

**Guidelines for
Improving Quality
of
STI Management
in a Health District**

**Lessons learnt from the
National STI Initiative**

RHRU

Reproductive Health & HIV Research Unit
of the University of the Witwatersrand, South Africa.



**HEALTH
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Guidelines for Improving Quality of STI Management in a Health District

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A joint project of the Reproductive Health & HIV Research Unit and the Health Systems Trust, working in conjunction with Provincial Departments of Health

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This publication was made possible through support provided by the Henry J. Kaiser Family Foundation (USA). The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the Henry J. Kaiser Family Foundation

The authors would like to thank the following departments and people for their contribution to this document:

- ▶ The Provincial Departments of Health of the Free State, Eastern Cape, Gauteng, KwaZulu-Natal, Mpumalanga, Northern Cape, Limpopo and Western Cape.
- ▶ District health managers and clinicians for their co-operation and hard work.
- ▶ Lesley Bamford and Arthi Ramkissoon for advice on the structure of the document and editing
- ▶ Sarah Davids
- ▶ ISDS facilitators at the sites where valuable lessons were learnt

Acronyms & Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-natal Care
CDC	Communicable Diseases Coordinator
CSM	Clinic Supervisor's Manual
DoH	Department of Health
DHIS	District Health Information System
DISCA	District STI Quality of Care Assessment
(I)DMT	(Interim) District Management Team
FP	Family Planning
GP	General Practitioner
GUD/S	Genital Ulcer Disease/Syndrome
HIS	Health Information System
HIV	Human Immunodeficiency Virus
IPU	Impendle-Pholela-Underberg
LA	Local Authority
MCH/MCWH	Mother and Child Health/Maternal, Child and Women's Health
MUD/MUS	Male Urethral Discharge/Male Urethritis Syndrome
PID	Pelvic Inflammatory Disease
PMTCT	Prevention of Mother-To-Child Transmission
PVD/VDS	Per Vaginal Discharge/Vaginal Discharge Syndrome
STI/STD	Sexually Transmitted Infection/Disease
VCT	Voluntary Counselling and Testing

For the purpose of these guidelines, the term “district” is not used to refer exclusively to a “health district”. It refers to a number of facilities within a given geographic area and may include a local area, a sub-district or a health district.

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Guidelines for Improving Quality of STI Management in a Health District

Lessons Learnt from the National STI Initiative

Purpose of this booklet

This booklet aims to provide guidelines that will assist managers, sexually transmitted infection (STI) programme coordinators and clinic supervisors to develop and implement strategies that will improve the quality of prevention and management of STIs in clients attending public health facilities.

Introduction

A number of resources are available for improving the management of STIs at the Primary Health Care (PHC) level. These include a training manual for the management of a person with an STI, national norms and standards for sexually transmitted diseases at PHC level and the District Quality of Care Assessment (DISCA) tool and booklets on its use, amongst others. (See Appendix 4)

This booklet outlines the processes that district level staff can implement to improve the quality of STI care in their districts. It is based on the lessons of the National STI Initiative. It has two parts:

- Part 1 outlines the key steps followed by the National STI Initiative in improving STI care at district level
- Part 2 describes two districts where the process was implemented.

This booklet, and some of the resources referred to above, are also available on CD ROM.

Why focus on STIs?

STIs are a major health priority in South Africa, both because of the high prevalence of these infections, and because of the morbidity and mortality associated with them particularly since the advent of HIV/AIDS. In South Africa, a rough estimate of some 8,000,000 episodes of STIs were treated in both the public and private sector in 2002 among a population (15 years or older) of about 30 million. In addition to this direct burden, STIs other than HIV infection also increase the risk of HIV acquisition and transmission. Prevention and early treatment of all STIs are priorities as reflected in the HIV/AIDS/STI Strategic Plan for South Africa 2000–2005.

The National STI Initiative

The National STI Initiative is a joint project of the Reproductive Health Research & HIV Unit (RHRU) and the Health Systems Trust (HST) working in conjunction with National and Provincial Departments of Health. It is funded by the Henry J. Kaiser Family Foundation.

The STI Initiative was established as an outcome of a national workshop held in Johannesburg in September 1997 to discuss strategies for controlling STIs. One of the top priorities identified during this meeting was the need to strengthen district-level capacity to implement an effective STI control programme. Subsequently, a framework for developing quality STI services was developed.

One of the main activities of the STI Initiative has been to strengthen STI management and prevention in the public health sector through monitoring and evaluation, training and support.

Initially, in 1999, four districts were selected as pilot sites for this intervention:

- Kopano – Free State
- IPU – KwaZulu-Natal
- Tonga – Mpumalanga
- Hillbrow – Gauteng.

The first three sites were also districts supported by the Initiative for Sub-District Support (ISDS), a project of Health Systems Trust. Hillbrow was chosen to provide support for an intervention managed by RHRU that involved hotel-based sexworkers.

In the latter part of 2001, three other districts were added:

- Alfred Nzo – Eastern Cape
- Frances Baard – Northern Cape
- Region 10, City of Johannesburg – Gauteng

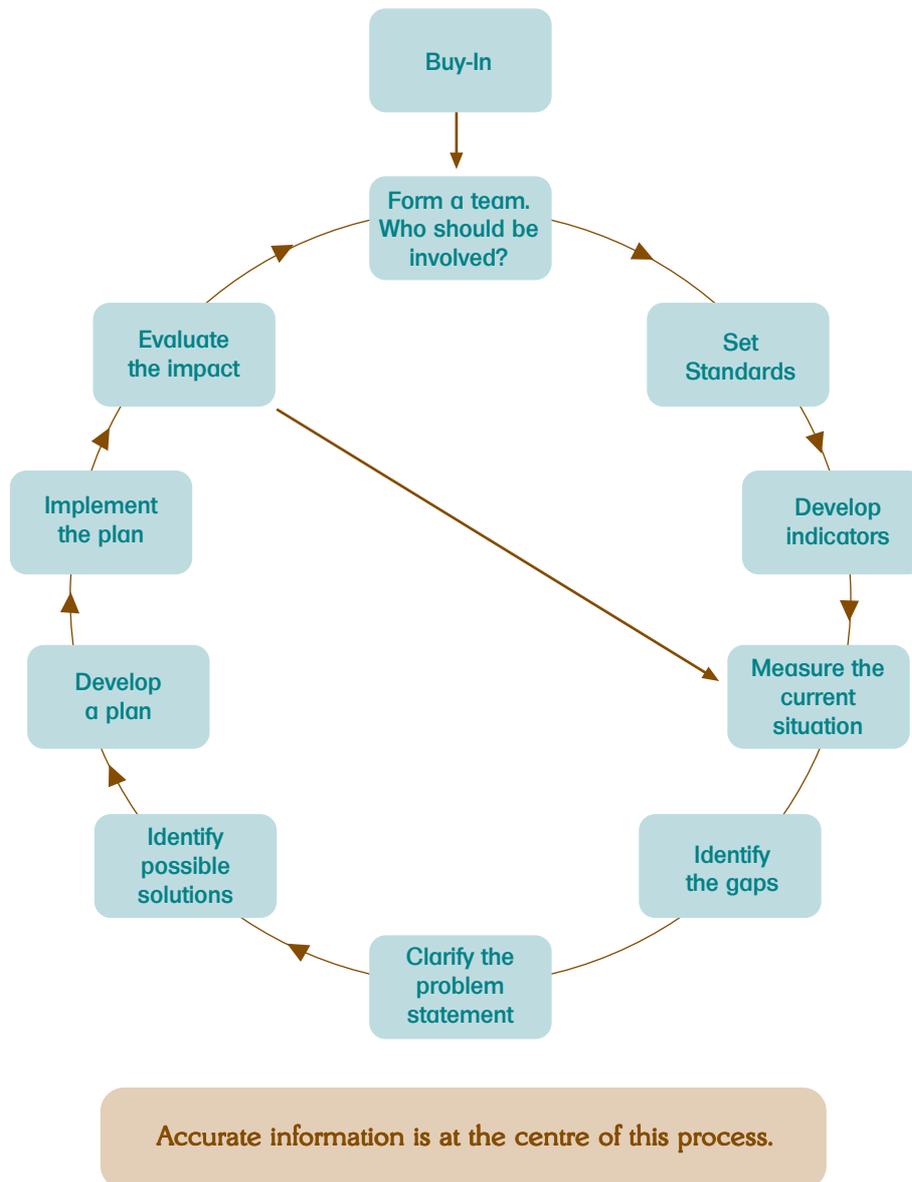
The guidelines recommended in this document are based on experiences, key successes and failures and lessons learned from the activities of the National STI Initiative. They are supplemented by experiences of health care workers and facilitators in other districts supported by ISDS, using the tools and resources developed from the Initiative.

Part 1:

Outline of the Key Steps followed by the STI Initiative to Improve STI Care at District Level

The Quality Assurance Cycle

The various steps involved in addressing quality of care are represented in the following diagram. Each of these steps will be described in the following pages.



Step 1: Buy-In

This is an important step, that is often overlooked. It applies whether the intervention is being co-ordinated by an external organisation (as was the case in the STI Initiative) or whether it is a local initiative. Commitment needs to be obtained from the people who could influence the progress (or otherwise) of the intervention. This would include the district manager, the relevant programme coordinator and the human resource development officer. In many cases the way in which an intervention is introduced will influence the ownership. Unless local staff grasp the vision, little progress will be made.

Introducing the tool in Region E, Eastern Cape Province

The intervention to implement the DISCA tool was introduced in this region in the Eastern Cape in June 2000 at a meeting with the regional Department of Health.

There was strong agreement that it should be implemented in all the districts in the region. However, this was subject to the districts buying-into the idea. A second meeting was then held where the districts were invited and the proposal (to introduce the tool in the districts) was outlined to them. Each district had a representative; either a District Manager, a district Communicable Disease Manager, a Health Information Officer, a Clinic Supervisor or a Programme Manager.

Sometimes, external influences impact negatively on the effectiveness and lifespan of a team, as illustrated by the story in Tonga.

Tonga

Tonga, in the south-east of Mpumalanga, was identified as one of the districts which would be supported by the National STI Initiative. Buy-in was done primarily through the ISDS facilitator who was working at the site. A meeting was held with the Provincial STI Coordinator at the time, who gave his blessing to the Initiative.

Progress was slow. The Provincial STI coordinator was moved and there was a period of confusion about who would replace him. A meeting was also held with the district Communicable Diseases Coordinator (CDC) and other members of the District Management Team (DMT). However, the CDC coordinator had his hands full with the malaria programme for several months of the year. In addition, Tonga was also affected by cholera. When it became possible for the CDC to give more attention to STIs, the demarcation process had begun leading to the re-constitution of the DMT.

Step 2: Form a Team

Development of a team is important in order to draw in all relevant stakeholders and to share the responsibilities. Greater impact will be achieved if a team can be formed that includes committed representatives from both local authorities and provincial health services. It may be appropriate to include staff from other relevant stakeholders and sectors such as prisons, defence force or mining industries.

The following questions can help to identify the appropriate and relevant people concerned with the quality of STI care in the clinics:

► **Who in the district is involved with STI management?**

- ✧ Provincial primary health clinics?
- ✧ Local authority clinics?
- ✧ Hospital gateway or out-patient clinics?
- ✧ Occupational health clinics – mines, factories, defence force?

- ✧ Private doctors?
- ✧ NGOs involved in reproductive health?
- ✧ Traditional healers?
- **Who are the people with motivation and commitment?**
- **Is it appropriate to form a team with representatives from all of these groups?**
 - ✧ How easy would it be to plan meetings with representatives from all these groups?
 - ✧ Would activities that are likely to be planned be relevant to everyone?
 - ✧ Would all these role players be committed to a joint strategy?

Suggestions

Invite representatives from all groups to a preliminary meeting to explore the possibility of a joint strategy.

The outcome could be cooperation in some areas (such as training programmes that include professional nurses from the different sectors) and independent action in others (e.g. ensuring a continuous supply of appropriate drugs.)

Forming a team from the public sector

At the District level, this should include representatives from both provincial and local authority clinics. This would include:

- The person who has overall responsibility for the quality of STI management in the district e.g. District Communicable Disease or STI/HIV coordinator
- The person responsible for STI training.
- One or more supervisors responsible for general oversight of clinics.
- Anyone who has a passion for improving the quality of STI management.

Other role players might include people responsible for the prevention of mother to child transmission (PMTCT), voluntary counselling and testing (VCT) and antiretroviral treatment (ART), maternal, child and women's health (MCWH) and health information systems (HIS) programmes. It is important to ensure that STI management and HIV programmes remain in constant partnership with one another. Remember that improving STI management forms part of the HIV prevention strategy.

Not all teams will comprise of the same people as illustrated by the examples of Kopano and Centurion:

Forming a team in Kopano

Following a meeting in February 1999 to introduce the STI Initiative, and where approval of the Initiative by the Interim District Management Team was received, an STI team was formed to lead the implementation of the intervention in Kopano. The team comprised the following members:

- the district STI programme manager (as team leader)
- the (provincial) sub-district trainer
- a local authority trainer
- a youth clinic nursing sister
- two trainers from the private sector.

Some members of the team were initially reluctant to be involved as they felt STI management in the area was of a good standard and that the intervention was unnecessary. This view changed through the course of the intervention.

Forming a team in Centurion

In Centurion, Tshwane, the intervention was implemented at a time when provincial and Local Authorities (LA) were managing and rendering health services in isolation of each other. The district was not demarcated into sub-districts, and the area managers were just beginning to hold joint meetings, albeit irregularly.

It was decided that the team would consist of the following members:

- the two area managers (LA & provincial) who were joint leaders
- a facility manager
- a doctor
- the nurse responsible for drug supply and management in the LA facilities.

The role of the team

The purpose of the team is to have a group of people who are committed to ensuring that STI management is conducted in the best possible way within the district.

This team has the responsibility of seeing that the steps involved in the quality assurance cycle are followed. They are not responsible for **doing** everything in that cycle **themselves**, but should ensure that appropriate steps are taken for improving and maintaining good quality of care.

The size of the team

The team should be big enough to be representative of all relevant role players. It should also be big enough to enable responsibilities to be shared in a way that does not put too much of a burden on any one person.

At the same time it should be small enough to be able to meet when necessary and to operate effectively. An appropriate size might range between 4 and 6 members.

Step 3: Set Standards

Whenever anyone assesses a situation, they automatically use some sort of standard in order to decide whether the situation is satisfactory or not. They may not have consciously thought about the standard, but the very process of deciding that some aspect of management is inadequate means that they have in their minds a picture or standard of what they would consider to be adequate.

In order to improve the quality of care, it is necessary to decide on particular standards that can be universally (or nationally or provincially) applied. The document *“The Primary Health Care Package for South Africa – A Set of Norms and Standards”* (revised March 2002) sets out norms and standards for primary health care facilities. The section dealing with sexually transmitted infections is reproduced on the following pages.

There is also a National document that deals specifically with guidelines for STI management: *First Line Comprehensive Management and Control of Sexually Transmitted Infections*. This is a recently updated document (2004).

These guidelines may be adapted for use at a local level and made appropriate for local conditions. For example, the National guidelines set a target of a 40% return rate for partner notification. If the current level of returns is 20%, aiming to achieve a level of 40% may be demotivating for staff if they don't succeed. However, if their goal is 30% within the next 6 months and they achieve that result, it is more likely to encourage them to set the target higher for the next 6 months.

NATIONAL NORMS AND STANDARDS

SEXUALLY TRANSMITTED DISEASES (STD)

(Source: "The Primary Health Care Package for South Africa" Dept of Health. March 2002.)

SERVICE DESCRIPTION

The prevention and management of STD is a service available daily at a clinic and is a component of services for reproductive health and for control of HIV/AIDS.

NORMS

1. Every clinic has a review of quality of care once a year by a supervisor preferably using the validated DISCA (District STD Quality of Care assessment) instrument.
2. Every clinic has at least one member of staff but preferably all professional staff trained in the management of STD using the "Training Manual for the Management of a person with a Sexually Transmitted Disease".
3. Every clinic has at least one member of staff (but preferably all who have been trained for STD) trained as a counsellor for HIV/AIDS/STD.

STANDARDS

1. References prints and educational materials

- 1.1 Standard Treatment Guidelines and Essential Drug List, latest edition.
- 1.2 Syndromic Case Management of Sexually Transmitted Diseases – guide for decision-makers, health care workers and communicators.
- 1.3 The Diagnosis and Management of Sexually Transmitted Diseases in Southern Africa, latest edition.
- 1.4 Supplies of patient information pamphlets on STD in the local languages.
- 1.5 Posters on STD and condoms in all the local languages.
- 1.6 Wall charts of the 6 protocols of STD management in consultation rooms.

2. Equipment

- 2.1 A condom dispenser placed in a prominent place where condoms (with pamphlets on how to use) can be obtained without having to request them.
- 2.2 Examination light (or torch if no electricity) for every room with a screened examination couch.
- 2.3 Sterile specula (specula plus steriliser).

3. Medicine supplies

- 3.1 List of drugs in accordance with the Essential Drugs List and latest management protocols.
- 3.2 A supply of male condoms with no period where condoms are out of stock.
- 3.3 Gloves.
- 3.4 Dildos – at least one per clinic but preferably one per consulting room.

4. Competence of health staff

- 4.1 Clinic staff provide STD management daily and have extended hours, or on call weekend time, if in an urban or peri-urban area.
- 4.2 The staff are adolescent friendly with friendly communication so as to be accessible and acceptable to shy patients whether male or female.

- 4.3 Patients have friendly, non-judgmental, confidential private consultations.
- 4.4 Staff are able to take a history and examine patients correctly with dignity and respect whenever patients have skin, mouth, genital and peri-anal areas examined.
- 4.5 The history is taken correctly and partner change enquired about (the gender of partners is not presumed).
- 4.6 Syphilis serology is done on all patients with STD – and twice in pregnancy (if RPR available at clinic this is done there), some do VDRL.
(Note: The only instance of routine RPR testing recommended in the new National Guidelines for STI management is during pregnancy.)
- 4.7 Pap smears are done on women over 35 or with a history of vulval warts.
- 4.8 Patients are counselled on safe sex and HIV/AIDS is explained to them.
- 4.9 Treatment is according to the protocol for each syndrome.
- 4.10 Condom use is demonstrated and condoms provided.
- 4.11 Contact cards in the correct language are given and reasons explained so that at least 60% result in the contact coming for treatment.

5 Referrals

- 5.1 All patients are referred to the next level of care when their needs fall beyond the scope of competence.
- 5.2 Conjunctivitis in the newborn is referred after initial treatment.
- 5.3 The patient is referred if pregnant and has herpes in the last trimester.
- 5.4 Pelvic inflammatory disease is referred if patient is sick, has pyrexia and tachycardia, or severe tenderness, or is pregnant.
- 5.5 A painful unilateral swelling age under 18 is referred immediately for a surgical opinion regarding a possible torsion.

6 Patient education

- 6.1 All patients receive health education on asymptomatic STD, misconceptions, rationale of treatment, compliance and return visit.
- 6.2 Time is given during counselling and discussion after treatment about the need for contacts to be treated.
- 6.3 If the patient's syndrome is vaginal discharge the possibility of it not being sexually transmitted is discussed.
- 6.4 If pregnant then implications for the baby are discussed (congenital syphilis, ophthalmia, HIV, Chlamydia).
- 6.5 The importance of condom use is stressed.

7 Records

- 7.1 Patient's records are kept according to protocol with confidentiality stressed.
- 7.2 Laboratory registers with return time for laboratory specimens not greater than 3 days.
- 7.3 A register is kept of contact cards issued and returned.

8 Community based services

- 8.1 Staff liaise with traditional healers about care of STDs.

9 Collaboration

- 9.1 Staff collaborate with different departments such as schools, churches, traditional healers and community organisations implementing health promotion activities leading to the prevention of STD.

Step 4: Develop Indicators

An indicator is a measure, often expressed as a percentage, which tells you something about a situation. It is the way in which you assess how close you are to the required standard. It involves a numerator (e.g. the number of partners who came for treatment) and a denominator (the number of partner notification cards issued).

$$\frac{\text{Number of partners treated}}{\text{Number of partner cards issued}} \times 100 = \frac{15}{67} \times 100 = 22\%$$

The indicator here is the return rate on partner notification cards issued, which in this case is 22%.

The records kept in the clinic provide data from which some indicators are developed.

Another indicator, included in the DISCA, but not based on routine clinic records, is the availability of STI drug treatment protocols in consultation rooms. The standard is that there should be a copy in every consultation room. The indicator would be the percentage of consultation rooms where protocols are available.

Managing with Information

For many clinicians, collecting data is just a routine part of their job. This data is generally not used to manage services or to improve the quality of the service.

The routine data available from the District Health Information System (DHIS) – daily register and monthly summary provides the first level of useful information that can be used to assess the performance of the service, and to develop interventions for improvement. This will be further discussed below.

If more information about STI management is required, tools such as the DISCA can be used. This is a quantitative quality assessment tool that measures key input, process and output indicators related to STI care at PHC level (See step 5 below).

If even more information is sought, particularly of a qualitative nature, STI clients could be interviewed using the STI Client Exit Interview Questionnaire (Appendix 1). Clinician consultations with STI clients can also be observed using checklists (Appendix 2 and 3).

Each of these yields increasing levels of information on the quality of the STI service. However, these tools cannot be used routinely; BUT all PHC facilities will have routine DHIS available.

The section below details how this routine data can be used to improve STI management.

Use of Routine DHIS Data

As part of their daily work, health workers at all health facilities collect data as part of the District Health Information System (DHIS). These data provide valuable information that should be used for planning and management of health services at local level, to improve both access and quality. Proper record-keeping is important to ensure the accuracy of this information. Records are also kept in patient files and registers.

Data from facility level are collated and forwarded to sub-district, district, provincial and national level.

It is important that clinicians have the correct understanding of the definitions of all the data elements. Without this, they cannot collect accurate data.

In order for clinicians to be committed to collecting accurate data, they need to understand the value of the data and, in particular, how they can use this information at facility level. Unfortunately, in a lot of facilities, data are neither discussed at facility level, nor used to plan and manage the health service.

In the DHIS, data elements and indicators of relevance to the STI programme include the following:

Data element	Indicator
STI treated – new episode	Incidence of STI treated-new episodes (annualised)
Male Urethritis Syndrome (MUS) treated – new episode	Incidence of MUS treated-new episodes (annualised)
STI partner notification slip issued	STI partner notification rate
STI partner treated – new	STI partner tracing rate
Male condoms distributed	Male condom distribution rate (annualised)

(Source: STI & HIV Prevention Unit, Department of Health)

Definitions and rationale for use

STI treated – new episode

Definition: A new episode of a symptomatic Sexually Transmitted Infection (STI) treated according to the Syndromic Approach. One patient can have more than one new episode at the same time.

The data element counts new episodes, not patients. Count **ONLY NEW** episodes of a **SYMPTOMATIC** STI. It includes all clients presenting with an STI except those who have attended the facility recently and have come for review/check-up or those whose current STI has not improved or resolved. It does **not** mean that this is the first time the client has had an STI or attended this health facility.

Rationale/Context: These data are used to calculate the incidence of STI treated – new episode, the Male Urethritis Syndrome ratio and the STI partner treatment rate.

Male Urethritis Syndrome – new episode

Definition: A new episode of Male Urethritis Syndrome (MUS).

Each new episode of MUS must **ALSO** be counted under 'STI treated – new episode'. The data element counts new episodes, not patients. Sometimes it is difficult to decide whether it is a new episode or a persistent episode: A thorough history needs to be taken in patients who report again to the facility shortly after receiving treatment of a previous STI: If symptoms of the previous episode disappeared, or substantially improved and there is a history of recent, unprotected intercourse with a sexual partner whose infection status is unknown or who has not been treated, a new episode should be assumed.

Rationale/Context: MUS is used as a proxy of the number of new STIs because there is little else that it could be (it is a true STI), is easily diagnosed, the patient usually has to come for treatment and it responds well to syndromic treatment. The reliability of this is dependent on the extent to which men in the community use public health facilities. In women, some vaginal discharges may actually **NOT** be STIs and to include them overestimates STIs.

These data are used to calculate the incidence of MUS treated – new episode and the MUS ratio.

Incidence of MUS treated – new episode (annualised)

Definition:	A new episode of Male Urethritis Syndrome (MUS)
Calculation:	$\frac{\text{MUS treated (new episodes)}}{\text{Male population 15 years and older}} \times 12$
Context:	Each new episode of MUS must ALSO be counted under 'STI treated – new episode'. The data element counts new episodes, not patients. Sometimes it is difficult to decide whether it is a new episode or a persistent episode: A thorough history needs to be taken in patients who report again to the facility shortly after receiving treatment of a previous STI. If symptoms of the previous episode disappeared, or substantially improved and there is a history of recent, unprotected intercourse with a sexual partner whose infection status is unknown or who has not been treated, a new episode should be assumed.
Use:	To track the occurrence of new MUS infections (spread of STIs) in the target population.

STI partner notification rate

Definition:	The number of partner notification slips issued as a percentage of all new STI episodes treated.
Calculation:	$\frac{\text{STI partner notification slips issued}}{\text{STI treated (new episodes)}} \times 100$
Rationale:	This measures the extent to which clinicians issue partner notification cards to new STI clients. The target is at least 100%; that is one partner notification slip per new STI client. However, rates above 100% are encouraged as they indicate that where a client has more than one contact, more than one slip is issued.

STI partner tracing rate

Definition:	Partners treated as a percentage of notification slips issued.
Calculation:	$\frac{\text{STI partners treated (new)}}{\text{STI partner notification slips issued}} \times 100$
Rationale:	This measures the efficiency of the partner notification system. A low rate means that clients have not had adequate health education about the need to get their partners treated. This needs clear messages to be taken into the community, particularly amongst the high-risk groups. The target is at least 45% (assuming that half the partners seek treatment in the private sector which is not captured in the DHIS).
Use:	To monitor efficiency of the partner notification system.

Male condom distribution rate (annualised)

Definition:	The number of male condoms distributed to patients at the facility or through other channels - per male 15 years and older (sexually active) over one year.
Calculation:	$\frac{\text{Male condoms distributed}}{\text{Male population 15 years and older}} \times 12$
Rationale:	The total number of condoms distributed can give an impression that a lot of condoms are distributed. When expressed per sexually active male, the extent of condom access is clearer. The target should be at least 78 over one year. If a facility is achieving this level, it should set its target higher.
Use:	To assess distribution of male condoms in the country.

Additional Indicators

Apart from the above elements and indicators, there are other useful STI indicators that can be calculated and monitored monthly:

- The percentage of adult clients treated for an STI

Calculation:
$$\frac{\text{Number of new STI cases in one month}}{\text{Number of adult clients in that month}} \times 100$$

How does this percentage compare to the provincial or district HIV sero-prevalence rate? Is it increasing, decreasing, constant? (Note that the adult PHC Headcount includes all patients who are 5 years and older – but this is how most provinces are collecting headcount data.)

- The percentage of FP and ANC clients diagnosed with an STI

Checking through the daily register, how many FP and ANC clients are diagnosed with an STI? How often are these clients asked about STI symptoms and examined in search of a STI?

Remember: Both groups are sexually active and are thus at risk of acquiring a STI! ANC clients have recently engaged - and are probably continuing to engage in unsafe (unprotected) sex. FP clients are protecting against pregnancy but might not be protecting against STIs.

Staff should be encouraged to discuss the risk of a STI, and to pro-actively look for STIs in all clients, particularly ANC and FP clients. All females suspected of having, or complaining of a STI, should have a speculum examination.

It is advised that the monthly facility data be discussed with all staff, noting trends, discrepancies and short-comings. Staff should be encouraged to come up with possible solutions to the problems experienced.

Client records and registers should also be checked regularly to assess accuracy and completeness (for example, does the prescription include the drug name, dosage, route, frequency and duration?).

Staff should be congratulated on good work done, and also motivated to improve where necessary.

Step 5: Measure the Current Situation

In order to evaluate the impact of an intervention, it is important to establish the quality of services at the start of the intervention. This will be the baseline against which progress can be measured.

There are a number of tools available which can be used to measure the quality of STI management. The main tool used by the STI Initiative was the District Quality of Care Assessment (DISCA) (Appendix 5).

What is the DISCA?

This is a quality assessment tool that measures key input, process and output indicators related to STI care at PHC level. It is a short questionnaire and was developed after extensive consultation with nurses, public health professionals and health service managers.

The DISCA tool is fairly easy to use and involves looking at clinic records, seeing what resources are available and asking some questions of health providers. It mainly provides quantitative rather than qualitative information – that is, it tells you whether the knowledge and resources for providing quality of care are available. It does not provide much information on the actual quality of consultations with STI clients.

Read carefully through the booklet “A Practical Guide to Using the District STI Quality of Care Assessment” which explains the process in detail.

The main steps to note:

- Familiarise yourself with the DISCA tool **before** using it
- Develop an assessment plan taking into consideration the number of facilities to be assessed, the

distance between these facilities, the availability of transport, the number of STI team members and their availability (who shall visit which facility, and when).

A training session can be held with the team to address the above two points.

In the experience of the National STI Initiative, the quality of information from the DISCA was often poor if training on the use of the tool had not taken place. Those who use evaluation tools need to understand how to use the tool effectively as well as being committed to the value of conducting an evaluation.

Tips for clinic visits to evaluate services

- Notify clinic staff to arrange a suitable time for the visit. Clinicians should not feel that supervisors are coming to catch them out. Explain that you will require the previous month's data and patient records/ files/ register. If clinic staff have this information readily available it will facilitate the evaluation process.
- If possible call all the staff together to explain the purpose of the visit. Some staff at clinics where several DISCA rounds had been conducted, did not know about the DISCA.
- Commend the staff for good quality care and initiative.

At one clinic there were some hand drawn health promotion posters that a nurse had asked a community member who was good at drawing to develop.

- Use the visit as a teaching opportunity. Many of the problems identified can be clarified immediately. For example, staff at one clinic were referring clients to another facility for all their treatment if they were out of stock of one drug. This was based on the misconception that no STI drugs should be given unless all the drugs for a syndrome are given simultaneously.
- Remember that availability of resources does not automatically mean that they are used appropriately.
- Encourage staff to come up with their own suggestions of how quality of care could be improved.
- Ensure that feedback is given to the clinic (and passed on to all clinicians) on the findings of the evaluation.
- Expect to spend between 45 to 90 minutes to complete an assessment at each facility, depending on the availability of the data and your experience with the tool and the process.
- When subsequent evaluations are done, point out the areas of progress and discuss the reasons for poor progress, as relevant.

The DISCA provides mainly quantitative information. It establishes whether all the necessary resources are available to enable quality of care to be provided. **It does not establish whether that quality is provided.**

Other methods that would give more qualitative information (but are more time consuming) include client exit interviews, observation of consultations or use of simulated clients. (Ethics approval would be required.)

Examples of client exit interview forms and consultation checklists are available in the appendix.

Limitations of DISCA

The DISCA is a useful tool for evaluating quality of STI care at a clinic level. It provides information on accessibility of STI services, availability of resources, routine data, staffing and training, knowledge of STI drugs and a clinic record of 10 STI clients. However, there are a number of key aspects of quality STI care that are not addressed by the DISCA.

What can't the DISCA do?

- It does not give information on the quality of history-taking.
- It does not show whether clients are properly examined, or even whether they are examined at all.
- It does not indicate whether clinicians screen other clients for STIs. For example do they establish whether clients coming for other reasons might also be at risk of having an STI. Particular categories of clients who might be at risk, because they are obviously sexually active, are those coming for contraception or for antenatal care.
- It indicates whether the correct drugs have been prescribed according to the diagnosis, but it cannot indicate whether that diagnosis was correct.
- It does not identify how well health education is done – whether it is done at all, whether it is relevant to the client or whether the manner of communicating is appropriate. It does not establish whether the client has understood any of the health education that might have been given.
- It provides no information on whether clients have been offered an HIV test or whether they have been tested.
- It gives limited information about infection control.
- It does not indicate whether clients are actually using condoms.
- It indicates the number of people who have been trained in STI management and HIV counselling, but it does not provide information on the quality of the training, nor does it indicate whether the training is being effectively implemented.
- It does not identify the causes of the problems revealed e.g. why there are drug shortages, why only some (or no) women have speculum examinations.
- It does not assess user friendliness or client satisfaction.

Step 6: Identify the Gaps

Once the information has been gathered it needs to be analysed and interpreted in order to establish the gaps between the actual and the desired quality of management. There are forms available for analysing information from DISCA reports, as well as a guide to using these forms and interpreting the findings (*“Evaluating the Quality of STI Management at a Regional Level Using the District Quality of Care Assessment Tool”*).

Analysis can be done using a computerised system, but it is best done manually by members of the STI team.

By calculating the indicators themselves, team members are able to gain an understanding of what the findings mean, both for service delivery (facility, equipment, staff training drugs, etc) and for their communities (incidence of STIs, profile of STIs seen).

The purpose of the analysis is to answer the following questions:

- What does it mean? (Is it high? Low? What did we expect to find and why?)
- So what? (What is the significance of the finding? What are we going to do about it?)

Below are some of the common gaps found during the course of the STI Initiative:

- ✧ STIs were mostly diagnosed in clients who came to the clinic specifically because of STI symptoms. Little attention was paid to finding out whether other clients, such as youth or antenatal and family planning clients, were at risk of STIs or even whether they had symptoms.
- ✧ Clinicians often did not know the infections and complications associated with each syndrome, nor why the particular drugs were prescribed for each syndrome.
- ✧ A significant number of clients did not get the correct treatment according to the diagnosis.
- ✧ Where more than one syndrome was present, treatment was usually incorrect.
- ✧ Few women with STIs were examined with a speculum.
- ✧ Many clinics had insufficient working examination lights or specula.
- ✧ Male condoms were promoted through women without establishing whether these women were able to discuss condom use with their partners. Condom use was rarely demonstrated with a dildo.
- ✧ In some areas drug shortages were a major problem.
- ✧ Quality of record keeping was often poor.
- ✧ Attitudes towards clients with STIs were sometimes impatient and judgmental.

Step 7: Clarify the Problem Statement

In order to find an appropriate solution to an identified gap, it is important to try and establish the reason(s) for the gap. For example, if speculum examinations are seldom done on women with STIs, there may be a number of different reasons for this. These reasons could include: shortage of specula or examination lights; lack of awareness that speculum examinations play an important role in correct diagnosis; lack of confidence in using specula or a perception that clinicians are too busy to have the time. It would be helpful to ask the clinic staff at the time of doing the evaluation, why they feel speculum examinations are seldom done.

If the correct reason is not identified, the proposed solution may be inappropriate. For example, ensuring there is enough equipment may not lead to any improvement if clinicians are not confident in the use of specula. On the other hand, providing training in speculum examinations may be a waste of time and money if the actual reason is that there are no functioning examination lights.

Step 8: Identify Possible Solutions

This step is linked with the previous step of clarifying the reason for the problem. It may be helpful to brainstorm various ideas for addressing the problem. For example if there is poor return on partner notification cards, there are a range of possible ways of improving this.

Ideas might include:

- approaching local radio stations and newspapers to increase awareness in the community of the importance of partners being treated.
- exploring ways of helping clients to discuss the need for treatment with their partners.
- providing leaflets in the clinic that explain the importance of the treatment of partners (The *Equity Project* has produced a leaflet for this as well as for other aspects of reproductive health).
- extending clinic hours to enable partners to come after work.
- creating a 'fast lane' so that partners can be seen more quickly.

Step 9: Develop an Action Plan

Having gone through all the preceding steps, the time has now come to decide on some CONCRETE ACTION! The action plan is obviously based on the findings and conclusions of these steps and is developed by the STI team.

Some actions may apply to individual clinics, while others may involve a strategy at district level.

Action plans need to be **SMART**:

- S – Specific** What exactly will be done (action)? By whom?
- M – Measurable** How will we know when it has been done?
- A – Attainable** Is that something we will be likely to achieve?
- R – Realistic** This overlaps with “attainable” above, but includes identifying the resources that will be needed. Are the necessary materials, finances, personnel and commitment available? Local conditions influence what is attainable and/or realistic.
- T – Timeframe** By when will this be done (action completed)? Do some of the plans need to have interim time frames?

An example from Senqu Local Area in Ukhahlamba District

One of the identified gaps from the DISCA assessment was that none of the facilities had sterilising equipment. As part of the action plan, a target of 25% was set to increase the percentage of facilities with sterilising equipment over one year. The ideal is 100%, and this could have been set as a target. However, given the limitations of financial resources and time, a lesser, more realistic and achievable target was decided upon.

Step 10: Implement the Plan

This stage will inevitably involve providing training and support for carrying out the decisions. Ongoing support for all role players is an important part of any intervention aimed at improving quality of care. This support should provide encouragement to nursing staff as well as ensuring that the resources needed for clinical management are available.

At a meeting of African leaders at Victoria Falls in 1999, President Thabo Mbeki said:

“The fact that we knew what needed to be done did not mean that what we planned to do was therefore done.
NOTHING IS DONE UNTIL IT IS DONE.”

*Many a good plan has been made and filed!
A plan is only as good as the extent to which it is carried out.*

Implementing a Training Plan: Kopano, Free State

After the establishment of a Kopano STI training team, three training modules on the clinical, administrative and managerial aspects of STI management were completed:

- 5-day module for local trainers
- 3-day follow-up module focusing on supervision
- 3-day practical clinical training organised at a dedicated STI clinic in Durban (February 2000).

This provided the opportunity for participants to be exposed to a great number of STI syndromes in a relatively short time, thus enhancing their skills.

Part of the intervention was to cascade the training to staff. In Virginia, for example, 99% of the nursing staff were re-trained using the materials and methodology learnt in the first and second STI training modules.

Training was also provided for LA managers, supervisors and clinicians. Community Service Doctors and some GPs were also trained. The accreditation of the training for CPD points was very effective in attracting professionals.

Targeted Supervision in Centurion, Tshwane

When the first assessment of the quality of STI management was conducted in November 2001, it was found that in spite of the availability of resources like equipment, drugs, protocols, stationary and condoms, up to 19% of STIs were treated incorrectly for the diagnosed syndrome. This was evidence that clinicians do not always refer to the protocol. The availability of resources does NOT imply their use.

At the time that the STI intervention was implemented, the *Clinic Supervisor's Manual* was being introduced to Tshwane. This new system required that supervisors visit each facility at least once a month using standard tools. In Centurion, a record review of at least one case of STI per visit was added to monitor clinician practice. The use of the speculum was also promoted at these visits.

Clinicians thus became aware that their management of STIs was being monitored. In the repeat assessment in April 2003, incorrect treatment had decreased to 15%.

No additional STI training was undertaken between assessments.

Key Points about Training

1. Establish Training Needs

- Not every aspect of improving quality of care involves training.
- For training to be relevant a performance needs assessment should be done. What is the current performance? What is the desired performance? What strategy will bridge the gap?
- So, the key questions to ask here are:
 - ✧ Is training needed?
 - ✧ If so, **who** needs to be trained?
 - ✧ What **type** of training is needed?

2. Designing Training

➤ **How much time can be given to training?**

This will depend on a number of factors, such as:

- ✧ How easily can staff be released from the workplace?
- ✧ What budget is available?
- ✧ Will it involve travel and accommodation expenses?

➤ **What type of training is needed?**

- ✧ Should the training focus on knowledge, attitudes, skills – or all three?

➤ **How will the skills component of the training be addressed?**

This is often the aspect of training most difficult to address. Clarifying knowledge can be done with a number of people at one time. For skills training to be effective, it really needs to be done one on one.

Skills training has 3 key steps – watch how it is done; try it yourself with someone watching you; show someone else how to do it.

One of the skills needed in STI management is examination of the vagina, both manually and with a speculum. One way to assist clinicians to acquire this skill is to identify those people in the district who are already competent (often those who have attended an extended training in family planning methods) and arrange for them to train the clinicians in their vicinity.

➤ **When should the training take place?**

- ✧ What other training is taking place around this time?
- ✧ Will training be done as a single block, or in modules?

Modular training is often more effective, especially if trainees are given some relevant practical task to do between modules, and provided the same people attend each module.

Example of practical tasks are:

- Ask all family planning clients about the presence of a vaginal discharge and calculate what percentage of them have a discharge.
- Ask all STI clients whether they think they may be at risk of HIV, document the results with reasons for their answers.
- There must be sufficient time for those who are going to attend training to make proper arrangements at work and at home to free them for the training.

➤ **What will make the training relevant, interesting and motivational?**

- ✧ Training should be based on principles of adult education.
- ✧ The flow of the different components of training should follow a logical sequence.
- ✧ Take into account the realities of the working situation. For example, there is no point recommending an approach to health promotion that takes 20 minutes for an individual client in a setting where the client/provider ratio doesn't allow this amount of time. A better approach would be to assist clinicians to identify principles of effective health promotion, together with key questions to raise with the client. It is far more effective to assist clients to discover for themselves, the risks they are exposed to, than to tell them those risks.
- ✧ Training should be done in such a way that trainees gain new insight into effective management. It should assist them to figure things out for themselves, rather than providing information directly.

➤ **How will you tell whether the training has been effective?**

This is a vitally important component of training that is often neglected. How will you know whether the training has been effective? This obviously links in with the performance needs assessment. Has the gap been narrowed?

This evaluation is much broader than a test of knowledge at the end of the training.

How can you try to sustain and further improve quality of management?

3. Delivering Training

- Create a learning environment where participants feel comfortable and safe. No one should feel their question is too stupid.
- Encourage participation, but remember not to focus only on those who participate readily.
- Be flexible in implementing your training plan without sacrificing important components.
- Don't feel you have to have all the answers. Both you and the participants can take responsibility to find out things you can't answer at the time.
- Where possible use icebreakers and refreshers that have an application to the topic, e.g. an activity illustrating HIV spread, or ways of addressing health promotion. Examples of this type of activity are in the Trainer's Package (see Appendix 4).
- Have fun. The impact of training which is enjoyable will go much further than that which is boring.

4. Evaluating Training

There are four sources of evaluation information:

- Informal information from learners
- Measures of learner satisfaction, e.g. through the use of an evaluation form for each day of training.
- Measures of knowledge acquired during training through the use of pre- and post-tests, through subsequent visits in the work place and the use of quality evaluation tools.
- Measures of skills acquired during training through on-the-job visits and use of skills checklists.

Where possible, follow-up visits should be made by those who conducted the training. Alternatively, there should be close cooperation between the trainer and those who will conduct these visits.

Step 11: Evaluate the Impact

It is this step that makes quality improvement a cycle, because we now return to measuring the new current situation. How successful were we in closing the gaps in the quality of care? Was our action plan appropriate? What is the reason for the aspects that were not successful? Do any of the proposed activities need modifying? What steps need to be taken to sustain and further improve quality of care?

The evaluation should use the same indicators used in step 5. You may now wish to go further and use more qualitative indicators to start a new quality assurance cycle. It is important to celebrate the successes, as well as identifying the reasons why some of the goals may not have been achieved.

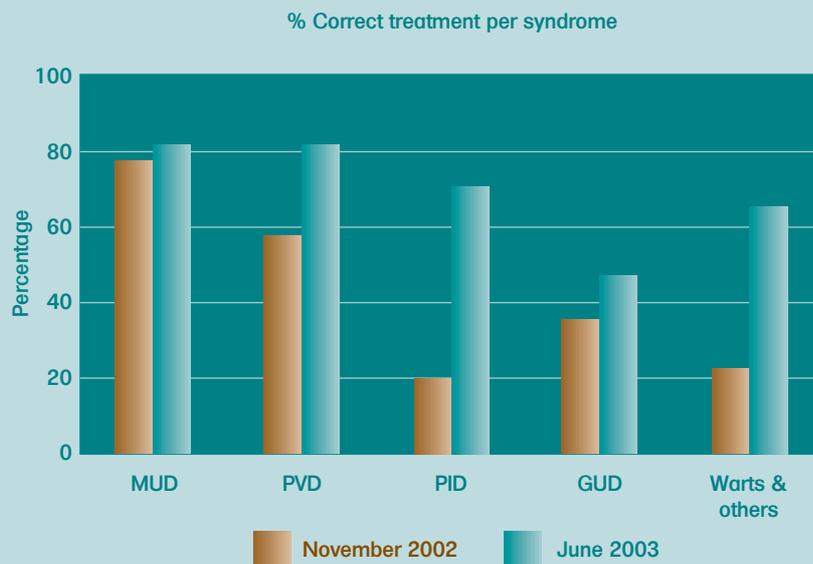
The timing of the repeat assessment is very important. On the one hand, sufficient time should be given to implement the action plan prior to repeating the assessment; on the other, the momentum of the intervention might be lost if too much time elapses. A period of between 9 months to one year has been found to be ideal.

Maluti-a-Phofung: conducting a mini-DISCA between assessments

A baseline assessment of the quality of STI management was conducted in November 2002 in Maluti-a-Phofung. An action plan was developed and implemented with the leadership of the STI team. To monitor the implementation of the plan, and the impact of the intervention thus far, the team conducted facility visits and assessed aspects of the DISCA questionnaire (mini-DISCA) in June 2003.

The team was encouraged by the positive gains they noted. The facility visits also presented an opportunity for the team to support facility-based staff, to praise them for the good work, and to offer them encouragement.

A repeat assessment (full-DISCA) was conducted after one year (November 2003).



Case Studies

The Kopano¹ Story

One of the first districts in which the National STI Initiative was implemented in 1999 was Kopano in the Free State. The district offices were in Welkom and there were nine other towns in the district with a total of 27 clinics (excluding mobile clinics). This area now forms part of Lejweleputswa – DC 18 in which there are 45 clinics.

Key Steps

► Buy-In

In February 1999, the STI Initiative was introduced to the Kopano district by staff from both HST and RHRU and received the approval of the Interim District Management Team.

► Establishing a baseline

During April and May 1999 a baseline survey, using the DISCA, was carried out by district staff in 24 of the 27 public sector clinics. It was assumed that the DISCA was self explanatory and no training was provided in the use of the tool. One of the lessons learned was the need to train people in the use of tools if good quality data are expected.

► Forming a team

In June 1999, people were selected by district staff to form an STI team. Kopano had a district manager for STIs who was the team leader. Other team members were a sub-district trainer, local authority trainer, youth clinic nursing sister and two trainers from the private sector.

► Analysis of DISCA finding

The completed DISCAs were sent to RHRU where the information was analysed and a report given to the district.

Key Findings from DISCA analysis

Results showed considerable deficiencies in STI care, as follows:

- ❖ Little was being done to evaluate the quality of STI care in clinics. Most clinicians felt the level of management was good until they examined the situation more effectively through the use of a quality of care assessment tool.
- ❖ Vaginal examinations were not perceived as being an important part of diagnosis for syndromic management.
- ❖ Clinicians mostly diagnosed STIs in clients who actively reported symptoms or signs. They were not proactive in looking for STIs among other clients who might be at risk.
- ❖ The knowledge and prescription of treatments often fell short of the standard, resulting in many clients being incorrectly treated.
- ❖ Insufficient supplies of drugs, condoms, treatment protocols and equipment also impacted on quality of care.
- ❖ Clients with STIs were often characterised unfairly, typically in terms of being difficult, unco-operative, blameworthy and even immoral.

1 Kopano is now part of Lejweleputswa district

Development of an action plan

Training

On the basis of the issues identified, a training programme was developed. This was divided into three modules. Feedback on the DISCA findings were given to district staff at the time of the first module of training.

- August 1999 – Module 1 (5 days). Comprehensive STI management aimed at trainers.
- Trainers cascaded training to clinicians at their clinics
- November 1999 – Module 2 (3 days) Focus on supervision.
- February 2000 – Module 3 (3 days) Clinical skills training conducted at the STI clinic in Durban.

District activities

The STI team developed action plans based on the DISCA findings. (Table 1)

The initial action plan stated the causes found for each problem, the action to be taken, when and by whom, and the date for following-up to assess the results.

Table 1: Action Taken to Address Problems

Problem Identified	Action Taken
Shortage of drugs	Went to Provincial supply depot to sort out problem. Training provided knowledge of alternative treatments.
FP and ANC clients not asked about STIs	STI team members promoted awareness in clinicians .
Low return of partners	Partner notification slips produced in Sotho.
Shortage of condoms	Requested more condoms based on the distribution network and stock levels .
Poor use of speculum	More specula ordered. Emphasised the role of speculum examination in diagnosis through training.
Lack of dildos	Ordered and distributed to clinics.
Shortage of awareness material	Ordered materials directly from supplier.
Perceived staff shortage	Encouraged change of attitude to improve motivation of existing staff.

Monitoring and evaluation

- During February/March 2000, a second round of DISCAs was conducted in 25 clinics. A report was given to the District Management Team in June 2000. There was significant improvement in several areas (See graphs on pages 27-28).
- Support was given for implementation of action plans and cascading of training.
- In six clinics in one town, the average number of STI clients identified in the six month period following training more than trebled. In the district as a whole, the percentage of adults treated for STIs increased from 4.5 to 5.6 between the first and second DISCAs – an interval of 10 months.
- A third round of DISCAs was conducted in November 2000. At this stage Kopano had merged with the neighbouring district with an additional 22 clinics, six of which were included in this DISCA round. The overall findings reflected ongoing improvement in some areas, but not in others. This was partly because of the additional clinics that had not been part of the Initiative. It also illustrates the challenges of sustaining improvements in quality of care.

- In October 2001 a fourth DISCA round was conducted. This included 37 of a total of 49 clinics. These DISCAs were analysed and interpreted by district staff at a workshop. Until this time DISCAs had been conducted by district staff, but analysed by RHRU staff.
- A year later in October 2002, 34 clinics were assessed using the DISCA. Analysis, interpretation and development of action plans were done by district staff. This round of DISCAs was done at the initiative of the district staff, without staff from the STI Initiative requesting it.

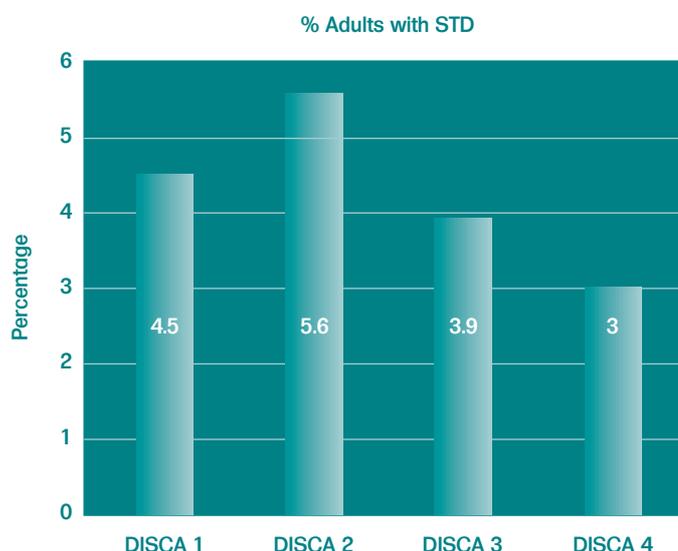
Other Activities

- Behavioural sentinel surveillance (BSS) was conducted to assess knowledge and behaviour that may contribute to STI risk. This was done in two stages. The first stage, in March 2000, involved 3 focus group discussions – 15 youth, 15 family planning clients and 16 antenatal clients.
The second stage in July and August 2000, involved in-depth interviews with 275 ANC clients and 602 youth.
- During September 2000, a DISCA workshop was held at Provincial level. District staff from Kopano shared their experience. Staff from other districts were encouraged by what could be done by 'ordinary district staff'.
- During November 2000, district staff were also asked to pilot an exit interview tool amongst FP, ANC and STI clients. Ninety-eight interviews were conducted and district staff made valuable comments on the tool, which were used to modify it.
- In May 2001 two people from the district presented papers at a symposium in Bloemfontein and in July five people from the district presented papers at an STI symposium in Durban.
- Training was conducted for other categories of staff, namely community doctors and some general practitioners, and members of the District AIDS Council and other community-based organisations.

Comparison of DISCA results over time

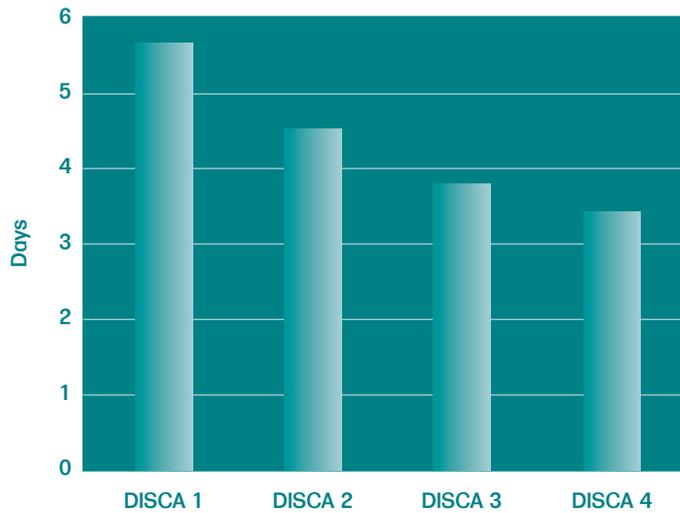
Graph 1: Percentage of Adults Treated for STIs

This graph illustrates the improvement in STI case finding following training after the first DISCA. New clinics were included in the third and fourth DISCAs. Training of clinicians in many of the new clinics had not taken place. However, even in clinics where staff had been trained, case finding tended to decrease after the initial improvement. A key challenge is sustaining improved quality of care at the clinic level.



Graph 2: RPR Turn-Around Time

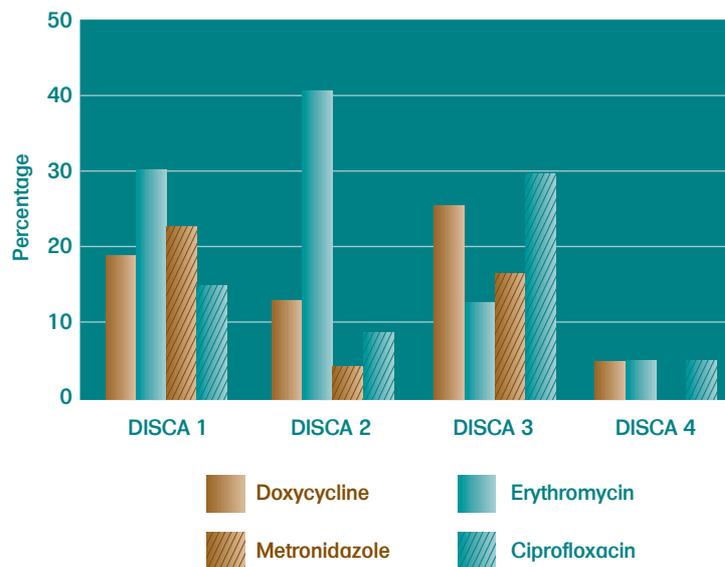
One area in which there was consistent improvement was in the reduction of turn-around times for RPR results.



Graph 3: Drug Shortages

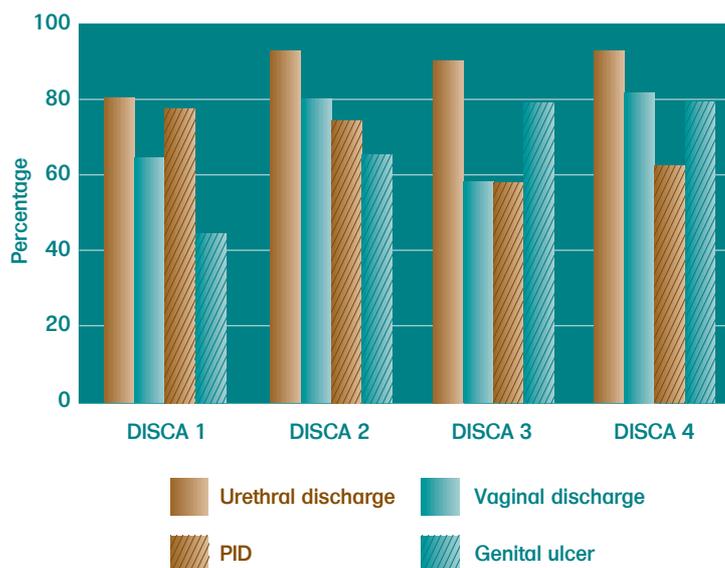
Shortages of STI drugs were a common experience in many clinics. When the problem was not resolved through phone calls, one of the members of the STI team drove to Bloemfontein to try to get to the root of the problem.

As this graph shows, over time, the problem was finally resolved in most clinics.



Graph 4: Correct Drug Treatment

This graph shows an improvement in the management of three of the four main STI syndromes between DISCAs 1 and 2, after training had been conducted in the district. At the time of DISCA 3, several other clinics had been included in the district.



The Centurion Story

Background

Centurion is a sub-district of Tshwane, one of three metropolitan municipalities in Gauteng.

Situation

Although an assessment of STI management had never been done in Centurion before, staff were convinced that STIs were being managed very well. Provincial and Local Government facilities were managed separately, with little interaction between the supervisors working under the two different authorities' area managers.

Approach

The first joint assessment of STI care in Centurion was conducted in November 2001 using the District STI Quality of Care tool. The ISDS facilitator introduced the tool and discussed its use with the team to gain a common understanding.

The assessment team consisted of:

- the two supervisors/area managers: Local Government (acting) and Province (appointed)
- a facility manager
- a doctor, and
- a nurse responsible for drug supply management in the LA facilities.

Some findings

- Equipment for safe examination was adequate at all facilities
- No drug or condom stock-outs were experienced
- Syndromic management protocols were available in all consulting rooms
- All clients with mixed infections were incorrectly treated
- Lack of dildos for condom demonstration
- Low percentage of adults treated for STIs
- Lack of educational materials in local languages
- Lack of partner notification cards in local languages
- Lack of a system to record partner management
- Speculum examinations were not performed on all female clients with STIs.

Interventions

1. Contact slips were translated into Afrikaans, Sotho and Zulu and made available to all facilities.
2. Educational materials in various local languages were sourced and distributed.
3. A flowchart for treatment of mixed infection treatment was developed, disseminated and communicated to all staff.
4. Targeted supervision was conducted by facility managers and area managers (using the *Clinic Supervisor's Manual*).
5. The number of speculum examinations was monitored.

A second DISCA (DISCA 2) was conducted in February/March 2003. The 2 graphs below compare findings in 2001 and 2003:

Figure 1: Clinician knowledge of correct treatment: 2001 and 2003

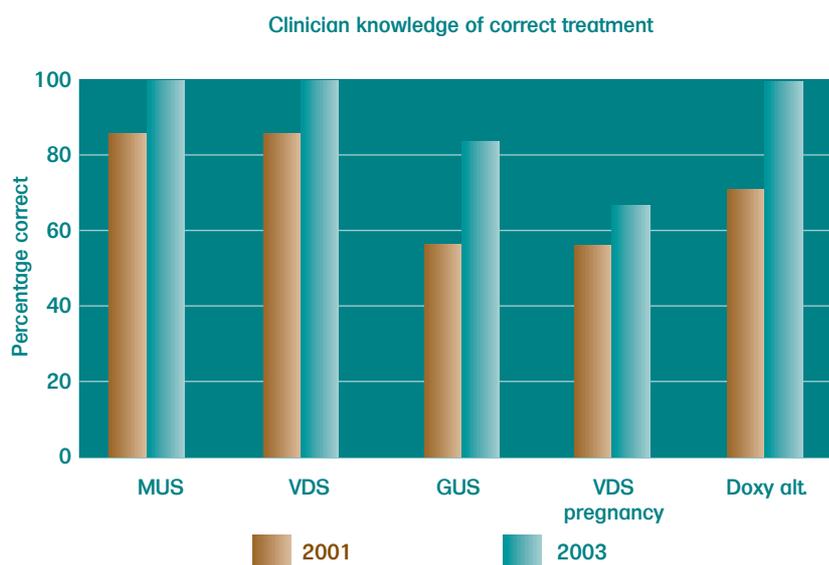
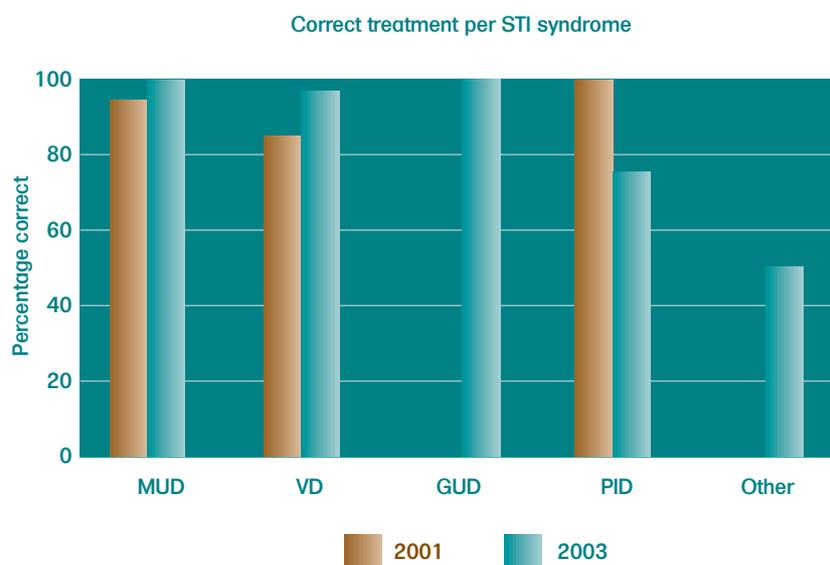


Figure 2: Correct treatment per syndrome: 2001 and 2003

These graphs show that both the knowledge and the management of STIs improved between the two assessments.

Additional improvements from DISCA 2

- Clinicians reported speculum examinations on all women with STIs.
- Contact slips were available in four local languages.
- All facilities had a dildo for condom demonstration.
- There was a 50% improvement in the treatment of mixed infections.
- Partner management records were in place.
- The percentage of adults treated for STIs increased from 6% in 2001 to 8% in 2003.

Key Lessons Learnt from the National STI Initiative

A Committed Team

Identifying a team of people committed to improving the quality of STI care plays an absolutely fundamental role. Members of the Kopano team became so motivated about improving STI management that they took a number of initiatives, some of which were adopted at Provincial level.

These initiatives included:

- the development of a workbook to support clinical training
- translating partner notification cards into local languages
- making use of data at clinic and sub-district level to track their performance
- contacting the Provincial pharmaceutical depot to resolve drug shortages.

The team needs to include key stakeholders. In both Kopano and Centurion, the team included staff from provincial as well as local authority structures. Formation of these teams fostered co-operation between provincial and local authority officials.

Importance of Evaluation and Monitoring

Unless an objective tool is used to measure the quality of care, the assessment of quality will be based on subjective opinions. Because clinic staff saw STI clients regularly and were familiar with the drug protocols, they assumed that the quality of STI care was good. Using an evaluation tool revealed that there were more gaps than they realized.

Despite its limitations, the DISCA tool has been shown to be a very useful monitoring tool to help strengthen the STI programme at district level. Wherever possible, STI team members should be trained in the use of the tool. This ensures that there is a common understanding of the questionnaire and the process of data collection.

Analysis of the information is best done manually by the team themselves. By interpreting the findings themselves, those involved in providing and overseeing the services are able to gain an understanding of what these findings mean both for service delivery and for the community.

Returning to repeat the evaluation after interventions have been carried out is an important way of assessing whether the interventions have been effective.

Development of a Realistic Action Plan

If an effective evaluation tool has been used, action plans can then be based on the real, rather than the assumed needs.

Regular review of any action plan (at least quarterly) is important in order to ensure that the actions are being implemented, and, if not, to identify the reasons why this is the case. Many a good plan has failed for lack of follow through.

Training Approaches and Content

- Training needs to address not only bio-medical aspects, but also attitudinal and interpersonal components. (Change to a non-judgmental attitude was identified by the nurses as one of the most important outcomes of the intervention.)
- There must be a clear association between the training and the actual work situation.
- Training should be interactive and include participatory exercises as much as possible. It should encourage trainees to draw on their own experience and motivate them to think about the bigger picture.
- Training should encourage a comprehensive approach to primary health care. This means that every training should have ‘windows’ that look into other aspects of health care. Some examples of these ‘windows’ in relation to STI training are:

Clients attending the clinic for other reasons may have an STI

Clients seeking contraception may be at risk of STIs (including HIV)

Awareness of HIV risk is a central component of STI management

People with TB may be HIV positive

Pregnant women are more vulnerable to candidiasis – not every vaginal discharge is an STI

Babies that fail to thrive may have congenital syphilis or be HIV positive.

- Opportunity to see a number of STI clients and to practice clinical skills is a key aspect of effective training. (The module conducted at the Communicable Diseases Clinic in Durban for the Kopano team was felt to be the most effective module in acquiring skills to manage clients with STIs.)

Ongoing Support and Follow-up

Ongoing, focused supervision by facility managers and supervisors is key to monitoring clinician practice. While availability of resources such as equipment and protocols is crucial, it does not always translate to their use by clinicians. Supervisors play an important role in monitoring and reinforcing good practice. It is also an important way of providing support and encouragement to clinicians who often feel overwhelmed and discouraged.

Improving quality of care is not a once-off or short term activity. Steps need to be taken to sustain improvement. Staff changes take place; other programmes receive priority, and the commitment to sustaining the quality aspects of primary health that are not in the limelight tends to decline.

The experience in Kopano showed that in the 6–12 month period following training, clinicians were more aware of the need to be proactive in detecting STIs in clients. Over time many clinicians reverted to only treating STIs in those clients who came specifically for that reason.

Although training in itself is important, ongoing supervision and support is more important in sustaining improvements in practice. In Centurion improvements were achieved without additional training of clinicians in syndromic management.

A Comprehensive Approach

In order to make an impact on the incidence of STIs, interventions need to take place at a variety of levels.

- Economic, social and cultural circumstances that contribute to risk behaviour need to be addressed.
- Health providers in both the private and public sectors (both doctors and nurses) need to know and implement effective management. This includes dealing with negative attitudes towards people with STIs.
- Managers, supervisors and community health educators all need to know the key components of effective STI management.
- A comprehensive approach to health will help clinicians be aware of the way in which different conditions impact on one another, e.g. STIs, malnutrition, AIDS and TB.

Appendix 1

STI Client Exit Interview Questionnaire

SITE:

DATE:

Directions: Introduce yourself to the client. Explain that the purpose of the interview is to learn how clients feel about services offered at the facility and to find out if they have any suggestions/improvements. Stress that the interview is confidential and that the client's name will not be used.

Adapt the questions listed here to your facility and to the client you are interviewing. Record any additional information the client volunteers. Thank the client for his or her assistance.

1. Is this your first visit to this clinic?

2. Why did you choose this clinic?

3. Was your problem attended to?

If not, what was the reason?

4. Were you given information about safer sex?

If yes, what was that information?

If no, would you like some information?

5. Were you given any information about your medicines?

What was that information?

6. Were you asked to inform your partner/s that they should seek treatment?

7. What do you know about HIV/AIDS?

8. Were you offered an HIV test?

9. Were you happy with the service you received?

10. How do you think we could give you a better service?

Appendix 2

Checklist for Consultation of a Female Client with an STI

The facility manager, supervisor or trainer would be the ideal people to use this tool. It is a guide to evaluate the quality of STI care offered by the clinician and can be used to assess individual learning needs to improve the management of people with sexually transmitted infections.

The components of the consultation are: history taking, speculum and bimanual examination, correct diagnosis and treatment of the syndrome/s, risk assessment and appropriate health information.

Instructions on how to use the checklist:

- One check list can be used to observe 5 consultations.
- The assessor must observe and listen to the interaction between the service provider and client.
- Place an **a** in the case box if skill or task is performed **proficiently** an **r** when performed **unsatisfactorily**, or **N/O** if not observed.

Participant's Name

<u>Date consultation observed</u>	<u>Supervisor's Signature</u>
Case 1	
Case 2	
Case 3	
Case 4	
Case 5	

Performance	1	2	CASES 3	4	5
Treating the client with respect and dignity by:					
1. Greeting the client and introducing herself/himself.					
2. Attending to the client in a private environment.					
3. Addressing the client by name.					
4. Establishing reason for the visit.					
5. Informing the client of, and ensuring confidentiality.					
6. Reassuring the client by explaining the process of the consultation.					
7. Answering any questions from the client.					

History taking by asking:

1. Duration and characteristics of signs/symptoms.					
2. History of previous STIs?					
3. Was treatment sought?					
4. Does the partner have any signs or symptoms?					
5. About condom use, including frequency.					
6. About use of contraception.					
7. When was the last menstrual period?					
8. About the possibility of pregnancy.					
9. History of other illnesses.					
10. History of drug allergies.					
11. History of recent weight loss.					

General examination, abdominal palpation, speculum and bimanual examination.

Preparation of the client and general examination:

1. Explaining the procedure and reason for the examination.					
2. Obtaining client's verbal consent.					
3. Asking client if she would like to empty her bladder.					
4. Testing urine if indicated e.g. in frequent vulval itch to exclude diabetes.					
5. Asking client to remove her underwear.					
6. Assisting client to lie down on the couch and covering her.					
7. Checking mouth, eyes, lymph nodes (neck and axillae), breasts and skin.					

Abdominal Palpation:

1. Observing the abdomen and inguinal area for lesions, swellings and rashes.					
2. Palpating all areas of the lower abdomen, first with light pressure, then with deeper pressure.					
3. Identifying any tender areas and checking for rebound tenderness.					
4. Putting on gloves if lesions are present. Palpating both groins for enlarged lymph nodes. Removing and discarding gloves after palpation.					

External Genital Examination by:

1. Positioning the client correctly.					
2. Switching on and focusing the light.					
3. Observing genitalia, anus, thighs and perineum for discharge, ulcers, warts, blisters, inflammation or any other lesions.					

Speculum Examination by:

1. Washing and drying hands. Putting on gloves.					
2. Choosing the correct size speculum, warming it if possible.					
3. Inserting the speculum fully, at the same time inspecting the genital area for any obvious lesions.					
4. Opening the blades and locating the cervix.					
5. Observing the vaginal walls and cervix for any inflammation, ulcers, discharge, warts and blisters.					
6. Noting the position, size, shape, and colour of the cervix and presence of any bleeding.					
7. Taking a Pap Smear if indicated.					
8. Removing the speculum gently and placing it in disinfectant.					

Bimanual examination to check for PID by:

The observer may wish to repeat this examination to confirm findings.

1. Parting the labia and inserting the index and middle fingers gently into the vagina. Using only one finger in a nulliporous adolescent.					
2. Locating the cervix and gently moving it from side to side (cervical excitation) noting tenderness from client's reaction to exclude PID .					
3. Palpating the uterus for size, shape, location, consistency, mobility and tenderness to exclude pathology.					
4. Palpating the adnexal areas for tenderness and masses in the ovaries and tubes. (PID, EP)					
5. Removing gloves. Washing hands.					
6. Assisting client off the couch and asking her to dress.					

Identification of the correct syndrome and treatment by:

1. Informing the client of the findings in simple terms.					
2. Issuing the correct treatment for the identified syndrome, according to the protocols.					
3. Discussing instructions for taking the treatment, possible side effects, importance of completion.					
4. Explaining the importance of partner notification.					
5. Providing her with a partner notification card/s.					

Health promotion by:

1. Identifying the client's level of knowledge on STIs/HIV and their prevention.					
2. Establishing client's awareness of STI/HIV risk and clarifying factors that increase/reduce risk.					
3. Exploring with her how she may reduce her risk.					
4. Providing condoms if appropriate.					
5. Demonstrating condom use if necessary.					
6. Finding out whether she has ever considered being tested for HIV.					
7. Offering an HIV test or referring as necessary.					

Were the following explored with the client according to her needs?

1. Ability to negotiate safer sex with partner/s.					
2. Myths and misconceptions about STIs.					
3. Asymptomatic infections.					
4. Complications of STIs.					
5. Relationship between STIs and HIV.					
6. Treatment of all sexual partners in the past three months.					
7. Attitude to and knowledge of condom use (including female condoms).					
8. Discussion of dual protection (prevention of pregnancy and STIs/ HIV).					
9. Information about referral or a return visit.					

Recording of information

1. Were the findings, diagnosis and treatment recorded on client card?					
2. Was the necessary information entered in the daily register and on the MDS?					
TOTAL SCORE	69	69	69	69	69
PARTICIPANT'S SCORE					
PERCENTAGE SCORED					

Remarks

Appendix 3

Checklist for Consultation of a Male Client with an STI

The facility manager, supervisor or trainer would be the ideal people to use this tool. It is a guide to evaluate the quality of STI care offered by the clinician and can be used to assess individual learning needs to improve the management of people with sexually transmitted infections.

The components of the consultation are: history taking, speculum and bimanual examination, correct diagnosis and treatment of the syndrome/s, risk assessment and appropriate health information.

Instructions on how to use the checklist:

- ▶ One check list can be used to observe 5 consultations.
- ▶ The assessor must observe and listen to the interaction between the service provider and client.
- ▶ Place an **a** in the case box if skill or task is performed **proficiently** an **r** when performed **unsatisfactorily**, or **N/O** if not observed.

Participant's Name

<u>Date consultation observed</u>	<u>Supervisor's Signature</u>
Case 1	
Case 2	
Case 3	
Case 4	
Case 5	

Performance	1	2	CASES 3	4	5
Treating the client with respect and dignity by:					
1. Greeting the client and introducing herself/himself.					
2. Attending to the client in a private environment.					
3. Addressing the client by name.					
4. Establishing reason for the visit.					
5. Informing the client of, and ensuring confidentiality.					
6. Reassuring the client by explaining the process of the consultation.					
7. Answering any questions from the client.					

History taking by asking:

1. Duration and characteristics of signs/symptoms.					
2. History of previous STIs.					
3. Was treatment sought?					
4. Does the partner have any signs or symptoms?					
5. About condom use, including frequency.					
6. History of other illness.					
7. History of drug allergies.					
8. History of recent weight loss.					

General examination, including the genitalia by:

1. Explaining the procedure and reason for the examination.					
2. Obtaining client's verbal consent.					
3. Assisting him to lie down on the couch if available.					
4. Checking mouth, eyes, lymph nodes (neck and axillae) and skin.					
5. Putting on gloves.					
6. Requesting the client to lower his trousers and underpants whether standing or lying down.					
7. Inspecting the genital and inguinal area for lesions, rashes and swelling.					
8. Palpating both groins for enlarged lymph nodes or other swellings.					
9. Asking the client to pull back the foreskin and milk the urethra to note any discharge (if not already evident).					
10. Inspecting the penis, perineum and anal area for warts, blisters and ulcers.					
11. Palpating the shaft of the penis and testes to exclude tenderness, nodules or swelling.					

Identification of the syndrome and treatment by:

1. Informing the client of the findings in simple terms.					
2. Issuing the correct treatment for the identified syndrome, according to the protocols.					
3. Discussing instructions for taking the treatment, possible side effects, importance of completion.					
4. Explaining the importance of partner notification.					
5. Providing him with a partner notification card/s.					

Health promotion by:

1. Identifying the client's level of knowledge on STIs/HIV and their prevention.					
2. Establishing client's awareness of STI/HIV risk and clarifying factors that increase/reduce the risk.					
3. Exploring with him how he may reduce his risk.					
4. Promoting and providing condoms.					
5. Demonstrating condom use if necessary.					
6. Finding out whether he has ever considered being tested for HIV.					
7. Offering an HIV test or referring as necessary.					

Were the following explored with the client according to his needs?

1. Ability to negotiate safe sex with partner/s.					
2. Myths and misconceptions about STIs.					
3. Asymptomatic infections.					
4. Complications of STIs.					
5. Relationship between HIV and other STIs.					
6. Treatment of all sexual partners in the past three months.					
7. Attitude to and knowledge of condom use.					
8. Discussion of dual protection (prevention of pregnancy and STI/HIV).					
9. Information about referral or return visit.					

Recording of information

1. Were the findings, diagnosis and treatment recorded on the client card?					
2. Was the necessary information entered in the daily register and on the MDS?					
TOTAL SCORE	49	49	49	49	69
PARTICIPANT'S SCORE					
PERCENTAGE SCORED					

Remarks

Resources

The Diagnosis and Management of Sexually Transmitted Infections in Southern Africa. – *RON BALLARD, YE HTUN, GLENDA FEHLER, GRAHAM NEILSEN*

Training Manual for the Management of a person with a Sexually Transmitted Disease. – *NATIONAL DIRECTORATE: HIV, AIDS AND STIs*

Trainers Manual for the Management of a person with a Sexually Transmitted Disease. – *NATIONAL DIRECTORATE: HIV, AIDS AND STIs*

HIV/AIDS/STD Strategic Plan for South Africa.
2000 – 2005

National Norms and Standards – Section 9
STDs/HIV/AIDS

The above resources are available from: DIRECTORATE FOR HIV/AIDS AND STIs,
NATIONAL DEPARTMENT OF HEALTH,
PRIVATE BAG X828,
PRETORIA, 0001.

Training Clinic Sisters – lessons learnt based on the experience of the National STI Initiative.

The District Quality of Care Assessment (DISCA).

A Practical Guide to Using the District Quality of Care Assessment (DISCA).

Evaluating Quality of STI Management at a Regional Level using the District Quality of Care Assessment (DISCA).

Evaluating the Quality of Care for Sexually Transmitted Infections using DISCA. A report from 3 health districts.

Skills enhancement for Barrier Method Promotion.

These resources are available from: REPRODUCTIVE HEALTH RESEARCH & HIV UNIT,
1301 MARITIME HOUSE,
143 SALMON GROVE,
DURBAN 4001.

Lessons learnt in the implementation of Primary Health Care–Experiences from Health Districts in South Africa (includes case studies focusing on interventions to improve the quality of STI care)

Available from HEALTH SYSTEMS TRUST
401 MARITIME HOUSE,
SALMON GROVE,
DURBAN 4001.
TEL: 031 307-2954 FAX: 031 304-0775
AND ON THE HST WEBSITE AT www.hst.org.za

Appendix 5

District STI Quality of Care Assessment

DISCA

INSTRUCTIONS

Please fill out this evaluation by:

1. Interviewing a senior clinician
2. Inspecting the facilities, equipment and supplies, and
3. Examining the laboratory specimen register and patient medical records

Province:

District:

Health facility name:

Telephone:

Fax:

Date of visit:

Day month year

Time of visit:

h

Name and title of district clinic supervisor:

Name and designation of person filling out the evaluation:

ACCESSIBILITY

1. Does this facility offer STI treatment at all times between 8am and 4pm on all weekdays?
2. Does this facility offer STI treatment as part of after clinic hours services?
3. How many consultation rooms are there in this facility?
4. a. Does this facility use all consultation rooms to treat clients with STIs?
- b. If no, how many consultation rooms are used for STI care?
5. Please observe whether this facility offers consultation in private for all STI clients i.e. consultations cannot be observed by other clients and providers?
6. Please request a caseload book or register and record the following figures for the last month:
- a. Total number of clients seen
- b. Total number of adult clients (13-15 years and older)
- d. Total ante-natal clients
- e. Total number of clients with an STI

SAFE EXAMINATION

7. Are the following pieces of equipment available in all adult consultation rooms?
- Total number in this facility:
- | | | | |
|-------------------------------------|------------------------------------|-----------------------------------|----------------------|
| Examination couch | <input type="button" value="Yes"/> | <input type="button" value="No"/> | <input type="text"/> |
| a. (i) Examination light | <input type="button" value="Yes"/> | <input type="button" value="No"/> | <input type="text"/> |
| (ii) How many are in working order? | | | <input type="text"/> |
| b. Vaginal specula | <input type="button" value="Yes"/> | <input type="button" value="No"/> | <input type="text"/> |
| c. Examination gloves | <input type="button" value="Yes"/> | <input type="button" value="No"/> | <input type="text"/> |
8. Speculum examinations are done on all women with STIs

PROVISION OF SAFE TREATMENT

9. a. Are there current STI syndromic management guidelines at this facility?
- b. Are STI syndromic management guidelines in all adult consultation rooms?
- c. Are there individual client education materials about STI/HIV prevention and treatment available in this facility?
- d. Are these educational materials written in a local language?
10. How are specula sterilised in this facility?
11. a. Is syphilis RPR testing done on site in this health facility?
- b. If not, what is the turn-around time* for the RPR test results?
(*The time elapsed between taking blood for RPR from the client and getting the results back from the laboratory.)
12. Has there been any occasions over the last month when male condoms ran out?
13. Whereabouts in the clinic are condoms available?
14. a. Are STI clients shown how to use condoms in this facility?
- b. Is there a dildo available for condom demonstrations in this facility?
- c. If no, how do you make sure that a client knows how to use condoms in this facility?
15. Which clients with STIs would you refer for treatment?

PROVISION OF SAFE TREATMENT (Cont.)

16. Partner Notification

a. Are Partner Notification cards / letters available in all adult examination rooms?

Yes

No

b. Are the cards written in a local language?

Yes

No

c. How many partner notifications were issued in the last month?

17. a. Is blood taken for RPR (syphilis) test from all STI clients?

Yes

No

b. If not, for which conditions do STI clients have blood taken for RPR test?

ANTENATAL SCREENING AND STI TREATMENT

18. a. Is syphilis screening done on all pregnant clients who attend antenatal care for the first time?

Yes

No

b. How many first time antenatal clients were seen last month?

c. How many tested positive for syphilis?

19. Do you examine and treat pregnant clients for STIs other than syphilis?

Yes

No

20. Which pregnant women with STIs do you refer for treatment?

STAFF TRAINING

	Number
21. a. What is the total number of professional nurses working at this clinic?	<input type="text"/>
b. How many clinicians working here have been on a formal training course in STI syndromic management?	<input type="text"/>
c. How many clinicians working here have been on a formal HIV/AIDS counselling course?	<input type="text"/>
d. How many clinicians (doctors or nurses who examine and treat clients) are working today?	<input type="text"/>
22. If you had a problem about STI management who would you consult? (State name and designation of this person).	
<input style="width: 100%; height: 40px;" type="text"/>	

STI DRUGS AND TREATMENT

23. Visit the pharmacy or drug store room. Ask the pharmacist or nurse in charge of drugs the following:

Drugs	Is it currently in stock?		Over the last month has the drug run out?		State the reasons for drugs running out.
1. Ciprofloxacin 250mg tabs	<input type="text" value="Yes"/>	<input type="text" value="No"/>	<input type="text" value="Yes"/>	<input type="text" value="No"/>	<input type="text"/>
2. Metronidazole 400mg tabs	<input type="text" value="Yes"/>	<input type="text" value="No"/>	<input type="text" value="Yes"/>	<input type="text" value="No"/>	<input type="text"/>
3. Erythromycin 250mg tabs	<input type="text" value="Yes"/>	<input type="text" value="No"/>	<input type="text" value="Yes"/>	<input type="text" value="No"/>	<input type="text"/>
4. Doxycycline 100mg tabs	<input type="text" value="Yes"/>	<input type="text" value="No"/>	<input type="text" value="Yes"/>	<input type="text" value="No"/>	<input type="text"/>
5. Benzathine Penicillin 2.4mu	<input type="text" value="Yes"/>	<input type="text" value="No"/>	<input type="text" value="Yes"/>	<input type="text" value="No"/>	<input type="text"/>

24. Fill in the information below for the 10 most recent clients treated for an STI. Use the client cards, daily register or pharmacy records to obtain the information.

STI clients	Syndrome See codes below	What type of drugs did the patient receive? State the type, dose and duration	Correct drug	Correct dosage	Correct frequency & duration	RPR test requested
1.	<input type="text"/>	<input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>
2.	<input type="text"/>	<input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>
3.	<input type="text"/>	<input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>
4.	<input type="text"/>	<input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>
5.	<input type="text"/>	<input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>
6.	<input type="text"/>	<input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>
7.	<input type="text"/>	<input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>
8.	<input type="text"/>	<input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>
9.	<input type="text"/>	<input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>
10.	<input type="text"/>	<input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>

Syndromic Codes: (to be used in the 2nd column above);

- 1 – Penile discharge 2 – Vaginal discharge 3 – Pelvic inflammatory disease (PID)
- 4 – Genital Ulcers 5 – Genital warts 6 – Other STI (specify)

25. Ask a clinician the following questions: (check answer with STI syndromic management guidelines)

a. What drugs (type, dosage, frequency and duration) would you use to treat:

(i) a man with penile urethral discharge?

Correct

Incorrect

(ii) a woman complaining of a vaginal discharge?

Correct

Incorrect

(iii) a man or a woman with a genital ulcer?

Correct

Incorrect

b. How would you treat a pregnant woman with an STI vaginal discharge?

Correct

Incorrect

c. If doxycycline was out of stock what would you use in its place for discharges?
(give drug, dosage and duration)

Correct

Incorrect

COMMENTS

26. What are the problems that affect the daily delivering of quality STI care in this facility?

27. What recommendations will you make to improve the situation?

28. What is the plan of action resulting from this supervisory visit?
(The supervisor should discuss this with senior clinicians)

29. Additional comments:

The first version of this tool was developed by Nicol Coetzee and Sphindile Magwaza.
This version is the result of further work by the National STI Initiative
The DISCA has been approved by the Department of Health
Further copies available from National STI Initiative – Telephone 031-304 8383 or
Health Systems Trust – Telephone 031-307 2954

This questionnaire may be photocopied for further distribution.

RHRU

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