Brief counseling can improve partner referral for management of sexually transmitted infection in Bangladesh

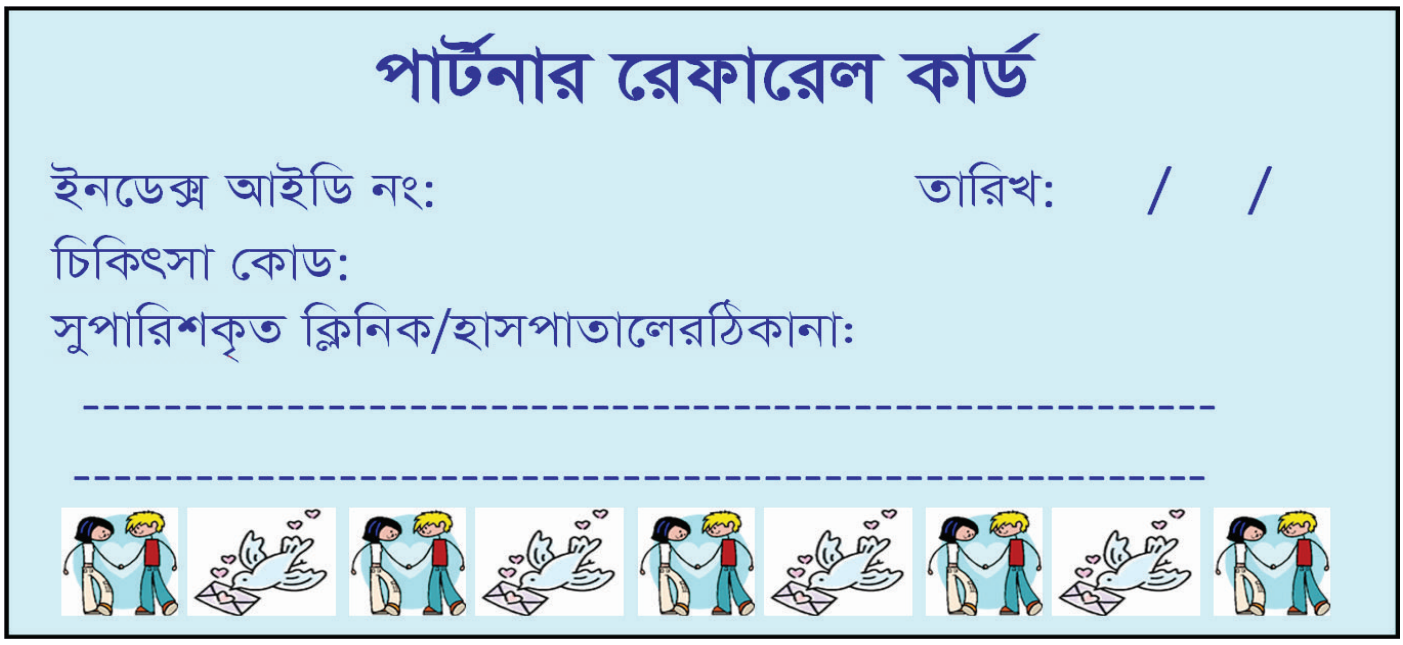
Background:

Partner referral is an important component of sexually transmitted infection (STI) management and control programmes[1,2]. Partner referral can result in earlier treatment for partners of STI patients, prevent re-infection, and break the chain of disease transmission[3]. In practice, however, partner referral is rarely utilized in low income countries where the vast majority of patients with STIs receive treatment without getting adequate counselling and advice on partner referral issues[4-6]. STI management in Bangladesh varies by the type of service delivery venues and providers. General physicians and secondary/tertiary level health care providers may follow STI management protocols in medical textbooks that may be supported by very basic laboratory investigations[7,8]. At the primary health care level, including most non-government organization (NGO) and public sector clinics, syndromic management protocols are used without the benefit of laboratory confirmations[9]. In both types of management, patients diagnosed with STIs receive very limited or no counselling on safer sex, HIV transmission, and partner referral, mostly because of severe time constraints of the service providers. Considering the potential of patient oriented counselling in improving STI partner referral, we evaluated the role of single session counselling on partner referral among STI patients in selected clinics in Dhaka, Bangladesh. We hypothesized that a higher proportion of index STI patients participating in a counselling session would refer their partners compared to the patients in the standard care group.

Approaches:

The study was conducted between January and September 2007 among 1339 men and women with symptomatic STIs recruited in 3 public and 3 non-government organization operated clinics in Dhaka and Chittagong city corporation area. Patients were randomly assigned either in the counseling group or usual care group. Patients in the counseling group received counseling on (1) risk of reinfection if partners are not treated at the same time; (2) risk of developing complications; (3) risk of further spread of infection; (4) the asymptomatic nature of infection; and (5) social obligations and personal coping. Information on demographic, socioeconomic, sexual behaviour, and psychosocial variables related to partner referral were collected using a structured questionnaire. Referral cards (Figure 1) were given to index patients in counseling group and in usual care group to pass to their partners to show in the respective clinics when seeking care.

Figure1: Partner referral card used in the study

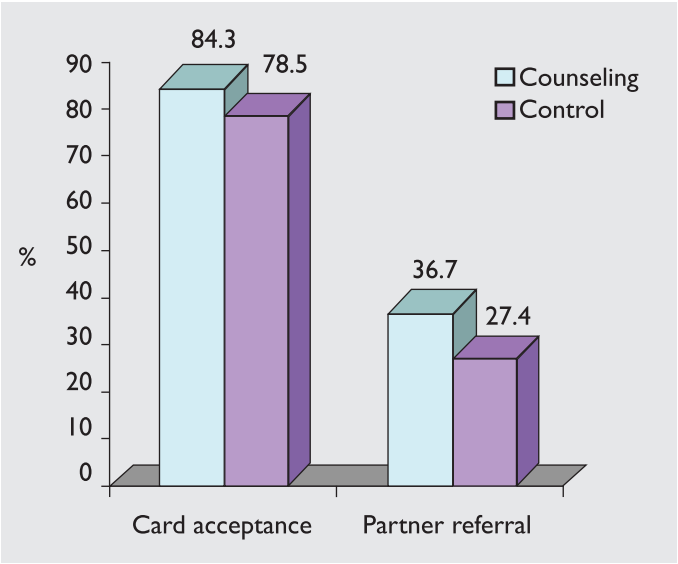


Results:

Out of 1339 index cases, partner referral was achieved by 37% in the counseling group and 27% in the non-counseling group (Figure 2). Index cases in the counseling group and non-counseling group were similar in terms of condom use rates, STI symptoms and duration of disease.

In multivariate analysis, the probability of partner referral was 1.3 times higher among index cases in the counseling group (prevalence ratio 1.3; 95% CI 1.1 to 1.6) as compared to index cases in the non-counseling group.

Figure 2: Card acceptance and partner referral rates by counseling and non-counseling groups



Conclusions and recommendations:

- Patient-oriented single session counseling was found to have a modest but significant effect in increasing partner referral for STIs in Bangladesh.
- This simple intervention is useful in promoting partner referral by shifting the burden of overwhelmed clinical providers to the counselors.
- Greater emphasis should be placed on examining further development and dissemination of partner referral counseling in STI care facilities. Further research with longer duration counseling on broader issues covering other known barriers of PR, along with cost effectiveness components, may be needed to demonstrate the more robust effect of counseling for promoting PR in resource limited settings.

Reference:

1. Hawkes S, Mabey D, Mayaud, P. Partner notification for the non-counselling of sexually transmitted infections: Effectiveness in resource poor countries is unproved. BMJ 2003;327:633-634.
2. World Health Organization. Consensus statement from consultation on partner notification for preventing HIV transmission. Geneva: World Health Org. 1989.
3. Wakasiaka SN, Bwayo JJ, Weston K, et al. Partner notification in the management of sexually transmitted infections in Nairobi, Kenya. East Afr Med J 2003; 80: 646–51.
4. World Health Organization and Joint United Nations Programme on HIV/AIDS. Sexually transmitted diseases: policies and principles for prevention and care. Geneva: UNAIDS Best Practice Collection, 1999.
5. Alam N, Chamot E, Vermund SH, Streatfield PK, Kristensen S. Partner notification for sexually transmitted infections in developing countries: a systematic review. BMC Public Health. 2010 Jan 18;10: 19.
6. Cowan FM, French R, Johnson AM. The role and effectiveness of partner notification in STD non-counselling: a review. Genitourin Med 1996 72:247-52.
7. Alam N, Streatfield PK, Shahidullah M, Mitra D, Vermund SH, Kristensen S. Effect of single session of counseling on partner referral for sexually transmitted infections management in Bangladesh. Sex Transm Infect. 2011 Feb;87(1):46-51.
8. Ahmed MU, Mirza T, Khanum P, Khan M. A, Ahmed S, Khan M.H. Management of reproductive Tract Infections in rural Bangladesh. Int J STD AIDS 1999;10:263-267.
9. National Integrated Population and Health Programme (NIPHP). Ministry of Health and family welfare. Technical standard and service delivery protocol for management of RTI/STD. 1999.

This Knowledge Translation brief was prepared by Nazmul Alam, Peter Kim Streatfield; M.Shahidullah; Dipak Mitra; Sten H. Vermund. It is based on the project 'Evaluation of Partner Notification for Sexually Transmitted Infections among Service providers in Bangladesh' being implemented by Centre for Reproductive Health of icddrb, Bangladesh. The study was funded by AusAid.

For more information, please contact Mr. Nazmul Alam, Epidemiologist, Centre for Reproductive Health, icddr,b, Mohakhali, Dhaka-1212, Bangladesh. Email: nazmul@icddrb.org, Tel: 8860523-32 Ext 2256, Cell: 01720281109.

This is the product of a grant from Maternal Health Task Force. The views expressed are not necessarily those of Maternal Health Task Force, full responsibility for all contents remains with the author(s).