

Integrating Reproductive Tract Infection Services Into Family Planning Settings in Indonesia

Integrated reproductive health services are usually discussed in the context of settings with high HIV prevalence, but should also be considered as part of a comprehensive response to HIV/AIDS in low-prevalence countries. Family planning and maternal and child health services are often a woman's primary, and sometimes sole, contact with the health care system; thus, it is important that these services offer the convenience of "one-stop shopping."

Packaging all four essential components of reproductive health—family planning, maternal and child health, adolescent reproductive health, and management of sexually transmitted infections (STIs)—as an integrated service avoids stigmatizing such clients as unmarried but sexually active women with STIs or other reproductive tract infections. In light of the stigma attached to STIs and fears about HIV, such women may be reluctant to visit stand-alone STI clinics. Therefore, community-level family planning and maternal and child health clinics provide ideal settings for providers to detect and diagnose HIV and other STIs. These clinics also provide opportunities to inform clients in nonjudgmental ways about the risk of HIV transmission from sexual contact, describe appropriate prevention behaviors, offer dual contraceptive methods for protection, and teach about the importance of early detection for effective treatment of STIs.

The available data suggest that Indonesia has substantial levels of STIs. According to reports from subdistrict health centers and district public hospitals, 5,000–10,000 new cases of syphilis and 20,000–30,000 new cases of gonorrhea occur nationally each year. Survey results indicate that 5–10% of sex workers have syphilis and 20–40% have gonorrhea, and that 4–10% of pregnant women attending health facilities for prenatal care have chlamydial infections. Moreover, HIV prevalence among anonymous blood donors rose sharply in 1998, from 0.001% to 0.004%, with Jakarta showing an increase from 0.003% to 0.03%.¹

In 1996–1997, a pilot project funded by the U.S. Agency for International Development sought to improve reproductive health services for women in North Jakarta, Indonesia, by incorporating diagnosis and management of reproductive tract infections (including STIs) into the routine services offered at two family planning clinics. The intervention provided an opportunity to examine the issues involved in integrating the two types of services. The settings—an obstetrics and gynecology outpatient clinic at a 202-bed district hospital and the family planning unit of a community-based health center—generally served low-income married women who had already had two or more children and whose primary risk factor for acquiring an STI

was intercourse with their husbands.

To determine the issues the intervention should address, the researchers gathered baseline data through interviews with local providers, a retrospective medical record review and extensive observations of health care facilities and provider-client interactions. A total of 14 health care providers—four doctors, six midwives and four laboratory technicians—were observed.

Although the two study settings had sufficient equipment and supplies, the staff had had little experience in diagnosing specific reproductive tract infections or STIs. According to the baseline data, most providers had a low level of technical knowledge and lacked the skills needed for practice and communication. For example, providers failed to practice a standardized clinical evaluation based on a risk-assessment history, a pelvic examination and results of laboratory tests. The six-month retrospective medical record review showed that providers generally failed to link gynecologic problems with a specific infection. At the hospital clinic, for example, more than 100 cases of vaginitis and cervicitis had been recorded between July 1 and December 31, 1996, but no further etiological diagnoses or records of counseling to inform sexual partners had been made. Further, there was no evidence that providers practiced a standardized prescriptive regimen. At the health center clinic, only three STI diagnoses had been made, all for gonorrhea, and diagnoses could not be linked to medical records to assess the appropriateness of the treatment because no client identifiers were included.

These findings pointed to the providers as the primary target group for intervention. Therefore, the primary project intervention was a series of educational activities for the providers on infection diagnosis and case management. The training also stressed that health providers have a duty, under oath, to deliver services to all individuals who need care, not just to married men and women. An advisory board of national experts, clinicians and leaders from the field of public health wrote the clinical protocols and acted as instructors during the training. Providers initially received training from February 17 to May 9, 1997 (Stage 1). Three months later, they received additional training, which ran from September 9 to December 29 (Stage 2). A quasi-experimental study compared the ability of providers to recognize and appropriately respond to infections in family planning clients before and after each stage of the intervention.

The providers were given protocols for obtaining a risk-assessment history for six selected reproductive tract infections that could be diagnosed by laboratory tests: can-

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didiasis, bacterial vaginosis, trichomoniasis, gonorrhea, chlamydia and syphilis. Nevertheless, by the end of Stage 1, they needed more training to acquire the skills needed to make a correct presumptive clinical diagnosis at the first visit. The proportion of medical records that did not list an initial diagnosis declined from 18% in Stage 1 to 2% in Stage 2. On the basis of combined data from the two stages of the intervention, 19% of the 189 women who had any of the six reproductive tract infections and 21% of the 70 women who had one of the four STIs were accurately diagnosed at their first visit.

The universal laboratory testing (by on-site and referral labs) of the participants showed that 39% of the participants had one or more reproductive tract infections and 14% had one or more STIs (28 women had two). In both stages, all clients who returned to the clinic received appropriate treatment. However, because only 60–73% of those with non-sexually transmitted infections and 74–79% of those with STIs returned, substantial proportions of infected women could not be treated.

Providers also needed additional training to improve their ability to communicate the importance of partner notification and treatment. During Stage 1, only 55% of the sexual partners of participants with STIs received treatment, but during Stage 2 this proportion rose to 76%. Providers showed especially improved communication skills in overcoming cultural concerns about telling clients about a positive STI diagnosis and making partner referrals. These changes, however, were seen only in the later weeks of the one-year study, after providers had become more comfortable and more convinced of the necessity of effective case management.

Stage I data showed the need for improvement in such basic infection-control measures as pre-examination hand washing (8% of doctors and 28% of midwives), use of new or sterilized gloves (99% of doctors and 61% of midwives) and hand washing after removing gloves (17% of doctors and 37% of midwives). By the end of Stage 2, those figures had risen to 86%, 99% and 87% among midwives, but had changed little among doctors.

Over the course of the study, clients showed greater willingness to refer their partner for treatment: The proportion of women with an STI who agreed to refer their partner to the clinic for treatment improved from 2% in Stage 1 to 51% in Stage 2. (Nevertheless, only 15% of partners came in during Stage 2.)

CONCLUSION

Our evaluation indicated that it is feasible to integrate detection and management of reproductive tract infections into family planning settings in Indonesia, but that the

process of reorienting and training providers will take time. The equipment and supplies at a community health center are adequate, and the location of a family planning unit within a health center provides easy access for adult women. What is needed for provision of integrated reproductive health services at these facilities is an environment that provides privacy, permits confidentiality and is run by well-trained providers with a nonjudgmental attitude.

Our data suggest that additional training is needed to improve providers' technical knowledge and skills in STI detection, diagnosis and prompt treatment. More attention also needs to be paid to improving providers' skills in counseling on partner notification and treatment and in promoting dual protection. In addition, as the results on presumptive diagnosis show, it is unrealistic to think that an accurate clinical diagnosis can be made without access to laboratory tests. In Indonesia, microscopes have long been available (though underused) at all health centers at the subdistrict level; if their use in STI diagnosis becomes standard practice, providers will not need to rely on syndromic management.

Even if all clinic-level issues are resolved, integrated services will not be able to succeed without strategic planning and political action. District-level health planners and parliament members who make the decisions on budget allocations for public services must be educated about the prevalence of reproductive tract infections and about their implications for the spread of HIV. In addition, it is necessary to build partnerships with nongovernmental organizations, local governments, health professionals and private clinics to lobby for the integration of services that diagnose and manage reproductive tract infections into family planning settings.

If these challenges can be met, family planning clinics can play an important role in countries where HIV prevalence is currently low. By adding services that diagnose and manage reproductive tract infections among women and their partners, family planning clinics can decrease their susceptibility to HIV infection, thereby helping to prevent an escalation of the epidemic.

REFERENCE

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