori of Sripur)* and many other medicines Inspite of several kinds of medicine he was not cured

The client informed, "The doctor asked me, if I have had sex with any woman But I have never been to any woman in my life (*Ami kono meyer kase jaini*)" The interviewer then thanked the client and said that, he could go if he does not have anything else to say or ask The client then asked, "I can't believe that my weakness is psychological One last question, could you tell me what is sexual disease *(Jouno Rog)"?* The interviewer said, why did he not ask this question to the doctor or the counselor? The client said, 'I did not feel like asking nor did they ask me if I have any questions Look, I am weak, I used to have nocturnal emission but now no more and the doctor said that this is not 'Sexual Disease', then what is sexual disease? While praying and doing my *Ozu* I feel giddy (*Namaz porle, Ozu korle, matha ghuray, hat pa tobdha hoye jay)*"

The client further said "Well, the doctor asked me if I have mixed with women, does such disease occur if any thing is done with men?" The interviewer said technically, "Yes, different diseases could occur with different kinds of sexual activities Men who have sex with men can also contract a sexual disease Have you ever used a condom, while doing such things?" He replied "No, in such a casual event it is difficult to find condom in time" The interviewer asked, "How many times have you been to other men? Are you active or passive?" The clients said, "Several times, when body become warm by rubbing and talking about sex *(Ghasha ghashi kore shorir jakhan gorom hoe jay)*, and is both active and passive"

The interviewer asked the client, "To make people understand such problems, what do you think, how should we approach?" The client replied that, "the doctor asked about going with females but nothing about men So, I did not answer I think, the provider should also ask about exposure with men" The process of being men having sex with men is eventual when friends (two males) chat together and become excited (*Shorir gorom hoye jay*), talking about sex" But the client felt guilty from having sex with men Although he was not satisfied with the treatment, but he liked the clinic environment, and attitude of the provider

Table 12 Length of time since last exposure						
Length of time	CSW %	Girl friend %	CSW & girl friend %	Other %	Total %	Total N
Last 10 days	9 3	3 2	(27 3)	(0 0)	7 9	36
11 to 90 days	21 5	11 7	(9 0)	(20 0)	17 9	82
91 days to 3 years	29 2	39 4	(27 3)	(40 0)	30 3	139
More than 3 years	14 7	21 2	(9 0)	(20 0)	16 6	76
No dates given	25 3	24 5	(27 3)	(20 0)	27 3	125
Total	100 % N=312	100 % N=94	(100 %) N=11	(100 %) N=5	100 %	458

❖ *Of 458 clients, information is missing for 36 clients*

Note The percentage in parenthesis denotes very small numbers

In order to see the relative propensity of getting an STD in association with the previous sexual exposure episode, according to the suggestion of WHO, of the 458 who had an exposure history, the distribution of the length of time since the last exposure is given in Table 12

Table 13 Length of time since last exposure by Diagnostic Groups					
Length of time	STD related conditions %	Psycho-sexual disorder %	Other diagnoses %	Total %	Total N
Last 10 days	7 7	6 6	8 8	7 9	36
11 to 90 days	26 3	11 2	15 3	17 9	82
91 days to 3 years	27 6	38 8	24 8	30 3	139
More than 3 years	16 7	17 8	16 0	16 6	76
No dates given	21 7	25 6	35 0	27 3	125
Total	100% N=156	100% N=152	100% N=137	100%	458

❖ *Of 458 clients, information is missing for 13 clients*

From Table 13, we can see that of the clients having STD related conditions, 34 percent had a history of sexual exposure other than their regular partner (implying mainly spouse) within the last 90 days Various loopholes of this finding are 1) the data were based on the clients response who, due to socio-cultural taboo could hide information, 2) clients might not have been conditioned to be honest about their sexual history and its relevance to the diagnosis, treatment and counseling, and 3) sexual exposure to regular partner (i e wife) was never added to the information Both the client and the provider tend to think that

infection exposure (that has to be confessed) is always with someone other a regular partner

Use of condoms was not very extensive for clients with any type of exposure history Only 6 percent of the total clients (458) who gave a history of exposure, are using condoms

Only four clients were able to answer a question on whether their partners had signs of STDs, and all of these said 'No' The most common answer was that the client said he did not know

There was information about clients' histories of drug abuse and addiction Sixteen clients indicated they did have such exposure

3 2 4 Partner Management

Whether partner management is required or not is not defined unambiguously in the data set We have taken all cases where the client is currently married and living with his spouse, or the partner's registration number is recorded, or partner management information is actually recorded in the data We excluded cases where the confirmed diagnosis was a psycho-sexual disorder, scabies or other non-STD condition, and where partner management was described as not applicable There were 124 cases where partner management was indicated These cases were handled as shown in Table 14

Table 14

Partner Management

Partner management	STD related conditions %	Psycho sexual disorder %	Others %	**Total**	
				%	N
Treatment and Referral	15 3	(15 4)	(15 8)	16 1	20
Referral Only	12 9	(69 2)	(31 6)	21 8	27
Treatment Only	23 5	(15 4)	(42 1)	25 0	31
Refused to Treat	1 2	(0 0)	(0 0)	0 8	1
No information	47 0	(0 0)	(10 5)	36 3	45
Total	100% N=85	(100%) N=13	(100%) N=19	100%	124

❖ *Of 124 clients, information is missing for 7 clients*

Notice that a large proportion of these cases came from among the clients who had come to the clinic for non-STD services This reinforces what was said earlier (pg 19) about the need for inclusiveness in the services offered by the clinics

3 2 5 Counseling Profile

Counseling is one of the major features of the services given to clients of the clinics, especially STD clients (65 percent) received counseling, and psycho-sexual disorder (60 percent), but a considerable number of other clients (44 percent) also received counseling

Table 15

Counseling Profile

Counseling given	STD related conditions %	Psycho-sexual health %	Other diagnoses %	**Total**	
				%	N
No	35 1	39 6	55 9	48 2	814
Yes	64 8	60 4	44 0	51 8	875
Total	100% N=256	100% N=379	100% N=996	100%	1,689

❖ *Of 1,689 clients, information is missing for 58 clients*

3 2 6 Impact of the Study

Over time, an increasing proportion of clients presenting for services have identified themselves as STD clients The proportion almost doubled between August-September 1996 and January-March 1997

Table 16

Types of Clients in Quarterly Distribution

Period	STD clients	Other sexual health	Other clients	**Total**
July to September	18	65	173	256
%	7 0	25 4	67 6	100 0
October to December	65	238	484	787
%	8 3	30 2	61 5	100 0
January to March	84	129	433	646
%	13 0	20 0	67 0	100 0

Much the same pattern is seen in the following table showing confirmed diagnoses But note that diagnoses of STD-related conditions are at a higher level than in the previous table, consistent with the earlier finding that many STD diagnoses come from clients other than STD clients

Table 17 Diagnostic Groups in Quarterly Distribution				
Period	STD-related condition	Psycho sexual disorder	Other diagnosis	**Total**
July to September	33	56	161	250
%	13 2	22 4	64 4	100 0
October to December	105	202	459	766
%	13 7	26 4	59 9	100 0
January to March	118	121	376	615
%	19 2	19 7	61 1	100 0

There has been very little change over time in the sources of information obtained by new clients about the clinics The change in the total number of clients between Table 16 and Table 17 is because, Table 17 is the distribution of clients according to diagnostic groups, and 58 clients were not found to have any diagnosis Some never came back to get their pathological results so their confirmed diagnosis was never recorded

The two main sources of information are the clinics' FC and personal contact between clients The increase in the 'other' category in the December quarter, and subsequent decrease, was mainly due to media sources The clinics are advertised in print and electronic media and on billboards

Table 18 Sources of Information in Quarterly Distribution				
Period	Field coordinator	Personal contact	Other	**Total**
July to September	114	99	22	235
%	48 5	42 1	9 4	100 0
October to December	324	263	113	700
%	46 3	37 6	16 1	100 0
January to March	258	229	39	526
%	49 0	43 5	7 4	100 0

Note. *There is no information for 6 new clients*

Of 256 confirmed diagnoses of STD-related conditions, 7 cases were clients who had previously had a similar diagnosis from the same clinic, representing identifiable re-infection While a longer time frame might eventually identify a larger proportion of cases

as re-infections, the proportion can only be regarded as a lower bound for the prevalence of repeat infection This is because the re-infected former client might medicate himself, now that he knows what treatment is indicated, or he might go to another service provider

CHAPTER 4
EPILOGUE

4 1 DISCUSSION AND CONCLUSION

MIS With this action research we obtained both some qualitative and quantitative information MSC will continue to track the quantitative impact of the study with the computer based MIS program

Development of the MIS is a major achievement of the research intervention This is the first computer based system for record keeping, measuring performance, quality of care, and obtaining a client profile for any health care service system The MIS is manually systematized so that information for a single client can be recorded from his/her event of entry to the clinic until the exit

However, the key to a good MIS is dependent on providers and those who will be entering the data both on the form and in the computer As obtaining information about sexuality and sexual behaviour demands privacy and an interactive environment, the openness and psychological construct of the interviewer needs to be supportive to the client While using such a technology the accuracy will also depend upon frequent auditing and monitoring by the program managers

IEC and Training Talking about sexuality is difficult both for service providers and clients Communication barriers are common and can effect quality service Thus the need for IEC materials, to support effective communication, was always mentioned by the providers since the beginning of the study

A major accomplishment of the intervention was the development of the three IEC materials which were the first of the kind in Bangladesh on sexual health It was extremely difficult to develop materials versatile enough to reach the diverse population of the MSC urban clinics However,

Communication Difficulties in Sexual Health Services

A 22 year old working adult, lives in a mess in a slum area, newly married for 3 months, heard about the clinic from a field coordinator He came with the complaints of burning sensation during micturation, frequency of micturation, weakness, continuous fever for 15-20 days and sour taste in the mouth (*Prossraber shomoy jala pora bare bare prossrab hoy dhurbalata onek din dhore jor, mukhe tita lage*) There was no pus through the penis before or after micturation He felt unable to walk because he had vertigo

The provider examined and diagnosed him as a case of urethritis He took some medicine (tablets) from the pharmacy for fever The provider then asked the client whether he is living with his wife? (*Apni ki bower shathe thaken)* The clients said, yes (*Haa*) But actually his wife lives in the village He visited his wife at only 2-3 month intervals The provider asked the client "Do you have any bad habits" *(Kono Kharap obbhash ache)* The client asked, 'Did you mean cigarette smoking?' (*Apni ki cigarette khaowar kotha bolchen*) Then the provider asked, "Do you go to any other bad places" *(Onno kono kharap jaygay jao)* The client says 'no' (*Na*) Actually the provider wanted to elicit multiple sexual history but had difficulty framing his questions

one has to keep in mind that any IEC materials is just a means to enhance communication An IEC material by itself will not change human behaviour

Use of a single IEC material with the client or community will vary from client-to-client community-to-community Effective use of IEC depends on the kind of people who are using it (i e FCs, counselors, doctors) Better communication also demands continuous refinement and a constant process of creativity It is also an interactive process between the service provider and the field or target population Correct and effective use demands much effort by the program personnel

Training was a vehicle for education for the providers Training on sexual health created an opportunity to talk and discuss things which were previously taboo to many Without such a vehicle, implementation of IEC and appropriate use of MIS would be almost impossible Training, also needs to take care of the working experience of the service providers at their own situation to deal with issues related to dealings with clients in the field and clinic setup The curriculum for training was developed based on the expectation and expressed need of the participants The curriculum for training is given in Appendix 1 To conduct such a training we required expert trainers, medical doctors, psychologist, sociologist and communication personnel Though all staff worked in the same organization, it was interesting to observe how their perception and level of knowledge varied

Findings The study revealed that, health care service provision for STDs needs personal contact The field coordinators were the primary information providers To develop awareness and education on sexual health (for men) one-to-one communication is necessary

Attention on STD services has often focused on transportation workers as it was presumed their mobility made them particularly susceptible to risky sexual behaviour and multiple partners It is revealing that a biased intervention focused primarily on garment worker and truck drivers may, in fact, mislead the whole intention of STD service provision Our study findings show that, the highest number (28 percent) of STD clients are coming from the occupation category of "service" Any STD intervention should not categorize high risk group according to their occupational category, age, education or even marital status

The findings show that when clients are divided by marital status (married living with spouse, 32%, married and not living with spouse, 14% and never married and not stated, 54%,) about 20 percent of those who are married and living with spouse are diagnosed as STD This was the highest proportion amongst the three categories However, there is no significant difference This finding raises question, if this category of clients are more prone to having STDs or multiple sex partners?

One reason for the raise of proportion of STD clients among the married and living with spouse category could be, married women from the female MSC clinic are advised to do

partner management if there are signs and symptoms of STDs That could lead married people living with spouse to come to the male clinic for STD service and thereby increased the proportion of STD clients by inference The aggressive partner management strategy of the MSC could also be another reason for this increase

Psycho-sexual Issues An important aspect of any STD focused intervention for men needs to take into consideration complaints of psycho-sexual nature The fact that 66 percent of the clients within the age of 20 - 29 are coming for problems related to psycho-sexual disorder must be addressed If service for such category of clients could not be incorporated then an effective network needs to be built for appropriate information and counseling for psycho-sexual clients Otherwise, these clients will eventually end up in the hands of quacks and inappropriate health service, they may get the wrong information and perception about problems related to their sexual health This will have adverse effect on the much vaunted effort of programs trying to build awareness and education

A Case of Sexual Performance Anxiety

A 35 year old, educated, married man working in a private firm came to the clinic with the complaints of sexual weakness, thin semen *(Dhatu patla)* starch like discharge from the penis *(Bhater Mar)*, change in shape of the penis *(Linger aga mota gora chicon hoy jacche)*, burning sensation in the urethra *(Linge jala pora)*, inability to sustain erection more than one minute during sexual intercourse *(Ek miniter beshi thakte pari na ebong linga beshikhon dhorey thake na)* premature ejaculation *(Dhukanor aagei mal ber hay jay)*" All of these feelings developed more than 3 years ago

The provider tried to assure the client that these are not diseases But the client was not convinced by the provider's assurance He said that he went to various kinds of physicians, kabiraj, spiritual healers and took lots of tablets and capsules He also had his semen analyzed but found no problem Some of the specialists gave him hormone injection and told him to use local spray on the genitals But it worked only for a few days He also had sex with CSWs to see whether this was actually his problem, but the outcome was the same The client said, "I went everywhere people suggested Please, help me restore my normal sexual performance as before"

In relation to this, mechanisms have to be built to develop and implement awareness and education appropriate precisely for adolescent on sexuality, sexual health, issues of STDs, decision making, peer pressure and empowerment

Partners The study revealed that men are completely unaware of their partners signs and symptoms of STDs Out of 124 individuals, identified as requiring partner management, only 50 percent have done this Many have hidden the information of their regular and irregular sexual partners More in-depth study needs to be done on identifying possible partners and ensuring an appropriate partner management mechanism

Condom use The fact that only 6 percent of the 458 clients giving history of exposure of using condom is quite alarming The study intends to highlight this finding to programs

who are working on condom promotion If condom use among people coming to clinics seeking service for sexual health is only 6 percent then condom use in general might account for a lower proportion

Laboratory At present MSC is doing qualitative RPR for cases diagnosed as syphilis and later they have also added TPHA test so that clients do not have to go to other laboratories However, it is advisable to any STDs clinical intervention to ensure quality services the client should be followed up, for 2 years by a quantitative RPR method This will show the treatment compliance and occurrence of re-infection

Counseling MSC has yet to reach 100 percent counseling for clients diagnosed as having STD and psycho-sexual problem This should also be implemented for those admitting to have multiple sex partners and other risky sexual behaviour Clients coming to the clinic for other health problem, knowing the clinic as an STD clinic Providing information on sexual health and STD could be a worthwhile effort for raising awareness and education

Impact As an outcome of the intervention of the study, the programmatic and policy changes MSC has gone through to improve service delivery, is plausible Signboards for male clinic with clinic hours are made more visible than before MSC has changed the interior setup of the clinic The layout of doctor's consultation room was changed to make it more client friendly To ensure more auditory privacy, MSC introduced music in the waiting area IEC material are displayed in the waiting area of male clients Clinic hours were adjusted to the felt need of the clients Clinic hours were doubled and a new male doctor recruited MSC has introduced a token to keep the serial number of the waiting clients Various category of MSC staff were given training on sexual health, STDs and communication TPHA test was introduced in the laboratory

Within a nine month period, including a baseline survey, it is rather difficult to identify any measurable impact of the program due to the intervention However, a qualitative change has occurred among the service providers on sexual health and STDs The communication pattern of the FCs and the counselors have shifted from mere bringing patients into the clinic to educating and raising awareness on issues related to sexual health and STDs in their field and community work MSC has also introduced a letter to the partner of an infected individual on voluntary basis, inviting to come to the clinic for treatment This strategy has improved the partner management of the program

One clear measurable impact is the 200 percent increase in the client flow between the first and the second quarter which was sustained until the third quarter, even though most of the FCs were engaged in other assignment Over and above, the flow of clients having STD related conditions are on a steady increase

However, more study needs to be done specifically on the presentation pattern of complaints, partner management, impact of continuous intervention after a year or two

4.2 POLICY RECOMMENDATIONS

Organizations undertaking a clinical STD intervention can consider the following

- An effective male STD intervention will have to target all age groups, service categories and education levels

- Personal contact appears to be a positive approach for reaching men seeking STD services although the role of media was not fully explored

- Exposure history should not be a singular screening criteria because clients tend to conceal this information Extensive training of the providers is needed to elicit complete client information

- Male STD intervention should be coupled with general and other sexual health services as 50 percent of the STD diagnosis came from these two client categories

- The perception that men, because they are symptomatic, speak more easily about STDs is erroneous

- Providing STD services to men therefore requires a two pronged approach
    a) Efforts have to be given on awareness and educating men
    b) Providers need training, backup and psychological support to deal with the issues of sexuality and STDs

There remains a culture of silence even among men on issues of sexual health and well-being Efforts have to be made to empower men to talk about sex and sexuality for themselves

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Appendix 1

Workshop Curriculum

Workshop Title

Understanding and Communication on Sexual Health Issues

Participants	A homogenous group of 12-15
Schedule·	One day in a week (Each day is divided into two sessions)
Session Hours	3 hours per session

Curriculum.

Session 1	Introduction, Expectation of the participants from the Workshop and knowledge on STDs/RTIs through a MCQ survey
Session 2	Ice Breaking Exercise "Articulation of Issues concerning Sexual Health" **Conceptualizing Reproductive and Sexual Health and Sexuality**
Session 3	Discussion on Reproductive systems and Functions Sexuality Perceptions and Mis-conceptions Plenary On RTIs and STDs
Session 4	Understanding Laboratory Tests on STDs/RTIs Knowledge on HIV/AIDS Plenary Open discussion and Questions and Answers
Session 5	Communication - Praxis Methods of Communication and Counseling GATHER Approach
Session 6	Counseling on Sexual Health Basic Counseling Techniques (Attitudes and Approach)
Session 7	Discussion on Sexual Problems and Improving Sexual Satisfaction Discussion on Problems faced in the fields by the participants
Session 8	Role Play on Problem Scenario Discussion on How to Face such Problems
Session 9	Recapitulation of the workshop Plan of Action by the participants (along with needs assessment)
Session 10	Evaluation of the workshop Closure

Appendix 2

Participants Expectations from the Workshop

Knowledge

- What is sex?
- Reproductive Health - Definition, Purpose and Related Issues
- **What are STDs and RTIs**
- **Modes of transmission of STDs and RTIs**
- Symptoms and Prevention
- The long term effects and complications of STDs and RTIs
- Males Sexual Diseases / STDs and Potency Males performance ability and duration
- Knowledge on VDRL test, Hepatitis B virus and vaccine
- Knowledge and discussion on HIV and AIDS
- HIV reaction on human body
- Why do women experience spontaneous abortion
- Does Copper T create or increase STDs?

Communication

- What is communication?
- IEC material to motivate our target groups
- Effective messages on Reproductive Health
- Counseling skills and tips on RTIs and STDs
- Easy communication to target people on STDs

C & S

- How to speak with people about STDs
- Communication skills to talk about STDs and the MSC services in the field

Knowledge and Communication

- Reproductive health
- Male and female infertility
- STD/AIDS signs & symptoms
- Primary signs & symptoms of Gonorrhea Syphilis
- Awareness on the prevention of STDs
- **FP** methods, Problems and solutions
- Knowledge on products (FP)

Skills

- Develop better communication with common people
- Develop or improve skills on communication on STD
- Motivate through oral communication
- Motivate **CSWs and Pimps** to come to MSC for treatment
- Intensive training

Appendix 3

Marie Stopes Clinic Society
Male Health Record

(Confidential for Marie Stopes Clinic use only)

Registration:

1 Clinic No [ ] 2 Registration No Client _____

Partner _____

3 Name _____ Age _____ yrs

4 Present address _____ Contact _____

_____ _____

_____ _____

5 Duration of stay _____

6 Education _____(no of school years)

7 Occupation
1 Service
2 Business
3 Transport Worker
4 Shopkeeper
5 Student
6 Factory Worker
7 Garments Worker
8 Others

[ ] Specify _____

8 Source of Information
1 Field Coordinator
2 TV
3 Radio
4 Cinema
5 Hoarding
6 Doctor
7 Pharmacist
8 Friends/Relatives
9 Clients
10 Others [ ]

9 Marital status **M**arried/**U**nmarried/**D**ivorced/**W**idower/**S**eparated [ ]

10 Currently living with spouse (only for married clients) Yes/No [ ] _____

11

Visit No	Date	SERVICES										Payment	
		STD		Other Sexual Health	FP		Gen Health	Immun		Lab	Oth		
		Scr	Const		Con	VSC		TT	Hbv			Drug	Service
1													
2													
3													
4													
5													
6													
7													
8													
9													

Note Payment 1 Full payment, 2 25% subsidy, 3 50% subsidy, 4 75% subsidy, 5 Free

Coding **N** - New Client, **O** - Old Client, **F** - Follow Up Client

43

Health Information

12 Chief Complaints

1 Urethral Discharge 2 Ulcer 3 Swelling 4 Itching 5 Urinary Problem 6 Nocturnal Emission
7 Impotence 8 Premature Ejaculation 9 Infertility 10 Others

Details of Complaints

Visit / Follow up No ☐	Visit / Follow up No ☐
☐☐☐☐☐☐☐	☐☐☐☐☐☐☐

13 History of Past Medical And Sexual Health

[1] STD, [2] Non-STD Genito Urinary, [3] Medical / Surgical, [4] NC, [5] NA, [6]Others ☐☐☐

Health Problem	Time Of Onset/Duration	Treatment
STD		
Non-STD Genito Urinary		
Medical / Surgical		
Others		

14 Current Contraceptive Use [1] Condom, [2] Vasectomy, [3] Tubectomy, [4] OCP, [5] IUD, [6] Injection, [7] Norplant, [8] Withdrawal, [9] Rhythm, [10] Non-User ☐☐☐

Examination Form

Examination	Visit / Follow up No ☐ Y / NA / ND / NAD	Visit / Follow No ☐ Y / NA / ND / NAD
General	Wt kg BP mmHg Anaemia [ ]Absent [ ] Present _____ Jaundice [ ] Absent [ ]Present _____ Lymph Gland Palpable Yes/No Cervical/ Axillary/Inguinal Tender/ non-tender matted/discrete Skin lesion _____ _____ Other _____ _____	Wt kg BP mmHg Anaemia [ ]Absent [ ] Present_____ Jaundice [ ] Absent [ ]Present_____ Lymph Gland Palpable Yes/No Cervical/ Axillary/Inguinal Tender/ non tender matted/discrete Skin lesion _____ _____ Other _____ _____
Local	**Y / NA / ND / NAD**	**Y / NA / ND / NAD**
1 Ulcer	1 Present/ improved / aggravated / absent Site _____ i Single/multiple ii Tender /non-tender iii Bleed on touch / not iv Border clear cut / elevated / undermined v Floor clean/ necrotic tissue vi Base hard/not	1 Present/ improved / aggravated / absent Site _____ i Single/multiple ii Tender /non tender iii Bleed on touch / not iv Border clear cut / elevated / undermined v Floor clean/ necrotic tissue vi Base hard/not
2 Urethral Discharge	2 Present/ improved / aggravated / absent Colour _____ Consistency _____ Morning Gleet yes/no	2 Present/ improved / aggravated / absent Colour _____ Consistency _____ Morning Gleet yes/no
3 Uro Genital Examination	Scrotum Swelling Yes/ No Lt/Rt/Both Tender / non-tender Type _____ Epididymis _____ _____ Vas Deference _____ _____ Testis - Any abnormality _____ _____ Penis - Any abnormality _____ _____	Scrotum Swelling Yes/ No Lt/Rt/Both Tender / non-tender Type _____ Epididymis _____ _____ Vas Deference _____ _____ Testis - Any abnormality _____ _____ Penis Any abnormality _____ _____

45

Examination	Visit / Follow No ☐ Y / NA / ND / NAD	Visit / Follow No ☐ Y / NA / ND / NAD
	Par rectal Examination _____ _____ Others _____ Remarks _____ _____	Par rectal Examination _____ _____ Others _____ Remarks _____ _____
Systemic 1 G I System	**Y / NA / ND / NAD**	**Y / NA / ND / NAD**
2 Respiratory System	**Y / NA / ND / NAD**	**Y / NA / ND / NAD**
3 Nervous System	**Y / NA / ND / NAD**	**Y / NA / ND / NAD**
4 Cardio-Vascular System	**Y / NA / ND / NAD**	**Y / NA / ND / NAD**
5 Locomotor System	**Y / NA / ND / NAD**	**Y / NA / ND / NAD**

46

Treatment History

Visit / Follow No ☐ Y / NA / ND / NAD	Visit / Follow No ☐ Y / NA / ND / NAD
1 Any treatment received for present problem ? Yes/No _____ _____	1 Any treatment received for present problem ? Yes/No _____ _____
2 Did the partner/s ever receive any treatment? Yes/No _____ _____	2 Did the partner/s ever receive any treatment? Yes/No _____ _____
3 Drug Allergy _____ _____	3 Drug Allergy _____ _____

History Of Exposure

** Attention! This section is extremely confidential Please explore according to the level and behaviour of the client*

Visit / Follow No ☐ Y / NA / ND / NAD	Visit / Follow No ☐ Y / NA / ND / NAD
1 Exposure Marital / Extramarital / Premarital / Both / No Regular / Irregular Specify type _____ Specify No of partners in last 3 months _____ Last exposure _____days back	1 Exposure Marital / Extramarital / Premarital / Both/No Regular / Irregular Specify type _____ Specify No of partners in last 3 months _____ Last exposure _____days back
2 Condom Use Yes/No Partner - Regular / Occasional / Never / NA Spouse - Regular / Occasional / Never /NA	2 Condom Use Yes/No Partner - Regular / Occasional / Never/NA Spouse - Regular / Occasional / Never /NA
3 Partner has signs of STD Yes / No / Don t Know Specify _____ _____	3 Partner has signs of STD Yes / No / Don t Know Specify _____ _____
4 Remarks _____ _____	4 Remarks _____ _____
5 Drug abuse and addiction _____ _____	5 Drug abuse and addiction _____ _____

Treatment & Compliance

	Visit / Follow up No ☐	Visit / Follow up No ☐
Diagnosis	Provisional Lab Test Results 1 _____ 1 _____ 2 _____ 2 _____ 3 _____ 3 _____ Confirmed	Provisional Lab Test Results 1 _____ 1 _____ 2 _____ 2 _____ 3 _____ 3 _____ Confirmed
Treatment / Advice	**Y / NA / ND** Rx Counseling	**Y / NA / ND** Rx Counseling
Partner Management	1 Not Applicable 2 Rx and Referral 3 Referral only 4 Rx Only 5 Refused to Treat Partner 6 Remarks _____ _____	1 Not Applicable 2 Rx and Referral 3 Referral only 4 Rx Only 5 Refused to Treat Partner 6 Remarks _____ _____
Prognosis	Client NA / Cured / Partially Cured / Not Cured Partner NA / Cured / Partially Cured / Not Cured	Client NA / Cured / Partially Cured / Not Cured Partner NA / Cured / Partially Cured / Not Cured
Treatment Compliance	Client Full course / Partial / No Partner Full course / Partial / No Partner Treated Yes / No / NA Remarks _____ _____ _____	Client Full course / Partial / No Partner Full course / Partial / No Partner Treated Yes / No / NA Remarks _____ _____ _____

48