Health & Rights

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In this issue

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Maternal healthcare in Bangladesh need policy rethinking

A recent Unicef, Bangladesh report throws much light on the level of awareness of maternal healthcare in Bangladesh. The report elaborates how conspicuous lack of awareness of maternal healthcare is exposing children and women to high risks in the country. There is no denying that lack of awareness about antenatal, delivery and postnatal care are the underlying factors that expose mothers and children to various life-threatening situations. The findings were compiled in the report after a survey was done on maternal and neonatal health among more than 13,000 women in four districts of Narail, Jamalpur, Thakurgaon and Moulovibazar.

The survey revealed that about 62% of the women respondents did not consider antenatal care or safe delivery at a health centre necessary or beneficial. Financial factor played a major role in women not going to health centres. But the surprising element was that about 10% of the respondents felt they would receive better care at home compared to health centre. The Unicef report further said that about 15% of the women delivered their last baby in a health centre and only about 23% of the poor women received antenatal care. Among the poor women, only 10% reported being assisted by trained health service providers during delivery, against 41% among women of solvent families.

The survey also highlighted that women are not the key-decision makers in matters relating to delivery and postanatal care. Only about 14% of women seeking treatment for complications said they took decisions themselves. But for about 78%, decisions were taken by their husbands and for 21% by parents-in-law.

Early marriage, teenage pregnancy and early child bearing were identified as major causes of increased vulnerability for women and newborn living in those four districts. The average age of marriage for the women interviewed was 16 years, and 72% became mother for the first time before the age of 20.

The report stressed that these findings would help policy makers and health and family planning officials to determine what is needed to reduce maternal and neonatal mortality. Key recommendations based on the survey are: improving access to skilled birth attendance, creating awareness on the importance of safe delivery by skilled service provider and encouraging women to use health services through an increased support from family and community; providing information about family planning and optimal birth spacing.

We believe the sample survey of Unicef speaks for the entire country, as awareness of post and neonatal care among men and women remains at the lowest level. Unless stakeholders can work concertedly to ensure wide-scale awareness of the needed care and facilities available, it would be difficult to reduce maternal and neonatal mortality and morbidity rate in Bangladesh.

Mapping of MR programme in Bangladesh

Need emphasis on public-private collaboration

Women who missed their regular menstrual period and who strongly suspect that they are pregnant but cannot or do not want to wait for the results of a pregnancy test can ask a gynecologist for a simple procedure called variously Menstrual Regulation (MR), menstrual aspiration, or menstrual extraction. It is defined as an interim method of establishing non-pregnancy for a woman at risk of being pregnant, whether or not she is actually pregnant.

According to Iso-Resource Group (IRG) service definition, MR is defined as a care of unwanted pregnancy episode, treatment of unsafe abortion complications (septic abortion) and treatment of amenorrhea/dysmenorrhea.

On the other hand, Abortion is the termination of pregnancy before the period of viability which considers occurring at 28 weeks at developing countries, 20 weeks in developed countries. The 1994 International Conference on Population and Development (ICPD) was the first forum to focus in a global way on the serious health threat to women from unsafe abortion.

Maternal death related to abortion

As per World Health Organisation-WHO, globally 50,000 to 100,000 women die every year due to unsafe abortion. Most of this occurs in developing countries.

In Bangladesh, complications from unsafe abortion is one of the leading causes of maternal mortality.[1] About 25% of the pregnancies are reported to be unwanted. The World Health Organisation estimates 14% of maternal death occurs in South Asian countries including Bangladesh due to unsafe abortion.[2]

Maternal mortality ratio in Bangladesh is 3.8/1000 live birth (WHO statistics 2000). It has been estimated that annually 730,000 pregnancies are terminated in Bangladesh (262,000 induced abortions plus 468000 MRs).[3]

According to USAID, POPPHI, EngenderHealth, causes of maternal deaths are:

- 19% for severe bleeding,
- 8% for infection,
- 14% for unsafe abortion,
- 11% for Eclampsia,
- 6% for obstructed labor,
- 11% for other pregnancy related causes,
- 17% for indirect causes and
- 14% for violence.

Causes of abortion

Causes of higher incidence of abortion in our country is due to unwanted pregnancy. And the unwanted pregnancy occurred because -

- 33% of all births in Bangladesh are unplanned
- 13% are unwanted
- 20% mistimed
- Lack of access to family planning information and services
- High unmet need for contraceptive methods, and
- Failure and low contraceptive use among the young couples are one of the important causes of unwanted pregnancies.

MR in Bangladesh:

As part of the Government of Bangladesh's health and family planning effort, MR has been declared an "interim method of establishing non-pregnancy" for a woman at risk of being pregnant to reduce female morbidity and mortality associated with indigenous abortion in 1974. Though abortion is not legal in Bangladesh, MR is permisable only up to 10 weeks of LMP (Last Menstrual Period). In 1998 the Government of Bangladesh introduced the Health and Population Sector Programme (HPSP) incorporating menstrual regulation into the essential services package.

The Bangladesh MR Programme is administratively based in the DGFP [4]:

- 1972 Abortion law waived
- 1974 GOB introduced MR service
- 1975 MR training programme began at MFSTC-Mohammadpur Fertility Services and Training Centre
- 1978 MR training programme extended: 8 Medical colleges and 2 govt. district hospitals
- 1979 National FP programme included MR services in all government SDPs SERVICE DELIVERY

Indicators	Data	Source
Population mid 2007 (millions)	149.0	PRB 2007
Percent of Population of age <15 yrs	33	PRB 2007
Percent of Population of age (65+)	4	PRB 2007
Population density/Sq kilo	1035	PRB 2007
Percent urban	23	PRB 2007
Births per thousand population	27	PRB 2007
Deaths per thousand population	8	PRB 2007
Rate of Natural Increase (%)	1.9	PRB 2007
Maternal Mortality ratio	320/1000 live births	BBS, 2000
Infant Mortality rate (IMR)	52/1000 live births	BDHS, 2007
Total Fertility Rate (TFR)	2.7 per women	BDHS, 2007
Contraceptive Prevalence Rate (CPR) modern methods	47.5	BDHS, 2007
Unmet need for family planning	18%	BDHS, 2007

The reasons for establishing MR services are many folds. The main reason for establishing the MR programme in the country was to save the life of mothers, it was estimated that in seventies and early eighties about one fourth of the maternal mortality was due to unsafe abortion and many more were suffering from life-time and long term complications. The second reason for introducing MR services was to provide back-up support for the contraceptive failure.

According to the Bangladesh Health and Demographic Heath Survey of 1999 -2000, five percent of currently married had had an

[1] Post Abortion Care: Technical Standard and Service Delivery Guideline-Developed by the Directorate of Family Planning and EngenderHealth BCO, June 2002)

[2] Post Abortion Care: Technical Standard and Service Delivery Guideline-Developed by the Directorate of Family Planning and EngenderHealth BCO, June 2002)

[3] Bangladesh National Strategy for Maternal Health, October 2001

[4] Initiative to Strengthen National Menstrual Regulation Programme in Bangladesh Launching Ceremony 23 June 2008, Dhaka, Bangladesh

MR procedure. An estimate published in 1997 found that about 500,000 MR procedures are performed annually in Bangladesh and another 300,000 abortions are also being performed in the country too.

Legality of MR

In Bangladesh, abortion is legally permissible only to save a woman's life. In 1979 the Government of Bangladesh (GoB) included MR in the national family planning programme. MR is defined as an interim method of establishing non-pregnancy for a woman at risk of being pregnant, whether or not she is actually pregnant (Bangladesh Institute of Law and International Affairs, 1979). MR services, using Manual Vacuum Aspiration (MVA), are officially sanctioned and provided within two to four weeks of a missed period (i.e. six to eight weeks since last menstrual period) and, if necessary, up to ten weeks.

Interventions:

MR is performed by physicians/paramedics at Upazila Health Complexes (UHCs), and by female paramedics called Family Welfare Visitors (FWVs) at Union Health and Family Welfare Clinics (UHFWCs). Nurses and FWVs can provide MR services if the length of gestation is no more than eight weeks; physicians are permitted to do so upto 10 weeks of gestation.

MR training and services are extended in phases and services are now available throughout the country. Training was given to government doctors, FWVs and a few private doctors. Around half of the doctors received training during internship in the medical college hospital. FWVs also received MR training after their formal posting in health facilities. FWVs are performing MR at community and primary (under supervision of a doctor) levels, and doctors or obs/gyn specialists perform MR at districts, secondary and tertiary level. Pre- and post-counselling is also given as well as post-contraceptive use. In addition, MR is performed privately by doctors, FWVs, other medical personnel and others such as unauthorised or unskilled providers including indigenous practitioners without formal training.

Besides there are huge number of clandestine providers who perform MR in unhygienic conditions in various towns and cities and even at the village levels. Mostly they are *kabiraj*- traditional healer, pharmacists, quacks, Village doctors, Aya of hospitals, and some times the untrained Family Welfare Visitors and Family Welfare Assistants are performing MR services. *Dais* (traditional birth attendants) and traditional practitioners were the larger groups of operators (42.1% and 18.1%, respectively).

Service stations:

Menstrual regulation is widely available in Bangladesh through public, NGO and private sector facilities.

A. Public sector

- All Medical College Hospitals (Through RHSTEP centres- former MRTSP)
- All District Hospitals (Through RHSTEP in some districts)
- Upazila Health Complexes (UHCs)
- Union Health and Family Welfare Centres (UHFWCs)
- Mohammadpur Fertility Services and Training Centre (MFSTC)
- Azimpur Maternal and Child Health Centre, Dhaka
- Maternal and Child Health Institute, Matuail, Dhaka

B. Private Sector

Private sector is very active in providing MR services in the country. Starting from the national level it goes down to the upazila levels, even further to the village levels. In Dhaka city about 1000 private clinics and other out lets are functioning, it is about 70 in Barisal City corporation, 76 in Rajshai, 75 in Sylhet, 83 in Bogra pourasava, 147 in Rangpur, 57 in Mymensing. Beyond these a large number of clinics are functioning at every district levels town in Bangladesh and it is believed that they are performing large numbers of MR services in the country and are not reported. Besides a large number of formally trained and untrained or trained by trained persons are performing huge number of MR services with high cost.

GO-NGO collaboration

In organising MR training and services the role of private and public sector is very prominent. As it was mentioned that the MR programme was the special programme of the government and later provision has been created to isolate the programme from the government, but the government continued to provide space in the Medical College Hospitals and also in the District Hospitals for Reproductive Health Services and Training Programme.

To implement the MR programme DGFP works closely with NGOs and similarly NGOs are playing complementary and supplementary role to the overall performance of the national MCH-FP programme.

The areas of NGOs collaboration are - (1) permanent and longer acting family planning method, (2) safe MR services and training, and (3) increasing coverage of family planning, safe motherhood and adolescent healthcare in low performing areas. Besides, there are about 400 NGOs working at national and local level across the country in the field of MCH-FP through domiciliary and clinic-based services, and community mobilisation.

Name of the NGOs currently providing MR services-

- Reproductive Health Services Training & Education Program (RHSTEP)
- Bangladesh Association for Prevention of Septic Abortion (BAPSA)
- Marie Stopes Clinic Society (MSCS)
- Family Planning Association of Bangladesh (FPAB)
- Bangladesh Rural Advancement Committee (BRAC)
- Bangladesh Women's Health Coalition (BWHC)
- Nari Maitree
- Progoti Samaj Kallayan Protisthan and Poribar Porikalpana Sangstha (PSKP&PPS)
- Unity Through Population Service (UTPS)
- City Coporation Health Depratment (CCHD)
- MAMATA
- Khulna Mukti Seba Sangstha(KMSS)
- Southern Ganounnayan Sangstha (SGS
- Srizony Bangladesh

Financial Support:

The funding of MR activities in Bangladesh can be viewed in the following way:

- USAID through the Pathfinder Fund (1972 - 1983)
- Ford Foundation (1984 - 1998)

See page 4

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- International Women's Health Coalition (1985 - 1994)
- Sida (1986 -1997; general funds for 1998-2003 HPSP; 2003 - present, 2001 - June 2011 to MR NGOs). Besides Sida supports bilaterally the SRHR consortium of Bangladesh comprising of RHSTEP and BAPSA.
- In 1998 HPSP, the 5th 5-year sector-wide programme, vertical programmes like MR into a unified health system supported through pooled GoB and donor funding until 2001
- Sida and DFID provide support to UPHCP-II and almost all the partner NGOs except few providing MR services in the setting of UPHCP-II.
- Some funds channelled through NGOs
- Embassy of the Kingdom of the Netherlands approved funding for "Strengthening of National Menstrual Regulation Programme for Reduction of Maternal Mortality and morbidity in Bangladesh" for 2008-2011.

Performance an overview

Accurate estimates of the annual number of procedures performed are not available due to a week reporting system and the tendency of MR providers to under report the performances. The number of MRs officially reported to the Directorate of Family Planning is now approximately 120,000 annually. MRs are also performed privately by doctors and FWVs, by other medical personnel and traditional practitioners without formal training are not reported anywhere. But some studies estimated that the MR performances range from 400,000-500,000.

Coverage of area and population by the NGOs

The NGOs are covering almost all the urban areas of Bangladesh and some part of rural areas also. Large numbers of rural areas are covered by BRAC. The populations covered by these NGOs are not estimated accurately but it is assumed that one tenth of the total populations are being covered by them.

Cost of MR services

The cost for MR services varies among the NGOs. It ranges from TK.100- 1500. The Sida supported NGOs provide free services to the poor. The NGOs also charge for other services.

Logistic support for the MR programme in Bangladesh

The major MR logistics includes MR syringe and cannuale and some other equipment those are necessary for providing IUD services in the clinic. Until 2007 the government provided MR syringes and cannuale to the NGOs but the current programme managers are not supporting the NGOs any more because of shortage of supplies. Earlier the government procured those in large numbers and currently they are procuring for their own providers. The NGOs are providing substantial numbers of MRs in the country and without the government logistic support it would have very difficult to run the quality services in the country. It is also feared that in such circumstances the numbers of unsafe abortion may increase in many folds and also the death tools. For combating such situation the MR NGOs should get uninterrupted supply from the government sources as it got in the past for almost two decades.

MR Forum

In 1987, four organisations working on MR and its related issues formed a committee titled Coordination Committee of MR Agencies in Bangladesh (CCMRA,B). Though initially four organisations were in the committee, later other large scale MR providing organisations joined the committee. Now the committee comprises of -

1. Director (MCH-Services), DGFP- Chairperson
2. Representative from OGSB
3. Representative from NGOs
4. Representative from BPMPA
5. Representative from funding agencies (one member per agency)
6. Representative from WHO - Management Agency
7. Deputy Director (MCH) - Member Secretary

The main objective of the committee is-

- to promotes public-private partnership for improving maternal health through evidence based practices, improved availability and accessibility of a spectrum of quality reproductive health services including family planning, MR and other services;
- to coordinates all technical and programmatic matters pertaining to the design, implementation, management and evaluation of the MR programme;
- to recommends ways and means to further improve MR programme coordination and management at the national and sub-national levels.

Other Committees

A National Technical Advisory Committee on MR is functioning headed by DGFP as Chairperson. Besides, a MR Steering Committee was formed in February 2006 where DGFP was Chairperson. Another Steering Committee was formed by Planning wing of the MOH&FW in 1998. It is also not functioning. Through an office memo in 1992, MOH&FW formed a committee on MR Supervision and Inspection Committee with Director (MCH-Service), DFP as its Chairman and representatives from MOH&FW, DGHS, DFP and MR organisation as its member. Objective of the committee was to ensure safe MR services at SDPs and ensure supply of MR equipments, ensure training of manpower and hygienic environment at the SDPs Currently for monitoring of MR activities of RHSTEP, BAPSA, and BWHC a monitoring mechanism is developed by the ESP (RH-CH unit) of the DFP. It monitors all the activities and found functional.

Management of complications (MR/contraceptives):

Emergency drugs, medicine & support supplies to be available at all the time & in good condition in a service delivery point to meet emergency needs of clients.

Immediate complications may arise from MR:

- Vaso-vagal attack (sudden faintness)
- Dizziness and nausea
- Per vaginal bleeding
- Perforation of uterus
- Laceration/tear of the cervix.

Complications may arise at later stage (After return to home)

- Incomplete MR
- Sepsis of the genital tract
- Unsuccessful MR.
- Haematometra

Service delivery protocol

The following service delivery protocol should be taken while performing MR-

Pre-MR counselling:

i) Provide information on contraceptives/ MR to clients.

ii) Counsell clients to help them to take decision. Counselling has to be done in a private environment & steps of counselling should be followed.

iii) Informed consent to be taken.

MR intervention:

i) Screen clients regarding eligibility of the procedure. History examination, investigation

ii) Pain control

iii) Infection control

iv) Perform procedure.

Post- procedure counselling & follow up advice.

Record keeping & reporting.

Abortion complication (D&C, post abortion complication management, referral, CT removal) is also included in service standard category.

Challenges to provide MR services in Bangladesh

A. Quality of services:

- Limited access to quality MR services in rural locations. Most of the SDPs are located in urban area.
- Poverty, illiteracy & low income levels of clients
- Government facilities are not client-friendly.
- Lack of privacy, confidentiality and poor hygienic condition.
- Poor infection control measure.
- Lack of quality pre & post MR counselling including contraceptive counselling.
- Poor training of staff.
- Turn-over/transfer trained staff - vacancy for long period.

B. Provider's attitudes:

- Some of the providers are not aware about SRHR.
- Lack of sufficient knowledge on SRH issues.
- Judgmental attitude and lack of sensitivity towards women particularly vulnerable women

C. Social stigma & low awareness:

- Compels women to delay seeking services or to seek services in an unsafe way.
- Legal status of MR.
- Facilities where quality services can be accessed.
- Not aware about dangers of unsafe abortion.
- Failed to distinguish between MR and abortion.

Conclusion

Above all, the issue of abortion is complicated by political, religious, and moral concerns. To develop MR programmes, the voices of women could add important aspects to its acceptability.

The most prominent perception is that, despite the moral dilemma inherent in terminating pregnancies, MR is still highly valued as a solution in problematic life situations. Using manual vacuum aspiration MR is 'one of the safest medical procedures when performed by trained health care providers with proper equipment, correct technique and applying universal precautions for infection control'. But, different survey results indicate that currently married women have a moderately high knowledge of MR, but in most cases they failed to distinguish between MR and abortion. For this in some cased they rejected in performing MR due to big sizes.

The programme needs to emphasise on some issues like-

- First of all, needs to identify gaps and areas for actions and research;
- Human resources in the field: production and retention;
- Adequate IEC/BCC materials and campaigns for improving knowledge on MR services;
- Improve information base data analysis and use;
- Quality MR should be available and accessible, especially for those at risk for unsafe abortion in rural and urban poor, adolescents etc.

And finally require more emphasis on public-private partnership for ensuring safe service delivery.

- Altaf Hossain, Director
Bangladesh Association for Prevention of Septic Abortion (BAPSA) & Sitara Sultana, Manager - Advocacy & Communication, PMT, RHSTEP

Nupur (21), is the mother of a one-year old child. She came for MR as she is unable to take another child at this moment. Her husband also agreed with her decision. Nupur said, "I was in fear before doing MR as I am afraid of taking injections. I could not even take my food the previous night. My throat became dry again and again. But the doctors and counsellors received me cordially and assured me not to be frightened. Their behaviour helped me overcome my fear. And now I found it's really a simple process and won't take much time. The cleanliness of the service is also appreciable. It's really a helpful procedure for those who need to do it".

Mosammat Jesmin Akter (25), came to RHSTEP clinic at Dhaka Medical College Hospital from Pargendaria to perform MR for the second time. First time she received MR services from a clinic two years ago. Jesmin has three children. Her husband is a service holder earning little amount of money. So, without finding any other way, Jesmin took the decision not to take the child. She said, "MR is a helpful method for us. If there was no scope to do it, it could be too difficult for us to solve the problem".

TOT on SRHR for youth friendly services held in Dhaka

A 5-day long workshop titled 'Training of Trainers: Sexual and Reproductive Health and Rights (SRHR)' was held from 29 November to 4 December 2008 at CCDB Hope Foundation, Baroipara, Savar, Dhaka. It was the institutional collaboration of RHSTEP, BAPSA and Swedish Association for Sexuality Education (RFSU)[5]. The major objectives of the training were: (i) to create awareness among health care providers about SRHR, and (ii) to help participants develop positive communication skills necessary for communication with service providers on SRHR. A total of 24 participants comprising medical practitioners, counsellors, and high officials from RHSTEP, BAPSA, BRAC, FPAB, Bandhu Social Welfare Society and Marie Stopes Clinic Society attended the training.

Dr. Tahmina Sultana, Project Coordinator of HASAB was conducting the session on HIV/AIDS facts & Figures

The training started with an informal welcome by Quazi Suraiya Sultana, Executive Director, RHSTEP. Dr. Sabera Rahman, the President of RHSTEP and Dr. Altaf Hossain, Director of BAPSA also spoke in the inaugurating session. Dr. Luna Chakma, Manager-Programme, RHSTEP presented the overview of "Need Assessments of Adolescent Sexual and Reproductive Health and Rights". She outlined ASRHR situation of Bangladesh and the contribution of RHSTEP and BAPSA in this regard. Following the presentation, Dr. Nasrin Khairun Nessa, Programme Coordinator, RHSTEP clinic, Sir Salimullah Medical College & Mitford Hospital shared the Adolescent Health Education Programme of RHSTEP.

On day 2, Mr. Paritosh Kumar Deb, Deputy Manager - Programme, Bandhu Social Welfare Society (BSWS) presented an outlined of "Homosexuality and its related issues". In this presentation, he discussed on sex and gender, sexuality, MSM, transgender/Hijra, masculinity and femininity, SRHR and the law related to homosexuality according to Bangladesh Penal Code-377.

Dr. Magfera Begum, Director-Access, Family Planning Association of Bangladesh (FPAB) illustrated "the present situation of contraceptives in Bangladesh and MR/Abortion" on 3rd day. On the same day, Ms. Sabina Faiz Rashid, Associate Professor, James P Grant School of Public Health, BRAC University presented an overview on "Gender and Health" and showed how gender based violence is happening throughout a woman's life starting from her chilhood, adolescence, reproductive and also in old age.

Dr. Tahmina Sultana, Project Coordinator, HIV/AIDS and STD Alliance Bangladesh (HASAB) discussed on "HIV/AIDS Fact & Figures and RTI, STI & STD" on 4th day of the training.

The 5th day, Professor Mahmuda Islam, President, Women For Women delivered her presentation on 'Sexual Abuse and Violence Against Women (VAW) in Bangladesh and globally'. Following the presentation, Ms. Samia Afreen, Senior Project Officer of Naripokkho discussed on Prostitution and its related issues.

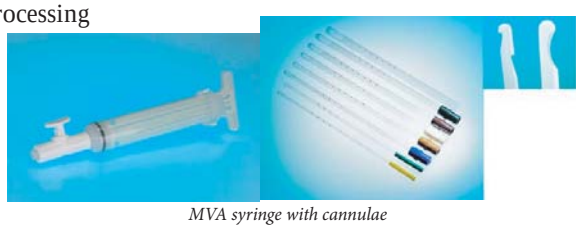
The last session of the training was on advocacy and its related issues discussed by Ms. Sitara Sultana, Manger - Advocacy & Communication, Project Management Team, RHSTEP. At the end of the session, a cultural programme was held performed by cultural team of RHSTEP. Different issues like dowry, AIDS etc. were highlighted through the drama and songs. After the cultural programme, the participants were rewarded through certificates.

Infection prevention protocol is a must in performing MR or safe abortion

Every woman has a right to the highest attainable standard of health and to safe reproductive health choices, including safe abortion care. The equipment most often used to perform MR or safe abortion by Manual Vacuum Aspiration (MVA) consists of a syringe and a flexible, soft plastic cannula. But to perform MR successfully infection prevention protocol of MVA instruments especially cannulae and syringe has to be maintained by a trained service provider. The four basic steps for processing MVA instruments are:

- Decontamination
- Cleaning
- Sterilisation or HLD
- Storage /Reassembly.

Personnel should wear gloves, mask- cap, and goggles during all stages of processing.



MVA syringe with cannulae

[5] The RFSU team could not join the training due to a seize of Bangkok airport during the period.

Decontamination

Draw the 0.5% chlorine solution through the cannulae into the syringe, and then drop the soiled instruments, including cannulae, syringe & gloves directly into the solution immediately after use to make them safer for staff to handle & clean. Allow the items to soak for at least 10 minutes prior to removing them for cleaning.

Cleaning

After decontamination, the syringe & cannulae should be washed thoroughly in water with detergent to remove all organic material. Thorough cleaning is the most effective way to reduce the number of microorganisms on soiled instruments. Neither HLD nor sterilisation procedures can be effective if items are not clean before processing. When washing the cannulae, tissue or blood is sometimes difficult to remove from the tip of the cannulae. It may be helpful to draw water (with detergent) repeatedly into the cannulae with the syringe to flush it out, or to flick the top of the cannulae with a fingertip.

Wash all parts of the syringe in water with detergent, taking care to remove all traces of blood or tissue. Scrub the syringe with a soft brush, such as toothbrush. Hold the syringe under water while scrubbing to prevent spraying of organic material. After washing, rinse the syringe & cannulae thoroughly with clean water to remove any residue. Dry the instruments by air or with a clean towel. Drying is not necessary for items, which are to be boiled.

Sterilisation/High- Level Disinfection

Sterilisation is the safest & most effective method for processing instruments. The process of sterilisation kills all microorganisms, including bacterial endopores, such as bacteria that cause tetanus & gas gangrene.

High- Level Disinfection is the only acceptable alternative of Sterilisation. By the process of HLD destroys all microorganisms including Hepatitis B virus & HIV, but does not reliably kill bacterial endopores.

After cleaning, all instruments that contact the bloodstream should be either sterilised or high-level disinfected. The exact method chosen will depend upon the facility capabilities for sterilisation/HLD, & the type of instruments involved. **Steam (autoclaving) or dry heat sterilisation should not be used on either the syringe or cannulae; the cannulae will melt & the syringe valve assembly will crack.** HLD is preferable method for cannulae sterilisation rather than autoclaving.

HLD/Boiling of cannulae

The cannulae should be boiled in closed lid boiler for 20 minutes from the boiling point. Boiling should be gentle & rolling. Do not add or remove **anything to the container after the water begins to boil.**

Syringe Disinfection

The syringe does not require either sterilisation or HLD, because the syringe serves only as the source of vacuum & receptacle for blood & tissue, & does not come in contact with the patient.

Reassembly/Storage

Appropriate storage of instruments is essential to maintain sterility/HLD.

Store HLD Cannulae

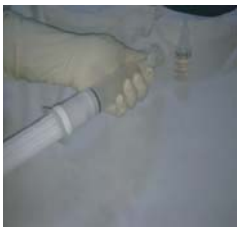
Store them in dry, covered HLD or sterile containers with tight-fitting lids. Do not store the cannulae in disinfectant solution or in previously boiled water because they may become recontaminated. When reaching into a container to retrieve a cannula, use only sterile or HLD forceps to avoid contaminating the rest of the cannulae. Grasp only the non aperture end of the cannulae. It is best to store small numbers of cannulae in each container, to minimise risk of contamination.

Storing the syringes

Air-dry all parts of the syringe completely. Store the syringes in covered containers or closed spaces, which will protect them from dust or other contaminants. It is not necessary to reprocess the syringes unless they become contaminated in some way.

Reassembling the Syringes

Replace the small o-ring on the plunger. Lubricate the o-ring by placing one drop of silicone on the o- ring, then spreading the silicone around the ring with a fingertip. Reassemble the syringe by holding the plunger arms in & inserting the plunger into the barrel. Reattach the collar stop. Push the plunger in & out several times to distribute the lubricant in the barrel. Check the syringe for vacuum tightness. This should be done after cleaning & again immediately before use. Do this by closing the pinch valve & pulling the plunger until the locking arms catch. Leave the syringe in this position for 2-3 minutes, & then release the pinch valve. You should hear a rush of air in to the syringe, which indicates that the syringe maintained the vacuum.



If you do not hear the rush of air, remove the plunger. Check the o-ring for foreign particles, & check the o-ring & syringe barrel for cracks. If the syringe parts appear undamaged, reassemble the syringe & lubricate the o-ring again (be careful not to over lubricate). Then repeat the test. If the syringe still loses vacuum then tested, it should be discarded.

Products incorrectly used as High-Level Disinfectants

The following products DO NOT achieve HLD & MUST NOT be used for that purpose.

- Cetrimide (Cetavlon)
- Cetrimide with chlorhexidine gluconate (Savlon)
- Chlorhexidine gluconate (Hibiscrub, Hibitane)
- Chlorinated lime with boric acid (Eusol)
- Carbolic acid 5% (Lysol)
- Phenol 1-2% (Phenol)
- Other skin antiseptics

(Source: ipas)

- Dr. Nasrin Khairun Nessa, Programme Coordinator, RHSTEP clinic
Sir Salimullah Medical College & Mitford Hospital

Performance Statistics

MR Services

Type of Centre	Last six months (July to December 2008	Since beginning of financial year (July to December 2008)	Previous financial year
Training/Service centres	72,450	72,450	1,13,039

MR Training

Name and Location of the Centre	Year of MR Training Facilities Established	Turnout of Fresh Trainees						Turnout of Refresher Trainees		
		Jul to Dec 2008		Jul 2007 to Jun 2008		Total turnout		Jul. to Dec '08	Jul 2007 to Jun 2008	Total turnout
		Doctor	Paramedic	Doctor	Paramedic	Doctor	Paramedic	Paramedic	Paramedic	Paramedic
MFSTC	1975	-	8	6	190	399	1,414	-	-	686
RHSTEP	1979									
DMCH	1979	6	4	10	23	1,510	354	-	13	745
SSMCH	1979	5	4	3	22	1,487	384	-	11	177
CMCH	1979	2	3	2	16	870	648	-	17	256
RMCH	1980	17	1	22	21	1,133	616	-	14	266
SBMCH	1981	3	-	24	17	1,274	550	-	9	222
SMCH	1981	-	-	-	11	807	412	-	14	197
MMCH	1981	4	2	8	12	1,004	695	-	12	182
PGH	1981	-	-	-	12	266	588	-	11	277
KMCH	1981	-	3	-	10	440	712	-	14	237
RIMCH	1988	8	2	7	12	691	288	-	8	271
NSH	1991	-	-	-	1	27	99	-	13	230
COMCH	1998	9	-	15	13	214	90	-	14	106
FMCH	1989	3	1	12	12	112	70	-	11	75
CBSH	1999	-	-	-	2	10	19	-	-	22
JGH	2001	-	1	-	2	7	8	-	-	19
MCD	2003	-	-	-	-	-	-	-	-	-
BMCH	2005	-	-	-	-	-	-	-	-	-
DIMCH	2005	-	-	-	-	-	-	-	-	-
Total		57	21	103	186	9,852	5,533	-	161	3,282
BAPSA	1983									
MRHC-1	2002	-	-	-	-	-	-	-	38	215
MRHC-2	2002	-	-	-	-	-	-	-	-	-
RRHC	2002	-	-	-	-	-	-	-	-	5
Total		-	-	-	-	-	-	-	38	220
Grand Total		57	29	109	376	10,251	6,947	-	199	4,188

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