SIMULATED PATIENTS' RATINGS OF SEXUALLY TRANSMITTED DISEASE CARE IN PRIMARY HEALTH CARE CLINICS

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ABSTRACT

HIV/AIDS is a major health concern internationally and nationally. The sub-Saharan region, South Africa in particular, has some of the highest prevalence rates in the world. This region is also one of the least economically developed regions, and in addition to the HIV/AIDS epidemic it is faced with the challenge of developing the economy for the citizens while maintaining high social services standards. Available literature suggests that the link between STDs and the spread of HIV, and the economic status of most developing countries influenced the World Health Organization's decision to recommend the syndromic case management approach to STD care. Moreover, literature evaluating the quality of STD care indicates that poor communication, counselling and history taking skills, long waiting periods and lack of support for staff contribute to poor quality of care. This study aimed at evaluating the quality of care that sexually transmitted disease patients receive at primary health care clinics from a simulated patients' perspective. Four post-graduate students, two of whom were females and the other two males, visited 24 clinics. After each visit they each completed a semi-structured questionnaire and recorded their experiences in a journal. Results indicate that health care providers are competent in some aspects of service provision, for example with regard to diagnosis and offering appropriate medical treatment. Other aspects of the service that were seen as influencing service provision included poor counselling, condom education and partner notification. It was recommended that future research should evaluate the impact of factors such as motivation and time management skills of health care providers on service provision. Further recommendations included the possibility of offering continuous support and training to health care providers.

Declaration

The author hereby declares that this whole thesis, unless specifically indicated to the contrary in the text, is his own original work.

Full name …………………………..   Date ……………………..

Signed ………………..………………

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CHAPTER ONE

GENERAL INTRODUCTION

1.1   Background to the study

The dawning of a democratic era in South Africa brought new challenges to the country. Whereas in the past the focus of people's struggle was on political liberation, after 1994 government was able to broaden its attention to include improving the quality of life for all citizens, ensuring the equal distribution of resources, reducing international debt and restructuring the economy. Thus improved health care, education, housing and job opportunities for the previously oppressed have become national priorities. Given the fact that there are limited financial and human resources, it has become imperative for government officials to generate creative and cost-saving measures of tackling major social and health problems while maintaining high standards. Moreover, they need to foster a partnership with the communities they serve.

It was with this in mind that the Department of Health (1997a) proposed a white paper for the transformation of the health system in South Africa. This document states the aims and goals of the Department to be inclusive of unifying the health system, to develop and strengthen the primary health care (PHC) clinics, to offer an integrated PHC service and make PHC clinics the first point of contact with the health system. In addition, the government's proposal was to ensure that the poor, rural people, the aged, women and children have access to health. It also promulgated law stating that children under the age of six should be treated without charge at hospitals. The Department of Health (1997a) also proposed the equal distribution of health personnel throughout the country, offering a high quality service, yet maintaining low costs and offering low cost essential drugs. The final element involved capacity building of the health care human resources. This includes recruitment and training of new personnel and the reorientation of the existing staff to meet the needs of all South Africans. Finally, government aims to ensure that the health sector personnel reflect the demographics of the population.

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As part of the primary health strategy, the Department of Health developed several promotional campaigns that focused on reducing substance abuse, improving the psychological well being of individuals and communities and preventing the spread of sexually transmitted diseases (STDs) and HIV/AIDS. It has thus become important that the PHC service offer an integrated care approach. Indeed the system places emphasis on a preventative health care system rather than a curative approach. The PHC service system encourages the health care providers (HPs) to educate their patients, so as to empower them to prevent contracting diseases like STDs and to encourage healthier lifestyles.

1.2   Rationale for the study

The problem of STDs poses a threat to the ever-shrinking government health budget. According to Dartnall and Schneider (1998), the World Health Organisation (WHO) argues that the incidence of curable STDs in sub-Saharan Africa is very high. Moreover, South Africa is believed to have one of the highest infection rates of STDs in the world (Pham-Kanter, Steinberg & Ballard, 1996). In addition to the enormous economic, social, skills and health costs that STDs have on a country, they are seen as important causes of morbidity in South Africa (Harrison, Wilkinson, Lurie, Conolly & Abdool Karim, 1997). In spite of the devastating consequences that STDs have on people, their management has largely been neglected and ignored as a major concern of public health, until a link was established between the occurrence of STDs and the increased risk of contracting the human immunodeficiency virus (HIV) (Laga, Nzila & Gorman, 1991). This therefore suggests that improved STD management may contribute to curbing the spread of HIV.

HIV/AIDS poses a major threat to human survival. South African data indicates that 4.5 million people are infected with HIV/AIDS and this accounts for roughly 10% of the world's HIV population, while South Africa constitutes less than 1% of the world's population (Crothers, 2001; Tillotson & Maharaj, 2001). According to Crothers (2001) the current prevalence rates of HIV/AIDS are growing at an alarming 3% per annum and he further points out that it has been estimated that half of all 15 year olds in South Africa will die of AIDS-related deaths. In addition he points out that sexual intercourse accounts for more that 75% of new infections, with blood

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transfusion and blood products accounting for 3-5%, and mother-to-child transmission for the remaining 20%.

These alarming infection rates are going to have a devastating impact on the economy. At a macro level it will impact on the gross domestic product (GDP): it has been estimated that the effect of the condition will result in a 1% decrease in the GDP and result in a decline of 3.1% of the GDP between 2006 and 2010 (Heinecken, 2001; Tillotson & Maharaj, 2001). At a micro level HIV/AIDS will result in increased absenteeism due to ill health, which in turn will result in reduced productivity for organisations. Increased ill health leads to increased hospitalisation, which in turn would cause government to spend more on treating these patients. According to a United Nations' (UN) report (1999 cited in Heinecken, 2001), 7 out of 16 African countries spend in excess of 2,5% of their GDP on AIDS alone. The other factor associated with the epidemic is the loss of lives. The loss of lives not only impacts on the families' emotional and financial status, it also has an impact on productivity. Estimates are that in South Africa, 12% highly skilled, 20% skilled and 27.2% semi-skilled workers will be HIV positive by 2003 and the cost of replacing one skilled worker is no less than R250 000 (Heinecken, 2001).

In addition to the economic impact that HIV/AIDS has on a society, the social implications must also be considered. These include a rise in the number of orphans due to the increase in numbers of HIV/AIDS related deaths, breakdown of families, loss of income/ breadwinners and increased spending in social welfare and health departments (Cross 2001; Tillotson & Maharaj, 2001). Kinghorn and Steinberg (1998 cited in Tillotson & Maharaj, 2001) have estimated the number of AIDS orphans to be 1 million by 2005.

It was under these conditions that the Department of Health (1997a) initiated a programme of action in the fight against HIV/AIDS that aimed at developing a partnership between government, non-governmental organisations and the private sector. The government also adopted the syndromic case management approach for STD care, which aimed at identifying mechanisms for controlling the spread of HIV and developing behavioural change strategies, encouraging early detection and treatment of classical STDs while popularising and distributing, as extensively as possible, protective measures.

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1.3   Aims and objectives

Since HIV/AIDS threatens human survival and it is commonly known that the first line of defence in the fight against this dreaded condition is through the effective treatment of STDs, the Department of Health commissioned a national study, of which this project was a subsection, on health seeking behaviour for STDs in South Africa. The quality of care was also assessed from the perspective of health care providers (HPs), patients and simulated patients (SPs). The present study aimed to assess the quality of care that STD patients receive at PHC clinics from a simulated patients' perspective. In addition it is intended to give health managers and policy makers a sense of the strengths and weaknesses of the syndromic case management approach to STD care as used in PHC clinics.

1.4   Structure of this report

This mini-thesis is divided into five chapters. The introductory chapter gives a summary of the latest prevalence data on HIV/AIDS. The socio-economic problems facing post apartheid South Africa and how the AIDS epidemic is impacting on these issues are highlighted. Among other socio-economic factors highlighted is the impact of the epidemic on families' financial and emotional status, the increase in number of AIDS orphans, the decrease in productivity due to high levels of absenteeism and loss of labourers due to ill-health or death. The background of the study and its aims and objectives were briefly highlighted.

The second chapter gives a summary of the relevant literature on the subject. An overview of the epidemiological literature is given as an introduction, followed by a brief discussion of the integration of all primary health care services. A model for evaluating the quality of care is also presented, followed by a synopsis of the syndromic case management approach and how it is intended to work in practice. This is followed by an evaluation of the literature assessing the quality of care for STD patients at clinics utilising the syndromic case management approach.

The third chapter focuses on the methodology utilised in this study. Firstly, the larger research and the study sites are described, then the research method, instruments and procedures followed

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in this study are highlighted. This is followed by a description of the data analysis methods, reflections on the process and ethical considerations.

The fourth chapter presents the results obtained. This is divided into two sections, with the first section focusing on the quantitative data while the second part focuses on the qualitative data.

The concluding chapter provides a discussion of the findings. The overall quality of care scores obtained from the simulated patients are then compared to that of health care providers and STD patients. An analysis of the limitations and strengths of the study follows as well as the recommendations for future research and for health authorities.

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CHAPTER TWO

LITERATURE REVIEW

This chapter gives a synopsis of the available literature on the prevalence rates of STDs, followed by a brief discussion on the integration of all primary health care services. A model of evaluating the quality of health care in general and STDs in particular is also outlined. An overview of the syndromic case management approach will be given, with a graphical representation of one of the treatment charts to illustrate the approach. The chapter concludes with a look at studies evaluating the syndromic case management approach.

2.1   Epidemiological studies

STDs are believed to be one of the leading causes of morbidity and mortality worldwide (Bryce, Vernon, Braithwaite et al., 1994). In addition, STDs have been linked to adverse outcomes in pregnancy, infection of newborns and infants. According to De Schryver and Meheus (1990) and Abdool Karim (1994), the most common complications caused by STDs in adults include pelvic inflammatory disease (PID), maternal infection, ectopic pregnancy, and infertility in both men and women; while in children the most common complications include congenital syphilis (which causes foetal and perinatal death in about 40% of infants), neonatal conjunctivitis, premature births, low birth weight and other neonatal and infant abnormality. De Schryver and Meheus go on to add that in a study conducted in Sweden, the PID incidence rate was found to be highest amongst women in the 15 – 19 age group, while the infertility incidence rate was highest in the 20 – 24 age group.

International literature suggests that while classical bacterial STDs have decreased in developed countries, their transmission rates continue to grow in the developing world and that in both developing and developed countries STDs caused by viral agents have high incidence rates (De Schryver & Meheus, 1990; Mabey, 1996). De Schryver and Meheus (1990) point out that since the 1980s the incidence of syphilis and gonorrhoea have reached low levels of less than 29 cases

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per 100 000 population in developed countries. On the other hand, the incidence of viral infections such as trichomoniasis, genital herpes and genital human papilomavirus infections have increased in developed countries during the 1980s; with genital warts reaching high levels of 260 cases per 100 000 in 1988 in the United Kingdom.

In an article on STDs and public health, Yankauer (1994) reports that, of the 1 million cases of infectious diseases reported in the United States in 1992, half were cases of gonorrhoea. Moreover gonorrhoea, syphilis and HIV/AIDS accounted for two thirds of all reportable infectious diseases in the United States during that period. The same author goes on to point out that even though reportable STDs tend to be underreported in the United States, available data suggests that there were 197.5 cases per 100 000 population of chlamydia in 1991. This supports the findings of De Schyver and Meheus (1990) that viral infections are on the increase in developed countries. Mabey (1996) cautions against assuming that the 'decrease' of bacterial infections in developed countries is true of all population groups and points out that this statement is true of more affluent communities in these countries, while the inner city population groups of the United States, which tend to be poor, have similar STD rates to those in African cities.

Previous research has indicated growing prevalence rates of STDs in developing countries and according to Abdool Karim (1994), they have been ranked first among the top 15 causes of disability in the poorest urban population groups, and were found to be major causes of morbidity and mortality. According to Mabey (1996) studies conducted in Africa indicate high prevalence rates of STDs. For example, he cites that in Zimbabwe the public sector was reported to be treating 1 million STDs annually. In addition, a study conducted in Tanzania revealed that, of rural men attending PHCs, 28% reported to have had a urethral discharge, while 68% reported to have had a urethral discharge in the previous year (Grosskurth et al., 1995).

De Schryver and Meheus (1990), looking at the global epidemiology of STDs, found that in developing countries over 10% of women had untreated syphilis, 5-10% had gonorrhoea, 5-10% had chlamydial infections and over 20% trichomoniasis. In another study conducted in Tanzania, the investigators confirmed the above findings in rural antenatal clinic attendees (Mayaud et al.,

1995).

One of the reasons cited for this scenario is that developing countries tend to have more young people and migrant workers in their population who are sexually active (Bryce et al., 1994; Grosskurth et al., 1995; Mabey, 1995). Moreover, Ballard and Dangor (1996) have suggested that the behavioural factors responsible for increasing the potential of acquiring STDs are exactly the same as those which place people at risk of being infected with HIV: thus young, single, mobile, the poor, substance abusers and prostitutes tend to be at high risk.

In addition to the high infection rates cited earlier, in South Africa there are indications that more than 45% of antenatal clinic attendees present with at least one STD (Pham-Kanter et al., 1996). These authors conducted a review of the epidemiological data captured in South Africa from 1978 to 1995. Their data showed that chancroid and syphilis were the leading causes of genital ulcer diseases (GUD) in clinic attendees. Kwazulu-Natal had up to 49% of STD patients diagnosed with syphilis, while in Cape Town syphilis was diagnosed in 10.4% female and 6.9% male migrant workers presenting at clinics. It must be borne in mind that migrant workers are predominantly black and that male migrant workers tend to have more than one female sexual partner, thus this might be one explanation for the higher percentage of infections in women. Ballard and Fehler (1996) support the finding that syphilis is a major cause of genital ulcer diseases in South Africa.

Chancroid has also been implicated as a leading infection in people with GUD. Lymphogranuloma venereum (LGV) was found to have a minor contribution to the STD problem in South Africa, although the viral agent was noted to be common in rural areas. Gonorrhoea was seen as a common agent in women presenting with PID in clinics. In a retrospective study, the incidence rates of human papillomavirus infections (HPV) were found to be as high as 64% in 1982 for women diagnosed with leiomyoma (Pham-Kanter et al., 1996).

Regarding the accuracy of estimates of STD infection in South Africa, both local and international literature suggest that because most infected people tend to be poor they are more likely to use public health facilities (Ndulo et al., 1995; Shekelle & Kosecoff, 1992). Moreover,

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according to these authors, patients also use the services of traditional healers, private doctors or they self medicate, thus delaying contact with primary health care clinics. The latter point, coupled with the lack of a comprehensive surveillance health system makes it difficult therefore to have accurate estimates of the extent of the problem in South Africa.

The evidence that the STD prevalence rate is very high in South Africa and the strong link established between STDs and HIV makes this issue a national priority. According to Ballard and Dangor (1996) people with histories of STDs have a higher likelihood of being HIV-infected. This is mainly because their vaginal walls or the epithelium of their penises, which normally act as barriers against transmission, have been breached by genital ulcerations, usually chancroid. Moreover, they indicate that higher HIV seropositivity rates (38%) have been detected in STD clinic attendees than in antenatal clinic attendees (12%) in the Gauteng area.

In their study on analysing genital tract infections at a dedicated STD clinic in Durban, Rajagopal et al. (1999) found that of the 250 women on whom specimens were collected for laboratory investigations, HIV antibodies were detected in 52% (130) of them. In addition 21% (52) of this group had reactive syphilis serological tests and, of these 52 women, half had ulcerative genital lesions while 65% had HIV and syphilis antibodies. In the same study, nine percent of the participants had ulcerative lesions and 68% of those with ulcerative lesions were HIV antibody positive. This supports Ballard and Dangor's (1996) argument that STD patients, particularly those with ulcerations, have high chances of being infected with HIV.

In addition to the increased risks that STDs pose with regards to the transmission of HIV, it has been pointed out that the relationship is not only one way. Thus HIV affects the conventional STDs in a number of ways 'including changes in patterns of STD, the clinical presentation of disease, the relative frequency of the complications, the performance of laboratory tests for diagnosis of disease and responses to standard therapeutic regimens' (Ballard & Dangor, 1996, p.6). Research demonstrates that effective STD management will have a positive impact on reducing the incidence of HIV infection (Grosskurth et al., 1995). Thus the constant evaluation of current STD management programmes is imperative. However, according to Yankauer (1994), in spite of the high transmission level and the considerable impact STDs have on people's lives,

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they have been a 'neglected health priority' well into the 1990s.

2.2 Integrated primary health care service

As mentioned in the previous chapter, the Department of Health (1997a) proposed that the health system should be reorganised, with the primary health care (PHC) clinics being the first level of contact and serving as referral sources for both the secondary and tertiary care levels. The document further suggests that PHC clinics should be integrated and offer services ranging from mental health care, antenatal services to STD care. In the new system, health care providers are expected to provide for all services and emphasis is not placed on developing specialised skill in a particular area.

The SAHR (2000) found that the integrated primary health care system resulted in improved access to a wide range of health services, including STD and antenatal care, particularly for rural people. A majority of the HPs they surveyed perceived their referral system to be efficient and on a national level the health care providers' patient load was substantially lower that in 1997.

The integration of dedicated clinics into the primary health care clinics raises problems. Petersen (1998), in a paper discussing the integration of mental health care into the PHC system, argues that the first problem with this process is that of the discourse of the two systems. According to this author the PHC system relies on a biomedical discourse, which places emphasis on physiological factors in the aetiology and treatment of diseases; and overlooks psychological, socio-economic and cultural factors.

A second problem identified about the biomedical discourse is that it de-contextualises and individualises social and health problems, thus entrenching the power relations that exist in society (Petersen, 2000). Thus it enforces the 'us and them' mentality, in the sense that health care providers (HPs) are seen as possessing all the knowledge and the patients know little or nothing. Thus this model fails to empower patients to understand the role they can play in improving their health. This disempowerment effect not only impacts on the patient, but it also has an impact on the nurses.

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The third difficulty in this system relates to the training that nurses receive at tertiary institutions, which emphasises the need for nurses to take instructions from doctors, thus discouraging the nurses' independence. Thus in primary health care, which requires people to work autonomously, nurses find it difficult. The other difficulties are as a result of poor relations between staff and their superiors and the fact that creativity and initiative are not rewarded (Petersen, 2000). All the above difficulties are not confined to mental health care in a primary health care clinic, they also apply to the integration of dedicated STD clinics in the PHC system.

According to Petersen (1998), mental health care should be focussing on providing a holistic approach to treatment and assessment of patients. The holistic approach encouraged in mental health care is similar to that advocated in the syndromic case management approach to STD care. An emphasis is placed on assessing and treating all facets of a patient's life and not just the symptoms. This in turn aims to empower the patient to take their well being into their own hands and the health care system to serve as a support network for them.

2.3   Evaluating quality of care

An evaluation of a health care programme should include a means of assessing the quality of care that patients receive. Heiby (1995) defines quality of care as the degree to which the care received at clinics resembles the standards adopted by the actual case management programme. Hanson et al. (1997) emphasize the importance of setting of standards for programmes and the aid of these standards in evaluating the efficacy of the providers in delivering the required service.

The concept of quality of care involves different aspects such as client participation, client and provider satisfaction, continuity, affordability, adequacy, accessibility, effectiveness and efficiency. It has also been emphasised that client satisfaction is crucial, because it determines the patients' compliance with treatment and the effectiveness of the care received (Bruce, 1990; Ndulo et al., 1995). In addition, poor quality of care can result in non-compliance and under/ non-utilisation of the health care service. Saturno (1995) also emphasizes the importance of the client's perception about the service, but goes on to add that the evaluation process should

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include structural and organisational matters as well, that is, the quality of medical records, availability of resources, organisation and skill levels of staff. Thus the evaluation of quality of care should take into account not only the impact of the programme on the prevalence rates, but should also evaluate the clients' perceptions of the service offered, the availability of resources (both material and personnel) and issues such as in-service training and the level of staff support available.

One of the major problems with many studies evaluating quality of care is the fact that they do not evaluate the clients' perception of the service rendered (Carneiro & Antunes, 1994). Some studies that evaluated the quality of care without evaluating the client's perception have, however, reported success in reducing prevalence rates of the diseases concerned; although it must be noted that these diseases were not stigmatised diseases like STDs. For research into stigmatised or sensitive issues, the model used in family planning units serves as a guide (Bruce, 1990; Madden et al., 1997). This model evaluates the information given to patients, the health care providers' technical competence, interpersonal relations, and mechanisms to encourage continuity and the accessibility of the service. This simply means that the researcher should evaluate the provider's level of competence through the information he/she gives to the client (that is, whether it is relevant and appropriate or not). Hanson et al. (1997) and Ndulo et al. (1995) suggest that the above factors impact on the client's compliance with the treatment regimen.

Bruce (1990, p. 61) argues that improved quality of care 'will result in a larger, more committed clientele of contraceptive users. Over the long term, this expanded base of well-served individuals will translate into higher contraceptive prevalence and, ultimately, reductions in fertility'. She goes on to point out that improvements in the quality of service delivered will lead to sustained use.

2.4 Syndromic case management approach

The lack of adequate health resources, as well as the unequal distribution thereof between rural and urban areas and between previously black and white areas, poses a major difficulty in the

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management of STDs. This is compounded by the fact that South Africa, like other developing countries, has high prevalence rates of STDs and lack of laboratory facilities and the required clinical expertise to make definitive diagnoses of individual cases (Pinto & Ballard, 1994). A recent study conducted on specimens obtained from female patients attending a dedicated STD clinic in Durban, confirmed the finding that local clinics have poor laboratory facilities, resulting in incorrect or inadequate diagnoses (Rajagopal et al., 1999). After considering the scenario that exists in developing countries, the World Health Organisation (WHO) recommended the use of a syndromic case management approach to treating STDs (Mabey, 1996; Pinto & Ballard, 1994). Below is a synopsis of the syndromic case management approach.

2.4.1 The syndromic approach to the diagnosis and management of STDs

The first stage of this approach is to classify the STDs into 11 of the most common syndromes: urethral discharge / dysuria, vaginal discharge, genital ulceration, pelvic inflammatory disease, inguinal bubo, balanitis / balanoposthitis, scrotal swelling, genital warts, lower abdominal pain, other STDs (such as latent syphilis, congenital syphilis, secondary syphilis, molluscum contagiosum, genital scabies, sexually acquired enteric infections and pubic lice) and not STD (Grimwood et al., 1996).

The second stage involves developing STD management protocols for each syndrome, which comprise algorithms or flow-charts which outline the actions that should be taken by HPs (Pinto & Ballard, 1994). Bearing in mind the geographical variations of diseases and their presentation, the protocols have been adapted to suit local conditions on the following basis: drug susceptibility patterns, aetiological agents, disease patterns, identification of potential users and their level of skill, an assessment of available health care facilities for referral and the availability of drugs (Grimwood et al., 1996).

The other aspect of the syndromic case management approach includes counselling, which is aimed at drawing a link between STDs and HIV and highlighting the devastating effects STDs can have on a person's reproductive and social life. Patients also receive condom counselling and should be offered condoms, in order to encourage safer sex. A final and important aspect of this

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approach is partner notification, the process whereby a patient is given a contact-tracing card to give to his/her partner(s) so that they present at a clinic for treatment. This measure is used to ensure that re-infection does not occur and that a large number of people are treated (Ballard & Ghidinelli, 1996).

2.4.2 Advantages of the syndromic case management approach

According to Grosskurth et al. (1995), the syndromic case management approach has been used with success in Zimbabwe for over 10 years and is reported to have shown a reduction in HIV infection incidence in Tanzania. In addition to the positive impact it has had on the reduction of HIV transmission, this method has been demonstrated to be cost effective relative to other methods (Grimwood et al., 1996). In a study on the analysis of genital tract infection in a dedicated STD clinic, Rajagopal and colleagues (1999) emphasised the importance of the use of the syndromic management approach in the patients' first contact with PHC clinics. They also point out that effective treatment of patients at first contact reduces long-term morbidity and financial costs.

In another study, Pinto and Ballard (1994) demonstrated that the use of the syndromic case management approach costs twice or three times less than the conventional methods. They also add that this approach offers the convenience that the procedures are easy to follow, thus making it easy for staff with limited clinical expertise and training. The two other advantages offered by this approach are that because of the broad-spectrum of treatment offered to patients on their initial visit, more diseases, which tend to co-exist, are treated at once; and patients have the benefit of receiving 'adequate therapy' in instances when they cannot return for another visit.

2.4.3 Illustration of the approach

The examination procedure in syndromic case management is as follows: all patients should be examined in a private area/ room, they should be assured that all the information is confidential and be treated in a non-judgemental way. A typical consultation using this method starts with a clinical interview that aims to gather the following information about the patient:

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- the presenting problem
- past STDs and any treatment received
- any other illnesses
- any drug allergies
- menstruation, symptoms of pregnancy and contraception

Risk factors, including social factors, number of sexual partners, the appropriate use of condoms, and age of commencement of sexual activity also need to be investigated.

The symptoms with which patients present would then be compared with those on the chart to obtain a diagnosis, and the treatment of the syndrome is identified on the protocol. The treatment involves drug therapy, counselling, which is aimed at exploring alternatives that could reduce risky behaviour and highlighting the link between STDs and HIV transmission, condom promotion and partner notification (Pinto & Ballard, 1994). An example of how the approach is applied is provided below for a case of urethral discharge.

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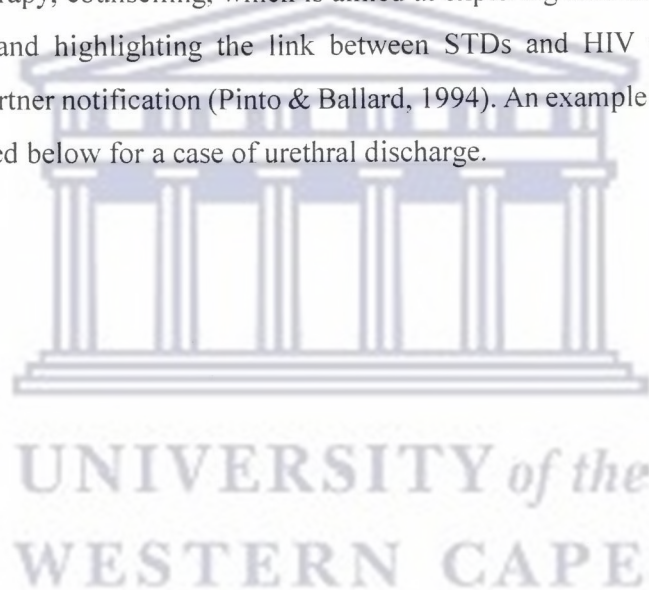
Figure 2.1: Urethral discharge treatment chart (Adapted from Pinto & Ballard, 1994, p.13)

URETHRAL DISCHARGE

Is there an abundant Purulent secretion?

Is there a scanty, muciod or serous secretion?

YES

YES

Rx

Rx

GCU AND NGU TREATMENT

Ofloxacin 400mg or Ciprofloxacin 500mg stat PLUS

Doxycycline or Minocycline 100mg bd x 10 days

OR Tetracycline 500mg qid x 10 days

NGU TREATMENT

Doxycycline or Minocycline 100mg bd x Tetracycline 500mg qid x 10 days

Follow up 14 days after treatment

Do symptoms persist?

NO

YES

Is compliance with treatment good?

Is re-infection unlikely?

Clinical Cure

YES

NO

Rx Consider treatment failure – start protocol again

If purulent secretion – ceftriaxone 250 mg IMI stat + Erythromycin 500 mg qid x 10 days. If scanty secretion – Erythromycin 500mg qid x 10 days

Start protocol again

IN ALL CASES, ADVISE PATIENT TO BRING PARTNER (S) FOR EXAMINATION AND TREATMENT. DISCUSS RISK BEHAVIOURS AND HOW THESE CAN BE REDUCED.

Another crucial factor that has been demonstrated in research conducted in other developing countries, and seems to result in poor quality of care, is the lack of privacy and confidentiality (Dartnall and Schneider, 1998). Harrison and her colleagues (1998) indicate that of their sample only 37% were consulted in private, which confirms the above statement that lack of privacy is seen as an essential issue in quality of care, and the lack of adequate training and ongoing support from supervisors exacerbates the problem. Colvin, Abdool Karim and Hoosen's (1997) study supports the above points of confidentiality and HPs' attitude towards patients, but they add that factors such as location of the health care facility, the time spent waiting before being attended to by an HP and the social stigma attached to STDs impact on the under-utilisation of the services provided.

In a study assessing the quality of STD care in KwaZulu-Natal work-based clinics, Colvin et al. (1997) found that, of the clinics surveyed, more than half used written treatment regimens and of those 62% used guidelines provided by the Department of Health. Out of the 51 clinics surveyed, 26 (51%) reported to be treating urethral discharge and most of them (69%) provided partial treatment. A further 22 (43%) of the clinics indicated that they provided treatment for genital ulcers, with a majority of the clinics (82%) again providing partial treatment. This study further illustrates that even though partner notification was encouraged in some clinics, it was not actively pursued and promoted.

In a study not related to the evaluations of the syndromic management approach nor of STDs but nevertheless of relevance to the quality of care, Petersen (2000) investigated the implications of integrating mental health care into the primary health care sector. In this study she found that HPs attributed to the following obstacles, 'low salaries, inadequate equipment and supplies, heavy workloads, poor infrastructure, bad relationships between staff in clinics and a lack of telephones', their inability to deliver good quality of care (Petersen, 2000, p. 323). She further points out that the health care providers' performance was assessed on daily records, which measured the quantity of consultations rather than their quality, the diagnosis offered rather than the HPs understanding, and the drugs administered as opposed to the care provided.

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2.6   Conclusion

There is overwhelming evidence, in both local and international literature, of the role STDs play in adult and infant mortality, in diseases such as PID and male and female infertility the world over. Yet they only received the necessary attention after the link between STDs and HIV was shown. This chapter also highlighted the differences in the types of infections between the more developed and the less developed countries. The importance of the syndromic management approach to STD treatment was also discussed. In addition, it appears that the quality of care in PHCs tends to be poor, mainly due to poor communication, counselling and depth history taking skills of the health care providers, the HPs' attitudes and their perceived lack of training and support.

Thus it is clear that the identification of the specific factors which inhibit provision of quality of care in STD management is crucial to the improvement of such services, and also in the reduction of rates of STD and HIV infection. The study described in the following chapters is a contribution to this endeavour.

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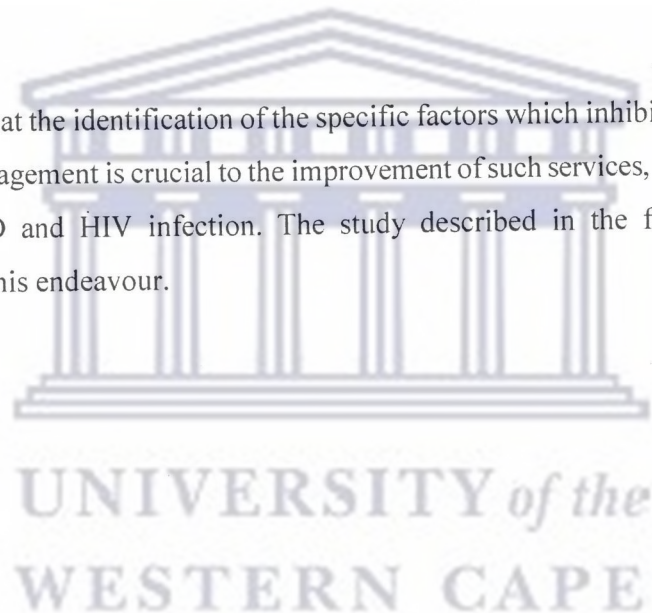
CHAPTER THREE

METHODOLOGY

This chapter aims to describe the research methodology employed in the study. The chapter starts by giving a synopsis of the original study, of which the present study is a subsection. Following this, details of the present study will be explained, namely the research method employed, the research instruments and procedures used in gathering the data, then methods used in analysis of the data, the reflection process of simulated patients on the study and ending off with a brief look at ethical considerations.

3.1   The original study

The present study was part of a national research project commissioned by the National Department of Health's (NDOH) Directorate of Health System Research and Epidemiology in conjunction with the Directorate of HIV/AIDS. The study was administered by the Medical Research Council and conducted by a research team of the Department of Psychology at the University of the Western Cape.

The larger study aimed at evaluating health care-seeking behaviour around STDs and STD management in primary health care (PHC) clinics. The specific aims were to conduct an audit of selected PHC clinics with regard to the available resources and personnel as well as to obtain a profile of STD patients; to examine the perceptions of the general public and STD patients with regards to STDs and to examine the perceptions of STD health care providers in the selected health care centres (Simbayi et al., 1999).

The study combined qualitative and quantitative methods, whereby semi-structured questionnaires were administered to STD and non-STD patients as well as health care providers (HPs). In-depth interviews were also conducted with STD patients and HPs, and focus groups with some groups in the general population that are considered to be at high risk, for example

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miners and youth. Simulated patients were also used to gather additional data on the quality of care.

Since the study utilised both qualitative and quantitative methods it allowed for the triangulation of methods and results. In addition, it aimed at assisting the NDOH in assessing the strengths and weaknesses of the syndromic approach to STD care, as used in PHC clinics. The data gathered could thus be used to give policy makers an idea of the impact of the syndromic case management approach on STDs and identify possible problem areas.

The study sites for this research consisted of 24 clinics, located in four provinces. According to the data obtained from the HIV surveillance of the seventh national HIV survey (Department of Health, 1997b), two of the provinces targeted were considered to have amongst the highest HIV/AIDS prevalence rates in South Africa (North West and Mpumalanga) and the other two had amongst the lowest prevalence rates (Western and Eastern Cape). In each province, six PHC clinics were chosen, of which three were based in urban areas and three in rural areas.

3.2 The present study

This part of the study was aimed at evaluating the quality of care received at PHC clinics from a simulated patients' perspective. The data gathered here would add a different dimension to that obtained from real patients and HPs.

3.2.1 Research method

The participant-observation method was used to gather data in this study. According to May (1993), this method assumes that social reality is constantly changing. Thus in order to understand it and how it changes, we must participate in it and record our experiences of it. Taylor and Bogdan (1984, p.15) define participant-observation as a method 'which involves social interaction between the researcher and those being studied in the milieu/environment of the latter during which data are systematically and unobtrusively collected'. Potter (1996) adds that this method is suitable because it assumes the researched to always be a participant in the

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research endeavour, and affords the researcher an opportunity to study the participants in their natural setting.

According to Taylor and Bogdan (1984), the participant-observation method can be categorised into two methods, those being the participant-as-observer, where the researcher participates by forming relationships with the subjects. The second is the observer-as-participant, which should be used if the researcher intends to keep his/her interaction with the participants to a brief, formal and limited period. The simulated patient method, in which researchers present for treatment as 'patients', complies with the principles of the observer-as-participant approach.

Kinnersley and Pill (1993) in their review on the use of SPs in research, note that the advantages of this method include the fact that the content of the simulation is predetermined and the SPs can be trained so as to standardize each of their presentations. This helps in increasing the efficiency of the data collection method and it overcomes the difficulty of patients who do not want to be observed during their consultation with health care providers. The simulated client method has proved to be economical, practical, and adaptable and also provides first hand information that would be otherwise difficult to access. This method has also been used effectively to evaluate the quality of health care in developing countries. Finally, it is seen as giving credible feedback to health providers and validating the real patients' experiences (Madden et al., 1997).

The disadvantage of this method includes the fact that those being studied might be aware that a study is being carried out and this will make them modify their behaviour and act in a manner they think will be satisfactory (Kinnersley & Pill, 1993; Shaughnessy & Zechmeister, 1997). Put another way this method raises the question of the effect the researcher has on those being studied.

3.2.2   Research instruments

Vignettes of possible symptoms with which the simulated patients could present were developed, with symptoms being of such a nature that no physical examination was required. For example

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the typical symptoms that the SPs presented with included burning urine, urinating often and pain when urinating. The elicited data was captured on a semi-structured questionnaire, designed in collaboration with the main study leaders on the basis of previous literature and consultation with relevant health and research personnel, to cover different aspects of the syndromic approach: in-depth history taking, diagnosis and treatment, condom counselling, partner notification, counselling about complications associated with STDs and the quality of the consultation (see Appendix A). In addition to the semi-structured questionnaire, the researcher-participants also kept a diary of their experiences in the clinics.

3.2.3   Procedures

Four post-graduate social science students, two female and two male, were selected and trained as researcher-participants, base on their ability to speak at least one of the languages spoken in the provinces, in addition to English. Oskowitz and Meulenberg-Buskens (1997, p. 83) point out that 'any type of research focussing on a sensitive topic necessitates a preparation period'. In accordance with this notion, researcher-participants were involved in group discussions on knowledge of and attitudes of STDs, in order to prepare for the clinic visits. One male and one female researcher-participant presented as patients with possible STD symptoms at each clinic. They then recorded their observations on a semi-structured questionnaire after each visit as well as writing up their qualitative experiences in a journal.

3.2.4   Data analysis

The data obtained from the questionnaire was coded and entered into the Statistical Package for Social Sciences (SPSS) for analysis. The results obtained were analysed through descriptive statistics. Further analysis of possible differences (between high and low risk provinces and urban and rural clinics) was also conducted. Furthermore two quality of care scores were obtained, the first being the SPs rating of the consultation and the second a composite score that was constructed for each SP visit. This score was constructed from 12 responses on the questionnaire, each of which measured an aspect of the quality of STD care. Each simulated patient rating received a score out of 12, with 0 being the minimum score and 12 being the maximum score.

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'These scores were also grouped into three to form a 3-point scale', with a score of 0-4 indicating 'poor' quality of care; a score of 5-8 indicating 'average ' quality of care and a score of 9-12 indicating 'good' quality of care (Simbayi et al., 1999, p.28). Thematic analysis was used to analyse the qualitative data derived from the journals of the SPs. Mostyn (1985) sees this method as the identification of specific characteristics of communications in a systematic and objective manner in order to convert the raw data into scientific data. According to Banister, Burman, Parker, Taylor and Tindall (1994), thematic analysis is a coherent way of organising data in relation to a specific research question.

3.2.5   Reflections on the process

The author and other SPs were inexperienced in the field of research; thus the assignment of being SPs proved to be very challenging. It was generally difficult to pretend to be a patient, while one knew that you had no illness. This made us anxious and the anxiety was exacerbated by the fact that STDs are generally stigmatised, so that we anticipated negative responses from the HPs. The possibility of being physically examined only helped to increase the anxiety. In fact the current author was physically examined at one clinic after numerous attempts to avoid the examination failed.

The stigmatising effect of STDs was demonstrated by one of the male SPs who was tempted to reveal his identity to an attractive HP, when he felt she would not want to interact with a person with an STD: 'I felt like telling her that I am not a patient, I am actually a psychology student doing research'. The other simulated patients also noted that there were moments where they felt tempted to reveal their identity. The current author and a female SP, on their first field trip, after having had to wait for 5 hours without seeing a health care provider wanted to reveal their identity to the clerks and HPs so that they could be assisted more speedily. The experiences, although at times unpleasant, were invaluable particularly to novice researchers such as ourselves. The most important lesson for the author was that even with the pre-fieldwork training we had received, the sensitive nature and the stigma attached to the disease under study made it difficult for me to be totally relaxed and it raised some of my concerns and fears regarding STDs. Secondly given the fact that the environment that participant-observers work in approximates

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reality, dramatic and unanticipated behaviour on the part of researchers might occur (Shaughnesey & Zechmeister, 1997). Although long waiting periods were anticipated, never did we imagine a waiting period longer than five hours and this posed a risk to the research, as the simulated patients were tired and had the urge to reveal their identities. The above made me understand the patients' frustrations of having to wait for long periods and it raised in me the feeling that we were not valued as patients. I felt that the information gathered from the HP was not worth waiting for that long and I imagine that these might be some of the feelings that real STD patients experience and that this could be a contributing factor in the delayed contact with PHC clinics.

3.2.6 Ethical considerations

The regional health offices were informed of the visits of the simulated patients to the different clinics, over a period of 3 months, and gave their approval. The sensitive nature of the study required that all the data be kept anonymous and confidential and that the true identity of simulated patients be concealed. Madden and colleagues (1997) point out that simulated patients run the risk of undergoing unpleasant or risky medical procedures. It is for this reason that the vignettes chosen required no physical examination.

Besides putting patients at risk of undergoing risky medical procedures, covert research has been seen by other researchers as unethical, as there is no full disclosure of the purpose of the research, and the technique described as 'morally obnoxious' and a 'manipulation' (Shils, 1959 in Patton, 1987). On the other hand covert research has been justified as ethical and helping in the scientific endeavour. Douglas (1976 in Patton, 1987) agues that this investigative paradigm is based on the assumption that people have conflicts of interest. As a result they tend not to disclose fully about themselves or their circumstances and at times they distort matters so as to fit their reality. In spite of all the ethical problems that the covert observation methodology raises, it was seen as valuable as it supplemented the data obtained from the overt methods used in the larger study, namely the interviews with patients and HPs.

To this end we followed the recommendations made by the American Joint Committee on

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Standards for Educational Evaluation (1981 in Patton, 1987), which outlines that evaluation programmes should be designed and conducted in such a manner so as not to infringe on the rights and welfare of the participants. Human dignity and worth should be respected in the research endeavour and the findings should be disseminated to clients and other right-to-know audiences, so as to afford them an opportunity to assess and use the findings. At the end of the larger study, a report was prepared and submitted to the National Department of Health.

CHAPTER FOUR

RESULTS

This chapter will be reporting the results of the data obtained from the clinic visits. The results will be presented in eight sections: the number of visits, the accessibility of health care providers (HPs), history taking and the examination the SPs underwent, diagnosis and treatment received, condom use, contact tracing and partner notification, counselling and the quality of the consultation. Finally, a synopsis of the qualitative data will be given.

4.1   Number of visits

As indicated in the methodology section, two male and two female SPs were utilised to gather the data. The total number of visits made to the various primary health care clinics amounted to 38. Of the 38 visits, 20 visits (52.6% of the visits) were made by male SPs while the remaining 18 (47.4% of the visits) were made by female SPs.

4.2   Consultation with HPs

This section of the questionnaire assessed the accessibility of the HPs. It therefore asked questions related to the time spent waiting at the PHC before being attended to by the HP, the duration of the consultation, the gender of the HP and whether the SP was consulted in a private or open area. With regards to the average time spent waiting before being attended to by the HP, it appears that on most visits the SPs had to wait for an average of 2 hours (see Table 4.1 below). Regarding the length of the consultation, data indicates that the majority of the visits lasted less than 15 minutes, with a third lasting less than five minutes and another third lasting between 6 and 15 minutes. On nine visits (23.7%) the consultation lasted between 16 and 30 minutes and on the remaining two visits (5.3%) the consultation lasted for more than 30 minutes.

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Table 4.1. Period spent waiting for the HP

Time spent waiting to be seen by HP	Frequency (N)	Percentage (%)
1. Less than 30 minutes	7	18.4
2. Between 31 – 60 minutes	7	18.4
3. Between 61 – 120 minutes	11	28.9
4. Between 121 – 240 minutes	9	23.7
5. Over 240 minutes	4	10.5
Total	**38**	**100**

Regarding the gender of the HPs, data indicates that only two (5.3%) of the consulting health care providers were male, whereas the other 36 (94.7%) HPs were female. In considering the consulting and history taking venues, it appears that on 32 visits (88.9%) SPs were consulted in a private room, and on 34 visits (97.1%) their histories were obtained in private rooms.

4.3 History taking and examination

In order to make the results of this section easy to comprehend, the results of the female SP visits (N =18) will be reported separately from those of the male SPs (N =20). Scanning through the data of the female SPs, it becomes evident that on most of the visits the HPs did not ask most of the crucial diagnostic questions from the SPs. Questions less often asked of female simulated patients focussed on the type of symptoms they presented with and the use of contraceptive measures. There was on average a 90% chance that in a consultation one or more of these questions would not be asked. Those questions most often asked of these patients revolved around the duration of the symptoms and the patients' medical and sexual histories (see Table 4.2 below).

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Table 4.2. Female SPs examination process

Question	Yes		No		Total	
	N	%	N	%	N	%
1. Pain when having sex	1	5.6	17	94.4	**18**	**100**
2. Heavy period bleeding	0	0	18	100	**18**	**100**
3. Irregular period	1	5.6	17	94.4	**18**	**100**
4. Bleeding after sex	1	5.6	17	94.4	**18**	**100**
5. Date of last menstrual period	2	11.1	16	88.9	**18**	**100**
6. Type of vaginal discharge	9	52.9	8	47.1	**17**	**100***
7. Lower abdominal pain	5	29.4	12	70.6	**17**	**100***
8. Sores	7	41.2	10	58.8	**17**	**100***
9. Duration of symptoms	10	58.8	7	41.2	**17**	**100***
10. Previous STD	9	52.9	8	47.1	**17**	**100***
11. Previous treatment	6	35.3	11	64.7	**17**	**100***
12. Last sexual intercourse	7	41.2	10	58.8	**17**	**100***
13. Number of recent sexual partners	8	47.1	9	52.9	**17**	**100***
14. Contraceptive use	2	11.8	15	88.2	**17**	**100***

* Note: Figures with a star indicate that participants failed to respond on one or more questions

Turning to the male SPs, data indicates that all questions that focused on symptoms tended to be asked on most visits, being asked on an average of eight out of ten interviews. Questions focussing on the medical and sexual histories of male simulated patients and their level of contraceptive use tended to be asked in fewer cases, being asked on average in three of every ten consultations (see Table 4.3 below). A rough comparison of the data of the male and female SPs shows a reverse type phenomenon, that is questions focussing on symptomatology were more often asked of male compared to female simulated patients, whereas questions focussing on both medical and sexual history and contraceptive use were less often asked of male SPs than female SPs.

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Table 4.3. Male SPs examination process

Question	Yes		No		Total	
	N	%	N	%	N	%
1. Urethral discharge	18	90	2	10	**20**	**100**
2. Pain when urinating	18	90	2	10	**20**	**100**
3. Sores on genitals	15	75	5	25	**20**	**100**
4. Duration of symptoms	13	68.4	6	31.6	**19**	**100***
5. Last sexual intercourse	3	15.8	16	84.2	**19**	**100***
6. Number of recent sexual partners	6	31.6	13	68.4	**19**	**100***
7. Previous STD within last 3 months	7	36.8	12	63.2	**19**	**100***
8. Previous treatment	4	23.5	13	76.5	**17**	**100***
9. Contraceptive use	6	33.3	12	66.7	**18**	**100***

* Note: Figures with a star indicate that participants failed to respond on one or more questions

4.4 Diagnosis and treatment

With regard to the diagnosis given after the examination process, data indicates that on most of the visits the HPs gave no diagnosis at all or gave an unclear diagnosis to SPs. Thus in four out of ten cases, no diagnosis was given, while in one out of ten cases a diagnosis not related to STDs was given. For almost a third of the cases a clear diagnosis was given and there were cases where the health care providers were not sure of a diagnosis but hinted the possibility of an STD. This mixed picture of diagnosis could be due to the fact that the symptoms SPs presented with were not clear enough and could be confused for other diseases (see Table 4.4 below).

Regarding the explanation about the causes of the illness given to SPs, it appears that on only 14 visits (36.8%) was there a clear explanation given that the cause of the illness was sexual transmission. However, on 16 visits (42.1%), no explanation was given at all and on the remaining 8 visits (21%) an inadequate, inappropriate or wrong answer was offered.

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Table 4.4. Diagnosis given to SPs

Diagnosis	Frequency (N)	Percentage (%)
1. Vaginal discharge	1	2.6
2. Gonorrhea	7	18.4
3. STD label	6	15.8
4. Other diagnosis	6	15.8
5. No diagnosis given	15	39.5
6. Not sure but possibility of an STD mentioned	3	7.9
Total	**38**	**100**

When considering the medication prescribed for the SPs on their visits, it turns out that, on almost all visits, medication was prescribed with doxycycline being prescribed more often than other medication, and with flagyl/metronidazole and ciprofloxacin being prescribed for about a third of the cases. There were cases where simulated patients were given medication not related to treating STDs and according to the data obtained this happened for every four in ten cases (see Table 4.5 below). According to Simbayi et al. (1999) almost a third of the female SPs and only 15% of male SPs were treated (medicated) in accordance with the syndromic approach.

Table 4.5. Prescribed medication

Type of medication	Yes		No		Total	
	N	%	N	%	N	%
1. Ciprofloxacin	13	35.1	24	64.9	37	100*
2. Doxycycline	21	56.8	16	43.2	37	100*
3. Flagyl/ Metronidazole	13	35.1	24	64.9	37	100*
4. Other	17	45.9	20	54.1	37	100*
5. No medication	3	7.9	35	92.1	38	100

* Note: Figures with a star indicate that participants failed to respond on one or more questions

With regards to the explanation given for the use of the medication, SPs felt that on most of the visits (that is 22 or 59.5%) the treatment was clearly explained. In addition, they indicated that on 24 (66.7%) of the visits they were told to finish the full course of treatment, while on 20 (57.1%) of the visits they were not informed to abstain from or practise safer sex during the course of

treatment.

In assessing the data regarding the follow-up measures recommended by the HPs, it appears that on only 17 (44.7%) of the visits simulated patients were told to return to the clinic. On 11 (78.6%) of these visits they were advised to return within a week and on three (21.6%) of the visits they were told to return within a month.

4.5   Condom use

Regarding the counselling received on condom use and the distribution thereof, the data indicates that on most of the visits condom use was encouraged although no condoms were distributed, with simulated patients reporting to have been encouraged to use condoms in six out of ten visits, yet no demonstration was given in nine of every ten visits. In spite of being informed about the importance of condoms on more that half of the visits, SPs were offered condoms on only a third of the visits (see Table 4.6 below).

Table 4.6. Condom counselling offered

Question	Yes		No	
	N	%	N	%
1. Did the HP encourage condom use	22	57.9	16	42.1
2. Was a demonstration of how to use a condom given	2	5.3	36	94.7
3. Were condoms offered to you	13	34.2	25	65.8
4. Were you informed about the importance of condoms	20	55.6	16	44.4

4.6   Contact tracing and partner notification

When considering the contact tracing of the SPs and their partner notification, it turns out that on most of the visits the SPs were informed about the importance of having all their sexual partners treated, yet on most occasions they were not given an appointment date nor contact tracing cards for their partners (see Table 4.7 below).

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Table 4.7. Contact tracing measures

Question	Yes		No	
	N	%	N	%
1. Informed that all recent sexual partner(s) should be treated	21	55.3	17	44.7
2. Informed to tell partner(s) to come for treatment	21	55.3	17	44.7
3. Were you given dates on which your partner should come for treatment	8	21.1	30	78.9
4. Were contact cards given for your partner	4	10.5	34	89.5

4.7   Counselling

With regards to the counselling that SPs received about adopting safer sexual behaviour, it appears that on the majority of the visits the SPs were not adequately counselled about avoiding risky behaviour. Even though half of the simulate patients reported to have been informed about the importance of avoiding casual sex, only three out of ten cases were told of the importance of mutual monogamous relationships. Again half of the SPs reported to have been informed about the causes of STDs, yet in 90% of the cases they were not informed of the reproductive risks associated with STDs. Simulated patients also reported that in only four of every ten consultations were they informed of the increased risk of acquiring AIDS associated with STDs, and they were told in only a quarter of the interviews that people with STDs might not show symptoms (see Table 4.8 below).

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Table 4.8. Counselling received

Questions	Yes		No	
	N	%	N	%
1. Were you counselled about the causes of STDs	19	52.8	17	47.2
2. Were you informed about the practice of monogamy	10	27.8	26	72.2
3. Were you told to avoid casual sex	17	48.6	18	51.4
4. Were you told about the increased risk of infertility associated with STDs	3	7.9	35	92.1
5. Were you told about the increased risk of spontaneous abortions associated with STDs	1	2.6	37	97.4
6. Were you told about the increased risk of getting AIDS associated with STDs	15	39.5	23	60.5
7. Were you told about the increased risk of congenital diseases associated with STDs	9	24.3	28	75.7
8. Were you told that people with STDs may not show symptoms	9	24.3	27	75.7

4.8   Health care providers' attitudes

Regarding the attitudes of the health care providers, data indicates that on most visits simulated patients found health care providers to be helpful, respectful and non-judgmental. However, they were considered to be unfriendly on eight out of ten visits and informative on only half of the consultations (see Table 4.9 below).

Table 4.9. Attitudes of HPs

Question	Yes		No	
	N	%	N	%
1. Did you find the HP to be helpful	23	60.5	15	39.5
2. Did you find the HP to be friendly	8	21.1	30	78.9
3. Did you find the HP to be respectful	33	86.8	5	13.2
4. Did you find the HP to be judgmental	10	26.3	28	73.7
5. Did you find the HP to be informative	19	50	19	50

4.9 Quality of the consultation

Regarding the overall rating of the STD treatment at the different clinics, simulated patients rated the treatment as good in 40% of the consultations, average on 10% of the consultations and poor on the remaining 50% of the consultations. The data obtained from the composite quality of care scores, as described in chapter 3, indicate that 16% of the visits obtained a good score, while 47% received an average score and 37% of the visits obtained a poor score (see table 5.1 on p.48).

4.10 Qualitative data: themes

Of the qualitative data obtained from the journals of the SPs, the dominant themes were about the accessibility of the HPs, counselling about the risks associated with STDs and their relationship to HIV/AIDS, and the history-taking process.

Regarding accessibility, the time spent waiting before being attended to by a HP posed great difficulty for the SPs. They indicated that the period spent waiting to be seen by an HP made them feel anxious and this anxiety was exacerbated during the history-taking period. The anxiety was partly due to the envisaged response of the HP to the presenting problem and partly due to the feeling of the stigma attached to STDs:

> *I sat in the foyer for more than 45 minutes waiting to be seen, by that time I had not even been to the clerk. I was getting impatient and more anxious as I thought more around the*

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issues of STDs. I thought the nurses would scream at me and tell me how irresponsible I have been. When I finally saw the nurse she spoke in a loud voice and the only thing I could think was that I hope the patient in the next cubicle does not hear that I have an STD. (Male SP)

On our first field trip we waited for over five hours before being attended to by a health care provider. During this period I became very anxious, there was point when I felt like leaving the clinic. I was irritated seeing the nurses going up and down the corridors, some leaving the clinic during working hours, while we were waiting to see them. (Female SP)

The long wait made me anxious. When I was finally attended to, my anxiety was so high that even though the nurse was kind and had a soothing voice it took a long time for my anxiety to alleviate. (Male SP)

The history taking process was seen as anxiety provoking, in that some HPs did not ask certain essential and confidential questions, thus failing to enable the SPs to speak openly about their sexuality and behaviour:

After I had presented my problem to the nurse, I was of the impression that she would ask me more questions about my sexual history, things that I did not feel empowered to just bring up, but she did not; instead she rushed to diagnosing and prescribing medication. As a result I feared asking certain things that I had thought pertinent to know. This was also influenced by the fact that she was an elderly lady who seemed not to be impressed by the possibility of me being sexually active. (Male SP)

I was out of the consultation room no sooner than I had entered. I could not believe that I had to wait that long for a five-minute consultation, in which I was not even asked how I got the STD. As soon as I listed the symptoms the nurse made a diagnosis and prescribed medication. (Female SP)

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With regards to counselling SPs felt that they were not empowered by the HPs, as they did not provide the SPs with adequate information regarding STDs and their link to HIV/AIDS. This would then hinder their ability to take informed decisions. Although the HPs seemed knowledgeable they failed to transmit the information to their patients:

The nurse informed me to use a condom during intercourse, but she did at no stage mention the fact that chances were higher for a person with an STD to contract HIV. She mentioned HIV in passing and again did not link it to STDs. This same nurse had not obtained much of my sexual or medical history, thus I felt that she did not give me adequate information. (Male SP)

The nurse was warm and asked questions related to my sexual history and medical history. She did not at any stage during the interview inform me about the reproductive risks associated with STDs, nor did she inform me that the chances of contracting HIV were increased for people who had STDs. (Female SP)
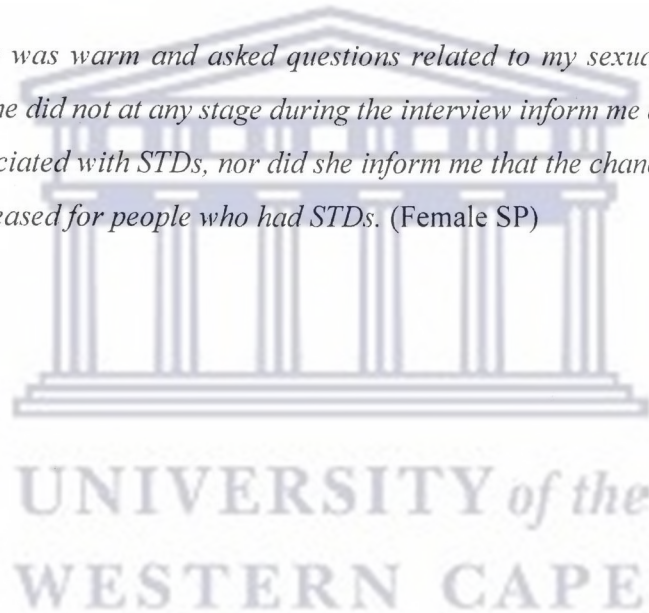
CHAPTER FIVE

DISCUSSION, RECOMMENDATIONS AND CONCLUSION

In this chapter the results outlined in the previous chapter will be discussed. The discussion will be followed by an analysis of the strengths and limitations of the present study, as well as recommendations for both future research and for the health authorities and policy makers.

5.1   Discussion

Overall there seem to be some positive aspects in the quality of care that is offered to patients, which include offering treatment appropriate for STDs. However there are areas of the approach that are less satisfactorily applied, especially regarding the waiting period, history taking, partner notification, counselling and condom counselling.

5.1.1   Consultation with HPs

The period spent before seeing a HP and the accessibility of HPs are crucial factors in service delivery, since they help to determine the client's continued use of the service (Bruce, 1990). Thus the longer the periods spent waiting to be seen the less motivated the clients will be about using the service again. The results indicate that, during most of the visits, SPs waited for more than an hour before seeing a HP, a finding that replicates the studies by Faxelid and colleagues (1997) and Harrison and her colleagues (1998). A female SP noted that on one of her field trips the long wait was due to health care providers taking tea breaks, going out of the clinics or showing each other photographs of their families. Thus the long waiting periods were not solely due to heavy patient loads, so that it appears as though staff members do no utilise the limited time effectively.

Regarding confidentiality, results show that although there are still people who consulted in open areas, this does not seem to be a general trend. This would suggest that the clients' privacy is

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prioritised. This finding differs from previous findings, like Harrison et al.'s (1998) finding that only four out of every ten patients were consulted in private. Even though privacy has improved it still remains a top priority for patients, as indicated by the concern of an SP that the patient in the next cubicle would overhear their conversation. It seems the sensitive nature of STDs makes it difficult for people to deal with, and suggests that such stigma may hinder patients from presenting for treatment in the early stages of the diseases, and make return visits unlikely if they do not receive privacy in the consultation.

5.1.2   History taking and examination

In line with the requirements of the syndromic case management approach, this part of the questionnaire assessed the level to which the HPs complied with the syndromic approach in eliciting the client's symptomatology, its duration and the client's medical history. It is assumed that every diagnostic question asked should help the HP narrow the possible diagnosis, so that they can refer to the appropriate chart for treatment. Studies by Djajakusumah and colleagues (1998) and Moherdaui et al. (1998) have shown the sensitivity of the syndromic case management approach in reducing diagnostic possibilities.

With regards to the **female SPs'** examination process section, the first nine questions were formulated for the purpose of finding out whether the HPs asked questions that help them reduce the possible number of diagnoses as suggested by the syndromic approach chart. Data indicates that on most visits of the female SPs, as many as half of the questions concerned with the SPs symptomatology were not asked. Thus on almost half of the visits their medical history was not obtained and on as many visits HPs failed to assess the simulated patients' risk exposure to being infected with STDs and HIV. This therefore suggests that HPs do not comply with the specifications of the syndromic approach, which outlines that the symptomatology and the history of the presenting problem needs to be clarified in order to make an appropriate diagnosis. The inadequate history taking raises the question of how a correct diagnosis could be made with insufficient evidence. This would in turn raise a related question of how one would provide the relevant and effective treatment without first making an appropriate diagnosis. The poor skills of in depth history taking, illustrated in the female SPs' examination, confirm the findings of Bryce

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et al. (1994), Dartnall and Schneider (1998) and Ndulo et al. (1995), who in their respective studies found that health care providers made poor diagnoses and this was partly due to poor history taking skills.

To elaborate on the matter of diagnosis, if the HP does not enquire about the nature of the symptoms such as the nature of the menstrual cycle, if there is bleeding after sex or if the client experiences pain during intercourse, it then becomes difficult for the HP to be able to differentiate one STD from another and between STDs and non-STDs. Furthermore in making a provisional diagnosis, HPs are supposed to enquire about the client's STD history and previous treatment, in addition to developing a client's risk profile, by establishing the number of sex partners in the last three months and the appropriate use of condoms. This information is meant to help the HP in reducing diagnostic possibilities to one clear diagnosis and ensure that an informed and relevant treatment plan is chosen for the client. The present study's results indicated that HPs complied with the requirement of collecting the clients' history on some occasions while on most occasions they failed to establish the clients' risk profile.

Regarding the examination process of **male SPs** the results indicated that on the majority of visits the HPs took an interest in asking the relevant diagnostic questions from the male simulated patients, and thus on a majority of visits health care providers complied with the syndromic approach. They nonetheless failed on many of the visits to comply with the guideline of acquiring the client's STDs infection and treatment history. As was previously highlighted, this is important for the purposes of diagnosis as it helps to clarify the possible diagnosis. In addition to the above, the medical history helps in determining the client's response to treatment and for assessing his/her risk profile (Djajakusumah et al. 1998; Moherdaui et al., 1998).

In addition the syndromic case management approach clearly indicates that one of its aims is to reduce risky behaviour. Thus the HP has to ask about the number of sexual partners the patient has and if they practise safe sex, and use condoms. It turns out the HPs tended not to comply with this guideline on most occasions, and an appropriate risk profile was only obtained on a few of the visits.

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A rough comparison of the diagnostic questions asked of male and female SPs shows that the HPs tended to ask relevant diagnostic questions on more occasions from male SPs than from the female SPs. This could be due to HPs feeling more equipped to elicit symptomatology in male clients than female clients. This is interesting because most of the health care providers were female and in their mid to late thirties. This did not appear to be due to the seniority of the female HPs as one of the female simulated patients was in her mid-thirties and would have been easily of the same age as most health care providers. However, it is possible that this situation was due to the perception that males tend to have more than one sexual partner and thus they are at high risk compared to females. This scenario could further be influenced by the fact that males tend to have symptoms and thus they can present with them at the clinic, while females tend to be asymptomatic and in this particular case female simulated patients did not present with any symptoms. In fact studies have shown women tend to be asymptomatic (De Schryver & Meheus, 1990; Mayaud et al., 1995). The common factor found in the assessment of both male and female SPs was the fact that in most cases HPs failed to comply fully with the syndromic case management's requirement of assessing the client's previous medical history and their level of risk.

5.1.3   Diagnosis and treatment

Turning to the diagnosis given to the SPs, on a third of the visits SPs were given an appropriate diagnosis, while on slightly over half of the visits health care providers failed to diagnose or offered an inappropriate diagnosis. The failure to obtain a clear and concise history from the SPs is clearly indicated in the poor diagnoses offered to the clients. This highlights the poor history taking skills mentioned earlier and is in line with the findings of previous studies (Bryce et al., 1994; Dartnall & Schneider, 1998; Ndulo et al., 1995). Bearing in mind that all SPs presented with a standardized vignette, it is expected that the diagnosis offered would be similar in most cases. Research has indeed on numerous occasions proved the reliability of the syndromic case management approach in the diagnosis of STDs. This would then suggest that if HPs complied fully with the algorithms they would be likely not to miss out on possible STDs (Djajakusumah et al., 1998; Moherdaui et al., 1998).

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The failure to offer clear diagnoses on most visits raises a concern related to the explanation of the aetiology and treatment of the disease. Indeed, on the few visits that an appropriate diagnosis was offered, a clear explanation of the cause was also provided. It follows that once an HP gathered all the relevant information from the patient and made an appropriate diagnosis, they would then be able to link the diagnosis, the symptoms the patient presented with and the risky sexual behaviour to the patient in a simple manner. To further illustrate the above point, the results showed that on the visits that inappropriate diagnoses were offered, inappropriate, wrong explanations or no explanations were also offered with regards to the cause of the disease diagnosed. The HPs thus failed to comply with the requirement of explaining the cause of the patients' disease, yet again confirming the findings of previous studies that HPs fail to communicate their knowledge to their clients (Harrison et al., 1998). This was well captured by one male SP who highlighted that he had waited for cues from the health care provider on what information is appropriate to divulge and did not feel confident to tell everything, thus further probing by the health care provider would have empowered him to tell more. Another simulated patient noted that after she had listed complaints she was diagnosed and given treatment, but no explanation for her diagnosis was given.

In spite of the inappropriate diagnosis on most of the visits, HPs tended to prescribe medication recommended by the syndromic case management approach for the treatment of STDs. It seems also that HPs tended to comply, on a majority of the visits, with the requirement of giving a clear explanation on how to use the medication. They gave clear instructions on most visits that the course of treatment should be finished, and encouraged safer sex. Although this indicates a positive aspect of service delivery, it nevertheless suggests that the health care providers are not fully complying with the goal of the syndromic approach of encouraging a preventative medical service rather than a curative service. Secondly, their failure to make an appropriate diagnosis, yet offer medication that is meant to cure STDs, could be an indication of the HPs lack of skills and frustration in dealing with an area that they do not have specialised skills in, and this ensures that patients are not empowered to understand the aetiology of their illness.

An important aspect in the treatment process is the follow-up measures suggested by the HP. Follow-up is done mainly to assess a client's progress regarding the presence of symptoms and to

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further educate the client about HIV/AIDS and STDs. This is done so as to contain the patient and to encourage the utilization of the service (Grimwood et al., 1996; Pinto & Ballard, 1994). From the data obtained it seems that, in only about half of the visits, health care providers complied with the requirement of the syndromic approach of informing the patients that they needed to come back for a follow-up visit.

Thus, the matter of diagnosis seems to be a major obstacle in providing quality care. Wrong or inappropriate diagnoses were made and unrelated treatment offered to patients. It seems that this is still a major shortfall in the provision of good quality of care for the treatment of STDs.

5.1.4   Condom use

The main focus of the syndromic management approach is to encourage preventative medicine and it is to this end that the treatment process encourages counselling as a form of education and reducing risky behaviour. Condom counselling is but one aspect of the counselling process. It seems that HPs complied with the requirement of encouraging condoms use on the majority of the visits, although on almost all visits they failed to comply with the requirement of demonstrating how to use a condom. Moreover, it seems that on most visits, HPs complied with the requirement of informing the simulated patients about the importance of condoms. However, SPs were not offered condoms on most of the occasions. Clearly, this does not comply with the requirements of the syndromic approach, which stipulates that condom use should be encouraged and condoms should be offered to clients after contact with HPs. Solomon and DeJong (1989) and Baker et al. (1995) have shown that with proper education, people's perceptions about condom use are likely to improve, which results in increased condom use.

Malan (1979) speaks about the process of psychotherapy (counselling in this context) as empowering a client and giving him/her adequate information, and at the right time, that will empower him/her to make informed decisions. In the above scenario, most of the clients were encouraged to use condoms yet they were not shown how to use them. Earlier results indicated that the client's utilization of condoms was not established. The question that this raises is; how do HPs know what information to disseminate to patients if they have not asked the right

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question, and how can they empower people if they do not give them appropriate information?

5.1.5 Contact tracing and partner notification

According to the syndromic case management protocol, HPs are required to inform their clients that all their recent sexual partners should be treated and that they should tell their partners to come for treatment. According to the available data, on most visits HPs clearly complied with both of these requirements. However, they failed on most visits to give dates on which the SPs' sexual partners should present for treatment. In addition, they failed on the majority of the visits to comply with the requirement of giving the SPs contact cards that would be used to identify their partners upon presentation at the hospital. These results confirm the findings of previous studies that partner notification cards are only given to a small proportion of patients (Harrison et al., 1998).

One of the benefits of partner notification would be to ensure that partners are treated, thus avoiding re-infection and further complications. Secondly, partner notification would serve as a 'ice breaker' for discussing safer sex options between patients and their partners, which is particularly true for females. Literature suggests that, although some women feel comfortable in discussing their STD or HIV status with their regular partners or husbands, there are still women who fear discussing their STD or HIV status with their partners. Moreover, even though women tend to be well informed about condoms they are reluctant to use them as they argue that they build mistrust (Dladla, Hiner, Qwana & Lurie, 2001). In South Africa a study assessing the risks involved for young women in sexual relationships, the authors concluded that adolescent sexuality is constructed around existing gender inequalities, and this is played out in the girls' belief that boys should determine the course of the relationship (Harrison, Xaba, Kunene & Ntuli, 2001). The physical and economic strength of males, both of which are regarded as social norms, act as disempowering factors in women's lives particularly those in rural areas. Moreover, the above authors point out that women stand the risk of being physically beaten or chased out of their house if they discuss adopting safer sex practices. Thus sensitive handling of partner notification regarding STDs could contribute to improved negotiation of safer sex within the context of gender inequality.

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5.1.6   Counselling

As has already been noted, counselling as a form of education is highly encouraged by this approach. So in addition to condom promotion, patients are taught about the risks associated with STDs. This process mainly aims to discourage risky sexual behaviour and to educate patients about the health problems associated with STDs, and draw the link that exists between HIV/AIDS and STDs and the detrimental effects STDs can have on their health.

HPs complied, on just over half of the visits, with the requirement of informing their clients about the causes of STDs. They also complied with the requirement of informing the clients to avoid casual sex on as many occasions. In spite of these strengths, they failed on most visits to encourage their patients to practice mutual monogamous relationships. Although the syndromic case management approach does not dictate the number of sexual partners, it is felt that the mutual practice of monogamous relationships, coupled with regular and appropriate condom use, reduces the patients' exposure to being infected with STDs or HIV (Grimwood et al., 1996).

With regards to the education process, data obtained in the present study indicated that on a large majority of the visits HPs failed to inform their clients about the increased risk of infertility associated with STDs. They also failed to inform their clients about the increased risk of spontaneous abortions associated with STDs on as many occasions. These findings confirm previous findings that HPs failed to convey their knowledge to patients about the risks associated with STDs (Harrison et al., 1998). Informing patients about this can make a difference as it allows people to act with the knowledge of the consequences to their action. Furthermore, if people are better informed they will be better empowered in exploring alternative behaviours that will reduce their risk levels.

Regarding the increased risk of congenital diseases associated with STDs, data obtained in the present study indicated that again HPs failed to comply with this requirement on a majority of the visits. In addition, they failed on many occasions to comply with what would be considered the quintessence of the syndromic management approach, which is to inform the clients about the increased risk of being infected with HIV associated with STDs. Finally, HPs failed on most

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visits to inform clients that contrary to popular belief, people with STDs may not show symptoms. It would seem that lack of proper counselling remains a big obstacle in STD treatment in PHC clinics and that, although previous research highlighted the issue, it still has not been resolved (Bryce et al., 1994; Dartnall & Schneider, 1998; Ndulo et al., 1995). Petersen (2000) indicated in her study that HPs tended to feel overwhelmed when they were expected to counsel patients, as they felt unskilled in this task. This matter raises the question of whether it is feasible for HPs to offer counselling to patients, given that this is a skill that is not always emphasised in their traditional training. Secondly, with the current system where HPs at primary health care clinics are expected to handle the full spectrum of presenting health problems (from mental health to STD care), is it feasible to train them adequately in all these fields?

5.1.7 Quality of the consultation

This section will be discussed in four phases with the first focusing on the length of the consultation, the second on simulated patients' rating of health care providers' attitudes, the third on the rating of the quality of care by simulated patients, and finally the composite quality of care score obtained from SPs will be compared to that of health care providers and STD patients.

Firstly, regarding the length of consultation, it seems that the time spent with the patient and the waiting period prior to seeing an HP are regarded as major obstacles by patients. This was clearly indicated in one simulated patient's comment that it was irritating to wait for a long period and then spend only five minutes in a consultation. On most visits SPs spent 15 minutes or less with the HPs in consultation. The finding that patients wait for long period is supported by Colvin et al.'s (1997) study in which they found that patients waited on average for an hour prior to being seen by a health care provider and that this was a de-motivating factor in continued use of the service. This again raises the point of the possibility of making an appropriate diagnosis and adequately educating a patient about STDs in only a few minutes. The short period spent with patients could be indicative of HPs feeling unequipped to deal with STD care.

It is easy to argue that the short consultations seem to be due to the increased numbers of patients presenting at PHC clinics and the fact that HPs are assessed by the quantity of patients consulted

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rather than the quality of the consultation, and this would be a valid argument. An equally important point to make is that long waiting periods seem to be partly due to the poor time management of staff members in the clinics, as was shown in the qualitative observations of simulated patients that HPs spend long periods roaming around the clinic while large number of patients were waiting for consultation. This matter raises a question of the staff's level of motivation. Is it possible that staff members in PHC clinics lack the required motivation and that this is associated with the findings of Petersen's (2000) study, in which she found that nurses complained that their poor service delivery was partly due to low salaries and being offered no reinforcements for showing initiative?

An interesting point to note is the difference between the SPs ratings' of the consultation and the composite quality of care obtained for each visit, as explained in chapter 3. Simulated patients rated the quality of the consultation as good on four out of every ten visits, while the score obtained for the visits indicate that only two in every ten visits obtained a good score. Only one in ten visits obtained an average rating, while almost all of the visits obtained an average score. Also of interest to note are the different scores obtained from the three groups involved in the original study, which were the SPs, HPs and the STD patients. Their results are summarised in the table 5.1 below (Adapted from Simbayi et al., 1999, p114).

Table 5.1. Composite qualities of care scores

Quality of care category	HP		STD Patients		SPs	
	N	%	N	%	N	%
Good	56	79	22	20	6	16
Average	15	21	83	75	18	47
Poor	0	0	5	5	14	37
Total	71	100	110	100	38	100

As was expected most HPs rated the quality of the service they provide as good, while only a few of them rated the quality as average and none at all rated the quality of care they provide as poor. The HPs' rating of their service supports Petersen (2000) finding that health care providers working in primary health care settings tend to rate the quality of care they provide as good on

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most occasions, even when it is not. She suggests that this is a defence and serves the function of upholding the importance of their profession and defends them against the anxiety they face as a result of the distressing conditions that they have to face on a daily basis. Health care providers in PHC clinics offer an important service, yet their service tends not to be appreciated. They are faced continuously with many serious diseases, some of which they fail to cure due to lack of resources. Thus when asked to rate the quality of their service, they may tend to rate it as good, and their rating is based on the importance they attached to their service and not their compliance to the adopted standards.

Most STD patients rated the quality of care they received as average, while only a small minority of them rated the quality of care as poor. This is in accordance with previous research, which notes that real patients tend not to provide reliable information about the quality of care they receive (Madden et al., 1997). This is perhaps influenced by the power relationship that exists between PHC users who, in the South African context tend to be poorly educated, and HPs who wield power and tend to flex their muscle on the patients as shown in the study on the comprehensive integration of the primary health care sector in South Africa (Petersen, 2000). One could infer that the real patients might have been afraid to reveal their real observations about the quality of the service, or they were just not aware of what to expect from the consultation, unlike the SPs. Overall, the SPs and STD patients' ratings indicate that there is some room for improving the quality of care in PHC clinics.

The author is of the view that a more holistic treatment of patients will help the health care providers to make informed decisions about the information that they should disseminate to patients. Moreover a holistic approach to treatment helps the HP to better understand their patients' circumstances and also indicates to the patients that the health care provider takes an interest in him/her. The adoption of this type of assessment and treatment could easily lead to improved perception of HPs by patients.

5.2 Recommendations

In this section, an overview of the strengths and weaknesses of the research project will be

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outlined. In conclusion recommendations on future research and for health service managers and policy makers will be made.

The use of SPs, instead of real patients, helps in obtaining a different perspective on perceptions of the quality of STD care. Secondly this method helps researchers to achieve more accurate ratings. This is influenced by the fact that SPs, unlike real patients, do not have any constraints, such as fear that the information will leak to the community at large and they will be stigmatised, or that the HPs will penalize them in future visits. They know what to expect in a consultation, therefore they have a standard to measure against. Another advantage of the study is the fact that it was part of a larger study, which obtained data from real patients and HPs in addition to SPs, so that the results of the three groups could be compared.

The weaknesses of this study include the fact that focus was only given to the rating of the SPs and contextual/structural matters were not given any attention. Saturno (1995) points to the importance of assessing medical records, availability of resources and the organisational level of staff in any evaluation of quality of care. Secondly, the limitations impacting on the HPs delivery of the service were not studied. This part was not covered in this current study, mainly because it was outside the scope of the project. However, it was covered within the larger study.

Future research in the assessment of quality of care in STD treatment should not only focus on the patients' perception of the service, it should also incorporate an assessment of the medical records, staff's' level of training particularly with regards to communication and counselling skills; and their support network. It is also recommended that HPs be studied regarding their time management skills and motivational levels.

In the light of the results obtained and the importance of reducing the transmissions of STDs and HIV/AIDS, it is necessary to empower communities and the important links in this process are HPs. Thus the following recommendations are made in order to facilitate the improvement of STD care in PHC clinics:

It would be helpful for HPs to receive continuous education, with a focus on empowering them

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so as to see health care as a collaborative effort. Workshops focusing on sexual and medical history assessment should be offered, which would include the importance of linking sexual history to current illness. In these workshops the emphasis needs to be on the importance of a holistic assessment and the encouraging of patients to make links between risky behaviour and the illness. The need for improved communication skills is also indicated. The provision of training for nurses could also be inclusive of other health care professionals, for example psychologists could be used to impart their therapeutic skills to HPs, as well as provide training in psycho-education (or counselling), and their skills could also be used in providing support to nursing staff.

5.3 Conclusion

The previous chapter highlighted the fact that the quality of care in PHC clinics does not fully comply with the standards set out by the syndromic case management approach. Although there are areas that have improved in the service provision, there are still a number of areas that need to be improved. The current author is of the view that the shifting of the biomedical discourse, which influences power dynamics between HPs and their patients, is central to improved quality of care and that this model needs to be replaced with a more empowering discourse. The biomedical discourse appears not to foster a partnership between patients and HPs, which in turn leads to a failure in cooperative problem solving. This enforces the notion that HPs are knowledgeable and can solve the health problems of the community. It appears that other factors such as poor motivation, meagre salaries and poor time management could also be contributing to the inadequate quality of care.

The second problem highlighted in the discussion was the fragmented view with which the biomedical discourse approaches illness. To the extent that one's physical illness is not viewed holistically, this fails again to empower the client. The biomedical approach was contrasted the that of psychotherapy, in which the aim is to empower the client by giving them adequate 'doses' of information and at the right time. Although the merits of integrating the health services were shown in the literature review section, one cannot but wonder if this system does not put an extra strain on HPs, nurses in particular and help to make them feel inadequate. While not advocating

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for the reinstatement of the previous system, which has dedicated STD clinics, one wonders if it would not be more viable to have nurses developing specialised skills and to consult mainly patients who present with those difficulties, for example STDs.

In conclusion, the study highlights the fact that there are positive aspects of the quality of care, particularly those aspects of treatment that form an essential part of training for nurses at college/university, which are mainly about treating physical aspects. The study indicates that skills that do not fall in the traditional realm of nursing, such as counselling, condom counselling and demonstration, and the nurses' communication skills still need attention. Improvements in these dimensions of the syndromic case management approach could contribute to reducing the number of new HIV/AIDS and STD infection rates.

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References

Abdool Karim, S. S. (1994). Editorial: Challenges to the control of sexually transmitted diseases in Africa. *America Journal of Public Health*, 84(2), 1891-1892.

Baker, S. A., Morrison, D. M., Gillmore, M. R. & Schock, M. D. (1995). Sexual behaviors, substance use, and condom use in a sexually transmitted disease clinic sample. *Journal of Sex Research*, 32(1), 37-44.

Ballard, R. C. & Dangor, Y. (1996). Conventional STDs and HIV – an intimate relationship. *Specialist Medicine*, July, 6-11.

Ballard, R. C. & Fehler, H. G. (1996). Syphilis – an underestimated public health problem in southern Africa: the disease and its diagnosis. *Specialist Medicine*, July, 20-26.

Ballard, R. C. & Ghidinelli, M. N. (1996). Syndromic management of sexually transmitted diseases – a new approach to the control of an old problem. *Specialist Medicine*, July, 12-19.

Banister, P., Burman, E., Parker, I., Taylor, M. & Tindall, C. (1994). *Qualitative methods in psychology*. Buckingham: Open University Press.

Bruce, J. (1990). Fundamental elements of the quality of care: A simple framework. *Studies in Family Planning*, 21(2), 61-91.

Bryce, J., Vernon, A., Brathwaite, A. R., Perry, S., Figueroa, J. P., Emerson, R. B. & the Collaborative Working Group on Indicators of STD Case Management. (1994). Quality of sexually transmitted disease service in Jamaica: evaluation of a clinic-based approach. *Bulletin of the World Health Organisation*, 72(2), 239-247.

Carneiro, M. & Antunes, C. M. (1994). A qausi-experimental epidemiological model for evaluating public health programmes: efficacy of a Chagas disease control programme in Brazil. *Bulletin of the World Health Organisation*, 75(5), 721-728.

Colvin, M., Abdool Karim, Q. & Hoosen, A. (1997). Management of sexually transmitted diseases in workplace-based clinics in Kwazulu-Natal – implications for HIV prevention. *South African Medical Journal*, 87(2), 245-249.

Cross, C. (2001). Sinking deeper down: HIV/AIDS as an economic shock to rural households. *Society in Transition*, 32(1), 133-147.

Crothers, C. (2001). Social factors and HIV/AIDS in South Africa: a framework and summary. *Society in Transition*, 32(1), 5-21.

53

Dartnall, E. & Schneider, H. (1998). STD management on the workplace: a national evaluation. *Occupational Health S.A*, 4(2), 38-41.

Department of Health (1997a). *White paper for the transformation of the health system in South Africa.* Pretoria: Department of Health.

Department of Health (1997b). *First report: National STD/HIV/AIDS review.* Pretoria: Department of Health.

De Schryver, A. & Meheus, A. (1990). Epidemiology of sexually transmitted diseases: the global picture. *Bulletin of the World Health Organisation*, 68(5), 639-654.

Dladla, A. N.,Hiner, C. A., Qwana, E. & Lurie, M. (2001). Speaking to rural women: The sexual partnership of rural South African women whose partners are migrants. *Society in Transition*, 32(1), 79-82.

Djajakusumah, T., Sudigdoadi, S., Keersmaekers, K. & Meheus, A. (1998). Evaluation of syndromic patient management algorithm for urethral discharge. *Sexually Transmitted Infections*,74(1), s29-s33.

Faxelid, E., Ahlberg, B. M., Freudenthal, S., Ndulo, J. & Krantz, I. (1997). Quality of STD care in Zambia. Impact of training in STD management. *International Journal for Health Care*, 9(5), 361-366.

Grimwood, A., Karpakis, B. & McNab, M. (Eds). (1996). *A manual of the Western Cape,* Unpublished manuscript.

Grosskurth, H., Mosha, F., Todd, J., Mwijarubi, E., Klokke, A., Senkero, K., Mayaud, P., Changalucha, J., Nicoli, A., ka-Gina, G., Newell, J., Mugeye, K., Mabey, D. & Hayes, R. (1995). Impact of improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania: randomized controlled trial. *The Lancet*, 346(26), 530-536.

Hanson, S., Engvall, J., Sunkutu, R. M., Kamanga, J., Mushanga, M. & Hojer, B. (1997). Case management and patient reactions: a study of STD care in a province in Zambia. *International Journal of STD & AIDS*, 8, 320-328.

Harrison, A., Wilkinson, D., Lurie, M., Connolly, A. & Abdool Karim, S. (1998). Improving quality of sexually transmitted disease management in rural South Africa. *AIDS*. 12, 2329-2335.

Harrison, A., Xaba, N., Kunene, P. & Ntuli, N. (2001). Understanding young women's risk for HIV/AIDS: Adolescent sexuality and vulnerability in rural Kwazulu/Natal. *Society in*

54

Transition, 32(1), 69-79.

Heiby, J. (1995). Quality of health services. In K. Janovsky (Ed.). *Health policy and systems development: an agenda for research* (pp.179-190). Geneva: World Health Organisation.

Heinecken, L. (2001). HIV/AIDS, the military and the impact on national and international security. *Society in Transition*, 32(1), 120-127

Kinnersley, P. & Pill, R. (1993). Potential of using simulated patients to study the performance of general practitioners. *British Journal of General Practice*. 43, 297-300.

Laga, M., Nzila, N. & Gorman, J. (1991). The interrelationship of sexually transmitted diseases and HIV infection: implications for the control of both epidemics in Africa. Antwerp, Belgium: *WHO. Collaborating Center on AIDS*, 5(suppl. 1), 555-563.

Mabey, M. (1996). Sexually transmitted diseases in developing countries. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 90, 97-99.

Macheke, C. & Campbell, C. (1998). Perceptions of HIV/AIDS on a Johannesburg gold mine. *South African Journal of Psychology*, 28(3), 146-153.

Madden, J. M., Quick, J. D., Ross-Degnan, D. & Kaple, K.K. (1997). Undercover care seekers: simulated clients in the study of health provider behaviour in developing countries. *Social Science and Medicine*, 45(10), 1465-1482.

May, H. (1993). *Social research, issues and process*. Buckingham: Open University Press.

Malan, D.H. (1979). *Individual psychotherapy and the science of psychodynamics*. London: Butterworths.

Moherdaui, F., Vuylsteke, B., Siqueira, L. F. G., dos Santos Jr., Jardim, M. L., de Brito, A. M., de Souza, M. M., Willers, D., Sardinha, J. C. G., Benzaken, A. S., Ramos, M. C., Beuno, H., de Macedo Rodrigues, L. G. & de Novias Chequer, P. J. (1998). Validation of the national algorithms for the diagnosis of sexually transmitted diseases in Brazil: results from a multicentre study. *Sexually Transmitted Infections*, 74(1), s38-s43.

Mostyn, B. (1985). The content analysis of qualitative research data: A dynamic approach. In M. Brenner, J. Brown & D. Canter (Eds). *The research interview uses and approaches* (pp. 115-146). London: Academic Press.

Ndulo, J., Faxelid, E. & Krantz, I. (1995). Quality of care in sexually transmitted diseases in Zambia: patients' perspective. *African Medical Journal*. 72(10), 641-644.

Oskowitz, B. & Meulenberg-Buskens, I. (1997). Preparing researchers for a qualitative

investigation of a particular sensitive nature: reflections from the field. *South African Journal of Psychology*, 27(2), 83-88.

Patton, M. Q. (1987). *How to use qualitative methods in evaluation*. Newbury Park: Sage Publications.

Petersen, I. (1998). Comprehensive integrated primary mental health care in South Africa. The need for a shift in the discourse of care. *South African Journal of Psychology*, 28(4), 196-203.

Petersen, I. (2000). Comprehensive integrated primary mental health care for South Africa. Pipedream or possibility? *Social Science & Medicine*, 51, 321-334.

Pham-Kanter, G. B. T., Steinberg, M. H. & Ballard, R. C. (1996). Sexually transmitted diseases in South Africa. *Genitourinology Medicine*, 72, 160-171.

Pinto, I. & Ballard, R. (1994). The syndromic approach to the diagnosis of sexually transmitted diseases. *Aids Bulletin*, 3(1), 12-15.

Potter, W. J. (1996). *An analysis of thinking and research about qualitative methods*. New Jersey: Lawrence Erlbaum.

Rajagopal, M., Hoosen, A. A., Moodley, J., Khsarsany, A. B. M., Moodley, P. & Sturm, A.W. (1999). Analysis of genital tract infections at a dedicated sexually transmitted diseases clinic. *The Southern Journal of Epidemiology and Infection*, 14(3), 77-82.

SAHR. (2000). Primary health care facilities survey. South African Health Review, pp. 1-30. Retrieved October 24, 2001from the World Wide Web: http://www. hst.org.za/sahr/2000/chapter 1. htm. Primary health care facilities survey.

Saturno, P. J. (1995). Towards evaluation of the quality of care in health centers. *World Health Forum*, 16, 145-150.

Shekelle, P. G. & Kosecoff, J. (1992). Evaluating the treatment of sexually transmitted diseases at an urban public hospital outpatient clinic. *American Journal of Public Health*. 82(1), 115-117.

Shaughnessy, J. J & Zechmeister, E. B (1997). *Research methods in psychology*. New York: McGraw-Hill.

Simbayi, L., Strebel, A., Wilson, T., Andipatin, M., Msomi, N., Potgieter, C., Ratele, K. & Shefer, T. (1999). *Sexually Transmitted Diseases in South African public health sector: Perceptions, sexual behaviour, health care-seeking behaviour and quality of care.*

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Bellville: University of the Western Cape.

Solomon, M. Z. & DeJong, W. (1989). Preventing AIDS and other STDs through condom promotion: a patient education intervention. *American Journal of Public Health*, 79(4), 453-458.

Taylor, S. & Bogdan, R. (1984). *Introduction to qualitative research methods*. New York: John Wiley.

Tillotson, J. & Maharaj, P. (2001). Barriers to HIV/AIDS protective behaviour among African adolescent males in township secondary schools in Durban, South Africa. *Society in Transition*, 32(1), 83-100.

Yankauer, A. (1994). Sexually transmitted diseases: a neglected public health priority. *American Journal of Public Health*, 84(12), 1894-1897.

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APPENDIX A

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SIMULATED PATIENTS - SEMI-STRUCTURED INTERVIEW

Date:

Place:

A   Biographic information of simulated patient:

1.   Sex: _____

B   Accessibility:

1.   How long did you have to wait before you were seen by
the health provider?

_____   1.☐

2.   Were you seen by a: ☐ Male   ☐ Female   2.☐

3.   Where was the history taken?_____   3.☐
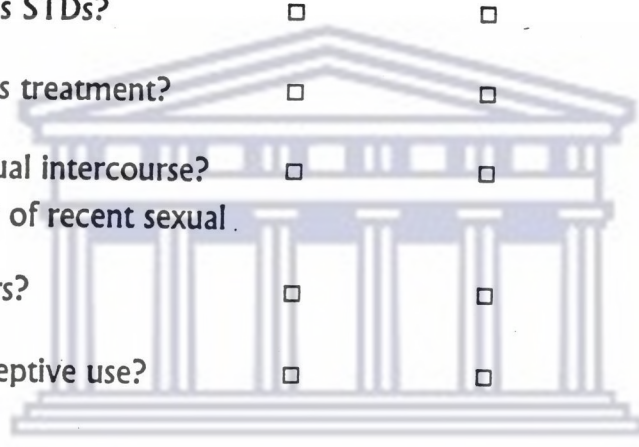
4.   Were you consulted in a private room?   4.☐

C   History and examination:

1.   Which of the following were you asked about?   1.

     Women

	YES	NO	
– pain when having sex?	☐	☐	☐
– heavy period bleeding?	☐	☐	☐
– irregular period?	☐	☐	☐
– bleeding after sex?	☐	☐	☐

1

	YES	NO	
– the dates of your last menstrual period?	☐	☐	☐
– the type of vaginal discharge?	☐	☐	☐
– lower abdominal pain?	☐	☐	☐
– sores?	☐	☐	☐
– duration of symptoms?	☐	☐	☐
– previous STDs?	☐	☐	☐
– previous treatment?	☐	☐	☐
– last sexual intercourse?	☐	☐	☐
– number of recent sexual partners?	☐	☐	☐
– contraceptive use?	☐	☐	☐

<u>Men</u>

	YES	NO	
- urethral discharge?	☐	☐	☐
– pain when urinating?	☐	☐	☐
– sores on the genitals?	☐	☐	☐
– duration of symptoms?	☐	☐	☐
– last sexual intercourse?	☐	☐	☐
– number of recent sexual partners?	☐	☐	☐
– previous STD within last 3 months?	☐	☐	☐

2

– previous treatment? □ □ □

– contraceptive use? □ □ □

D **Diagnosis and treatment:**

1. What diagnosis did he/she give you? 1. □

    □ vaginal discharge
    □ urethral discharge
    □ syphilis
    □ gonorrhea
    □ warts
    □ genital ulcers
    □ other _____

2. What did he/she say was the cause of the illness? 2. □

    _____

3. What medication did he/she give you? 3. □
    (Give dosage)

    □ Ciprofloxacin
    □ Doxycycline
    □ Metronidazole
    □ Other _____

4. What instructions were you given for taking the medication? 4. □
    (Be specific).

    _____

    _____

5. Were you told to complete the full course of treatment even if you 5. □
    feel better?

    Yes □ No □

6. Were you told to practice safe sex or abstain from sex during the treatment?

   Yes ☐   No ☐   6. ☐

7. Do you feel that the treatment was clearly explained to you?

   Yes ☐   No ☐   7. ☐

8. Were you asked to return for a follow-up session?

   Yes ☐   No ☐   8. ☐

   If yes, were you asked to return:

   ☐   within 1 week
   ☐   within 1 month
   ☐   within 6 months

9. Overall, how would you rate the STD treatment at this clinic.   9. ☐

1	2	3	4	5
Very Good	Good	Average	Poor	Very Poor
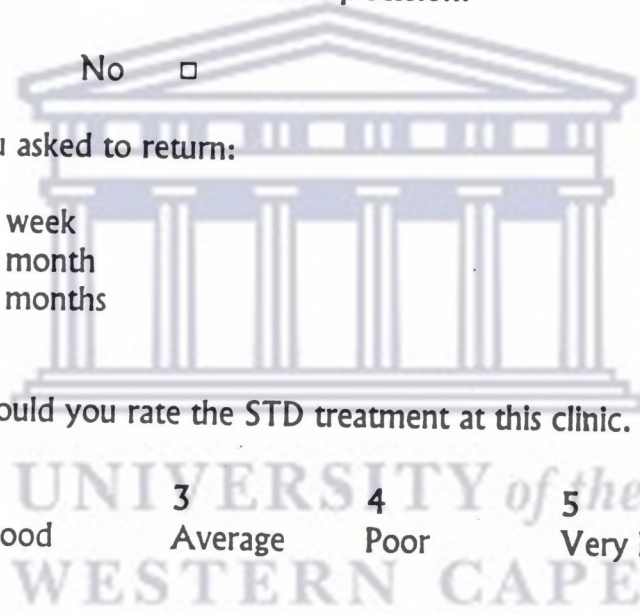
E   Condoms:

1. Did the health provider encourage the use of condoms?   1. ☐

   Yes ☐   No ☐

2. Were you given a demonstration of how to use condoms, using a dildo or penis?   2. ☐

   Yes ☐   No ☐

3. Were any condoms offered to you?   3. ☐

   Yes ☐   No ☐

4

F   Contact Tracing:

1.   Did the health provider say that all your recent sexual partners should be treated

       Yes   □   No   □

1. □

2.   Did the health provider ask you to tell your partners to come for treatment?

       Yes   □   No   □

2. □

3.   Did the health provider give you a date for your partners to come in?

       Yes   □   No   □

3. □

4.   Did the health provider give you a contact tracing card(s) for your partner(s)?

       Yes   □   No   □

4. □

G   Counselling:

1.   Were you given counselling and information about the following:

1.

	YES	NO	
– causes of STDs	□	□	□
– practice of monogamy	□	□	□
– avoidance of casual sex	□	□	□
1. the use of condoms	□	□	□
– STDs increase the risk of infertility	□	□	□
– STDs increase the risk getting AIDS.	□	□	□
– STDs increase the risk of having spontaneous abortions	□	□	□

5

- STDs increase the risk of congenital

  diseases   □   □   ☐
- people with STDs may not show any

  symptoms   □   □   ☐

H   **Quality of consultation:**

1.   Please rate the attitude of the health provider using the following scale: **1.**

		YES	NO	
–	Helpful	□	□	☐
–	Unfriendly	□	□	☐
–	Respectful	□	□	☐
–	Judgemental	□	□	☐
–	Informative	□	□	☐

2.   How long did the consultation with the health provider last?   **2.** ☐

- □   up to 5 minutes
- □   6 - 15 minutes
- □   16 - 30 minutes
- □   over 30 minutes

3.   Are there any other comments you would like to make regarding your experience at this clinic?

_____

_____