PN-ACJ-292
105711

Evaluation

In-service training in Syndromic Management of STDs

Malawi

July 1997

USAID Contract No. 623-0238-C-00-4058-00,
Support to AIDS and Family Health (STAFH) Project 612-0238

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Acknowledgements

This evaluation was a true team effort — from the establishment of the parameters for the evaluation through the development of appropriate questions and approaches, the complex management of the logistics, the observations, the data input, the data analysis and the review.

The evaluation was carried out at the request of the government of Malawi, and the initial parameters, objectives and methodologies were reviewed closely with the AIDS Secretariat of the Ministry of Health before the detailed questionnaires and training of observers were carried out. After initial analysis of the completed data, several meetings were held with the Ministry of Health and training institutions to clarify the issues involved and to determine the final structure of the report of the evaluation.

Thanks must also be given to the staff and clients of the units visited — who gave generously of their time and thought. Some of the richest and most useful observations have come from non-clinical ground staff who responded to a specifically-written questionnaire, and from the managers of the various units who made very valuable suggestions about the requirements in future training.

Technical and financial assistance for the evaluation was provided by JSI-STAFH with funds from the U.S. Agency for International Development (USAID) under contract No. 6332-0238-C-00-4058-00.

Views expressed in this report do not necessarily reflect those of the funding agencies.

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Executive summary

An evaluation of the training of health staff in the Syndromic Management of Sexually Transmitted Disease (STD) was carried out in 26 health units of the government and private sectors in Malawi from 5th May to 21st June 1997.

Objective

The objective of the evaluation was to assess the extent to which current training of service providers (as opposed to pre-service trainees) in the syndromic management of STDs should be modified in Malawi before widespread adoption of such training for the whole country. After piloting the approach, approximately 1,000 staff have received this training over the last two to three years. Curricula have been developed already for pre-service training by the major health service training institutions, and the outcomes of this evaluation may be found useful in the review of these pre-service curricula.

Methodology

It was clearly impossible to undertake an evaluation of the training in isolation, since there has been little monitoring of the work of those trained and little supervision that would have given indications of its immediate effect after training. The nearest that can be found to monitoring are the reports on the extent of correct treatment in the pilot sites, which have indicated accuracy rates in two syndromes. However, this is only one facet of the syndromic management, and further comparison is impossible.

It was therefore decided to use a multi-faceted approach using a variety of inter-linking research tools that together would give a picture of the combined effects of training and the work environments of those trained.

26 health units in Malawi were selected to ensure representation of the range of services available. This included

- Pilot sites in which the syndromic approach was first introduced and in which there has been intensive support for the approach;
- 'Expansion sites' which are units with staff who have been trained in the approach, but do not have special support;
- Teaching hospitals, district hospitals and health centres in both of the above categories;
- CHAM hospitals and Family Planning Clinics (which are not in the pilot programme, but who have staff trained in the syndromic approach;
- 2 health centres in which staff have not been trained in the approach, but who are using the approach based on reference materials they have acquired.

The evaluation used a multi-faceted approach based on:

- 158 questionnaires completed by service providers;
- 129 observations of client-provider interactions;
- Interviews with 9 trainers of Syndromic Management of STDs;
- Interviews with 85 clients both before and after being seen by a service provider;
- Interviews with 25 non-clinical ground staff at the units;
- Interviews with 21 managers.

Two days were allocated to each unit in order to ensure that a sufficient number of observations could be made. Three teams (each consisting of a supervisor and two observers) were involved in planning the questionnaires and forms, and visiting the units in three regions over a two-week period.

Those who were interviewed were assured that the answers and observations would be anonymous and confidential. It was established that there would not be any way in which individual performance could be linked to the data, and that the purpose of the exercise was solely to improve training.

The questions were a mixture of open-ended and categorised, with several methods of cross-referencing.

All the staff who had been trained and took part in the exercise had been trained with the same methods, using the same materials (*Management of Sexually Transmitted Diseases: A Training Manual for Health Workers*, National AIDS Control Programme Malawi 1995).

Observer instructions

The teams were instructed at each unit to **interview** at least

- The manager of the unit
- one service provider trained in Syndromic Management,
- two STD clients, (before and after their diagnosis & treatment)
- two non-STD clients (only in integrated and FP clinics)
- one member of staff who is non-clinical (such as a clinic attendant, a gardener or a gate-keeper).

Wherever there was a trainer in a unit, the trainer was to be **interviewed**.

Observations of clinical practice were to be made on a minimum of

- 6 STD clients in STD-only special clinics;
- three STD clients with each STD-trained provider in integrated and FP clinics;
- three non-STD clients in integrated and FP clinics.

This meant that:

- each Out-patient clinic had at least ***7 interviews*** (STD service provider, 1 male STD client, 1 female STD client, 1 male non-STD client, 1 female non-STD client, non-clinical staff member, manager) and ***6 observations*** (3 STD case management, 3 non-STD case management).
- each FP clinic had at least ***7 interviews*** (Service provider, 2 STD clients, 2 non-STD clients, non-clinical staff member, manager) and ***6 observations*** (3 STD case management, 3 non-STD case management).

Where more interviews or observations were possible, they were to be included.

For both service providers and clients, it was established that an ***equal number of males and females*** should be interviewed or observed for each part of the exercise.

To allow for the fact that the observers would notice important facets of the training not covered by the questionnaire when interviewing or observing, the observers were asked to provide comments on the exercise as a separate report.

Parameters

In the evaluation of any training, it is important to assess the relative impact of the wide variety of factors that may influence the ways in which that training is put into practice. Because of this, the evaluation took on as broad an aspect as possible by examining factors that included other training they have received; their supervision; their other responsibilities; other practices in their work environments; gender; attitudes; the availability of resources and the interaction with clients — all in addition to the basic observations of how well they managed the syndromic diagnosis of STDs.

Major findings

1. Considered by itself, the in-service training on syndromic management of STDs seems to have been reasonably successful in preparing for an adequate management of the syndromic approach in general—**but only in the pilot sites**. The pilot sites performed far better than non-pilot sites in almost all instances (in terms of history taking, use of flowcharts, accuracy of treatment and communication). The **only factor** that might explain this difference in performance was the **constant support and attention** in terms of regular and frequent visits and feedback on performance. Other factors such as availability of resources (drugs, equipment, staff, reference materials etc), previous experience or other training were not different between pilot and non-pilot sites.

2. Although the pilot sites had overall better performance, a number of components require improvement. On the diagnostic side:

   - The following of diagnostic **algorithms** was accurate and thorough in **only 56%** of observations in pilot sites (25% in non-pilot). *[See table 32 on page 22].*
   - The **accuracy** of STD treatment was **only 67%** overall in pilot sites (100% for Urethral Discharge, 63% for Genital Ulcers, and 50% for Genito-Urinary Symptoms in women) compared to **17%** overall in **non-pilot** sites. *[See pages 23 to 26].*
   - Observers believed **genital examination** was generally **very poor in quality**. Male genitals were examined in only 69% of pilot site observations of STD clients (50% non-pilot), although female genitals were examined in 89% of pilot site STD observations (82% non-pilot). *[See observer remarks on page 22 and table 33 following].*
   - A **speculum** was used for female examination in only 1 out of 9 instances when a speculum was available in the pilot sites (compared to 7 out of 8 instances in non-pilot sites). *[See page 22].*

3. The above two sets of findings imply that the basic *training itself is modulated considerably by other factors* in the workplace, and that the more important variable in ensuring good syndromic management is the frequency and extent of support provided. Only 43 (29%) of the 156 staff interviewed said they had any supervision at all (pilot sites were equal to non-pilot sites in this regard), and of these 43 **only 5 said they felt their supervision was adequate** *[See page 6].* It should be noted that the pilot site staff were referring in this instance to supervision from their unit managers or coordinators — and not to the support from the JSI STAFH project *[observer comments].*

4. **Education** was provided on all the required aspects in over 83% of pilot site observations (compared to 35-50% in non-pilot sites), but this was often regarded as defective by observers. *[See pages 26 & 28].*

5. Providers' **listening skills** were seen to require some improvement: providers asked about the **knowledge** of the client in pilot sites in about 65% of observations, and in about 25% of non-pilot sites *[See page 26, and remarks by the observers on page 28].* Providers asked questions about a client's **feelings** in both pilot and non-pilot sites in approximately 60% of observations *[See page 28].* **Client** interviews revealed a majority stating that they had not asked the questions they would like to *[see page 33].*

6. **Attitudes** to issues of **gender, sexuality and STDs** may be playing an important part in interactions between staff and other staff, as well as between staff and clients *[see page 10].* One of the most obvious of these concerns beliefs about condoms. However, examination of genitals of the opposite sex also caused some problems *[See page 22],* and there were several stated beliefs about sexual practice that revealed considerable prejudice *[see page 11 onwards & remarks about promiscuity on page 28].*

7. There were many statements by service providers that the **courses** they attended were **too short** (4 days total) to allow of any **practical experience** or practice, or of adequate training in any of the varied communication skills required in the syndromic approach *[see statements by observers on pages 6 & 8 and the table on page 7].* In general, the key elements that require better preparation are:

- a better understanding of Genito-Urinary Symptoms in women and of Pelvic Inflammatory Disease *[poor accuracy in examination, treatment and diagnosis page 8 & pages 23 to 26]*;
- more accurate following of the flow charts and of prescribing practice *[See page 22]*;
- a better understanding of Reproductive Anatomy and Physiology *[see table on page 11]*;
- improvement of listening and communication skills *[see, for example, pages 26 to 28, and client statements on page 33]*;
- better management of the impact of personal views and biases (particularly with regard to gender & condoms) during the interactions with clients and other staff.

8. **Partner notification** was seen as a difficulty by most staff *[see the lists of statements starting on page 14]*, but the issue was discussed with clients and slips for partners given in 87% of observations in pilot sites (compared to 43% in non-pilot sites).
9. Attempts at **follow-up** were good, with all pilot sites asking the client to return (82% in non-pilot sites) and 92% of clients receiving a card or stamp to do so (63% in non-pilot sites) *[see page 28]*. However, only **half** had a **method to check** if clients returned *[see page 17]*.
10. **Counselling** was done well in pilot and non-pilot sites only in certain respects, and remarks by observers suggested a less than satisfactory performance *[see page 28]*.
11. The availability of **condoms** was very high (96% of pilot sites, 89% of non-pilot sites). However, while they were given to clients in 86% of pilot site observations, they were **only given in 44% of non-pilot site** observations. *[see table on page 29]*.
12. The overall approach is very well received by the majority of managers of the units, who believe it is appreciated by both staff and clients, and that it is an easier system to manage than previously. This is despite the fact that some of the managers had had no orientation to the syndromic approach *[see manager's comments on page 39]*.
13. Most of the staff involved had a good idea of why the approach was used, and the principles on which it was based *[observer comments]*.
14. There is a **lack of consistency** in the extent to which STD management services are **integrated** with those of the rest of the health service. In some units the staff and facilities are separated from the rest of the clinic work, and in other units people with STDs are seen in the same area and by the same providers as others. This at times led to problems in the separation of staff and responsibilities, and in the management of resources such as drugs. There was also a belief that separation led to stigmatisation of clients *[observer comments]*.
15. Many service providers commented to the observers that their training had been hampered because of the mixture of trainees with widely different experiences and abilities.
16. There was a noticeable **incompatibility** of various management **information** systems. The old system of record-keeping had little relevance for the syndromic approach, and this made accurate assessments of numbers of patients seen or comparisons with other units difficult *[observer comments]*.
17. Perhaps as a result of clinging to older systems, it was reported by **25%** of service providers that they **check** their results for STDs with the **laboratory** *[see page 10]*. This is despite their training in a syndromic approach and occurs in both pilot sites (29%) and non pilot sites (24%). This clearly wastes resources and time, as well as making pointless the syndromic approach.
18. One major problem with the system, noted by all the observers, is that despite the fact that **nurses** have been trained to **prescribe** drugs for the STDs, and are legally allowed to do so, in the majority of cases they continue to **refer** clients to Clinical Officers or Doctors for agreement with the diagnosis and prescribing. This practice takes away from the whole point of Syndromic Management, and considerably increases the amount of time clients have to wait.
19. Interviews with several categories of **non-clinical staff** revealed their extensive involvement with clients and with their communities in terms of providing advice and education in relation to sexuality, AIDS and STDs *[see section starting on page 34]*.

Management, supervision and support

There are different interpretations of the terms used in relation to supervision and management. It was noted earlier that over 70% of staff in the pilot sites said they had no supervision whilst they have been having very regular and frequent visits from the STAFH project which monitored progress and provided feedback. The observers believed this was because the staff were referring only to the supervision they would otherwise receive within their units, or by coordinators or other staff at district or regional level.

Since the support from the STAFH project is the only variable found by the evaluation to differ between pilot and non-pilot sites, it will be important to define precisely the nature of that support. To ensure institutionalisation of the syndromic management of STDs throughout the country, the conditions in the pilot sites have to be replicated as nearly as possible in every institution. If this is not done, the current level of performance of the non-pilot sites would mean not only that a very large number of people with STDs would not be treated correctly, but that the spread of resistance to antibiotics would be very much faster.

The STAFH support consisted of review of data, monitoring and provision of resources (drugs, equipment, educational & reference material), and feedback to the units on accuracy of treatment. Each unit is visited once every three months. From April 1996, a thorough review of client-provider interaction was started at each quarterly supervision visit. Unfortunately, due to turnover of local (not STAFH) supervisors and of staff at the units, not all providers have had this extent of support, and this may partly explain why the overall results from the pilot sites were not better than was found during the evaluation.

A **distinction** has to be made between a **generalised** form of support in the context of staff management and a **specialised** type of support that reviews individual technical performance of staff.

While it is important to put the specialised form of review into place (as was provided by the STAFH project), and this can be done quickly through the training of existing supervisors and managers, this would be very much a short-term measure in the absence of better general management in the units—staff turnover alone would make it difficult to maintain such a specialised system.

The **generalised** form of supportive management includes personnel management policies and practices, coupled with provision of resources. This general management would manage the balance of factors that influence the practice of providers, as illustrated in the diagram on page 1 of the Introduction following. If instituted, this alone would contribute greatly to effective implementation of activities. Good management provides encouragement, review of problems, feedback, management of resources, and ensuring that the environment of the providers allows them to practice at their best.

If such a general form of supportive management is in place the more specialised forms of technical supervision can be integrated in an appropriate manner. For example, standard general management allows managers to find out if their staff are comfortable with the procedures they are carrying out, whether the staff have any difficulties (personal or otherwise), whether the resources are sufficient, whether the social environment is supportive or a hindrance, and whether the staff are in need of any further training to improve their support.

It is for these reasons that the following recommendations focus on the need to establish in all units a better form of local management which is supportive of any training that is received. Training can never be seen in isolation of any other part of the spectrum of factors that influence the way providers function in practice. It is the function of the manager to keep in review all of these various factors.

If such a system of management were in place in all units, the result would not only be an improved performance in syndromic management of STDs, but also improved performance in the management of all health issues.

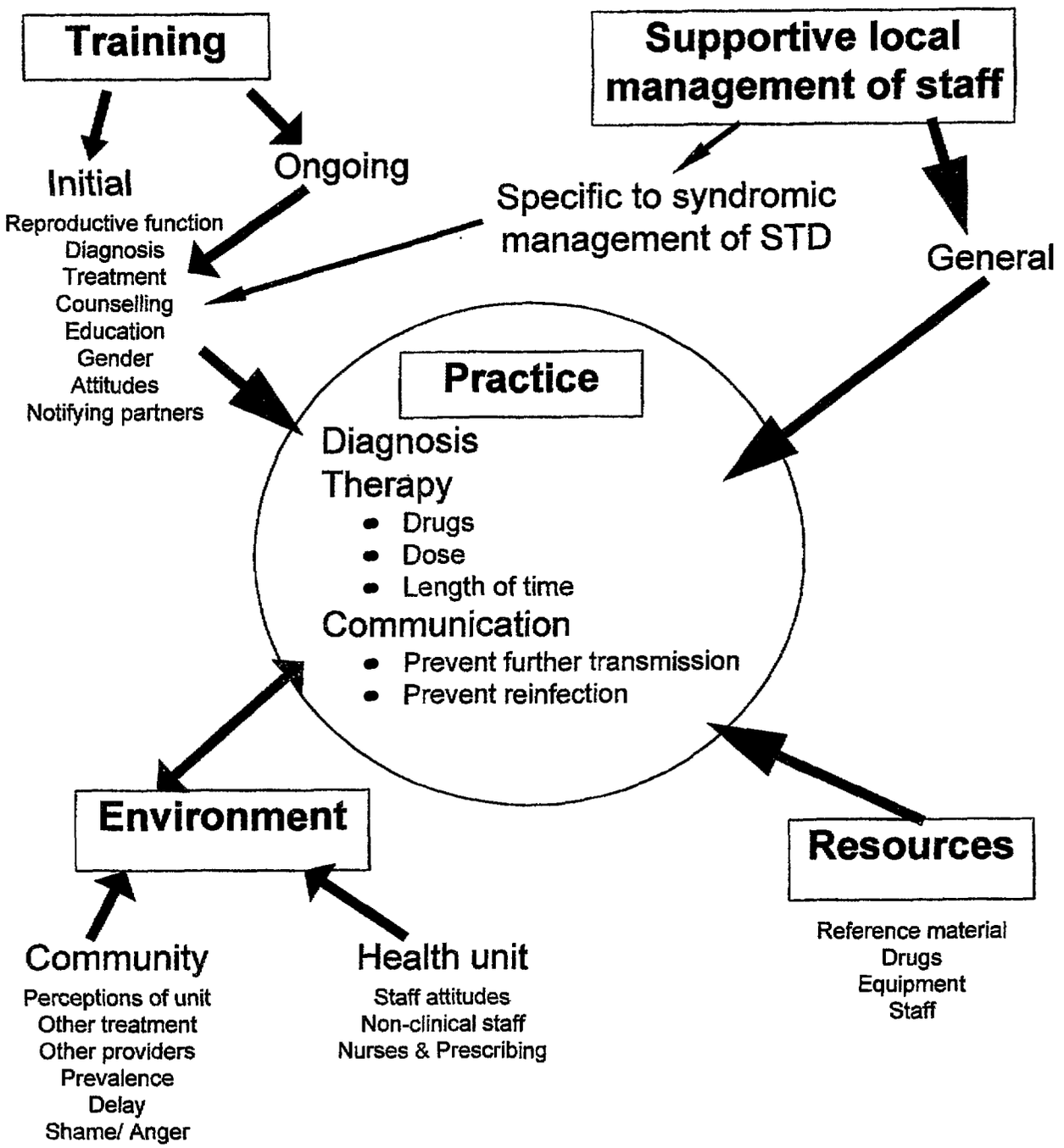
It would also mean that if the training is improved to ensure providers are fully competent in the first place, then their level of competence will be maintained.

Recommendations

1. A series of **orientation courses** for locally-based trainers, supervisors and managers to the Syndromic Management of STDs so that they can understand the requirements of support and supervision for the syndromic approach (notably the management of the range of factors influencing clinical practice outlined in the diagram on page 1 of the Introduction following).
2. Improvement of **general management of staff** *[as outlined in the previous section]*. This would be as important as STD-specific supervision and would require improvement of the skills of manages/ supervisors/ coordinators/ trainers so that they can provide better general and management support, consistently and frequently, to service providers as they come across difficulties. This measure should by itself improve current performance of those trained, and maintenance of the system once established.
3. A series of **refresher courses** for all those currently trained in Syndromic Management.
4. **Extension of initial in-service training** which would be separated as follows:
   - five full days be allocated to the **development of clinical skills**. This aspect of training to build on the existing curricula, and cover history taking, use of algorithms, physical examination, anatomy and physiology, and treatment. Considerably more emphasis on the development of practical skills using role plays, models and where possible clinical experience.
   - A further **five days of in-service training** on providing adequate **communication skills** for counselling and education. This aspect of the course to borrow extensively from the curricula developed for inter-personal communication skills training. Emphasis that the whole approach to the client is part of communication skills.
5. The training in **counselling and education** to concentrate on a **few sharply focused areas of investigation** into the client's knowledge, establishing whether the client needs to ask questions, and providing education only that is relevant to the situation of the client. Referrals can be made for further advice or counselling. Particular attention to be paid to the development of active listening skills in the service provider.
6. Include in all training a set of **values clarification exercises** to review and understand feelings and beliefs of providers concerning sexuality, STDs and gender, and their potential impact on the work.
7. Mention in training that it is a function of trained staff to **provide education to the non-clinical staff** in their units.
8. Trainees to be of equal background and experience.
9. Standardisation of the **Management Information System** for the recording of data related to STDs, HIV and AIDS.

Introduction

The various factors that will affect the performance of service providers can be summarised in the following diagram:



These factors were all taken into consideration in the evaluation. Multi-variate analysis was impossible, but it was clear that the most important factors influencing performance were lack of supervision, lack of practical exposure in training, and the values and attitudes of service providers. These were mostly revealed by comparing the performance of pilot and non-pilot sites.

The units

The selection of units was to ensure representation of the different types of institution in the country, and to include the pilot sites where the syndromic management is carried out in areas separated from the normal outpatients as well as those sites ('expansion' sites) where staff received training in syndromic management but were then to continue providing their service in family planning or general outpatient clinics.

Table 1: The units visited by type

Region	Name	Type	STD	FP	Pilot
North	Ekwendeni	CHAM Hospital	✓		
	"	"		✓	
	Mzuzu	Health Centre	✓		✓
	"	"		✓	
	Nkhata Bay	District Hospital	✓		✓
	Mhuju	Health Centre	✓		
	Mzokoto	Health Centre	✓		
Central	Likuni	CHAM Hospital	✓		
	Lilongwe Central Hospital	Teaching Hospital	✓		✓
	Mchinji	District Hospital	✓		
	"	"		✓	
	Mkanda	Health Centre	✓		
	Nkhwazi	Health Centre	✓		
	Ntcheu	District Hospital	✓		
	"	"		✓	
	Kasinje	Health Centre	✓		
South	Mangochi	Teaching Hospital	✓		✓
	"	"		✓	
	Monkey Bay	Health Centre	✓		
	Mulanje	District Hospital	✓		
	"	"		✓	
	Queen Elizabeth Central	Teaching Hospital	✓		✓
	"	"		✓	
	Thyolo	District Hospital	✓		
	"	"		✓	
	Trinity	CHAM Hospital			

Numbers of clients per day

24 of the 26 units saw STD clients every day. In order to get some idea of the general workload of the units, an attempt was made to establish the numbers involved. There was a slight problem in this in that the information systems varied from unit to unit — with some using the old system which measures gonorrhoea, syphilis and genito-urinary disorders, and others using other systems. The measurements are therefore not strictly comparable, but the following table gives some idea of the numbers involved.

If the three teaching hospitals are excluded, it will be seen that the units see between 1-10 male STD clients per day, and between 1-9 female STD clients per day.

Table 2: Numbers of clients seen per day per unit

	STD MALE	STD FEMALE	OTHER MALE	OTHER FEMALE
Ekwendeni (STD)	4	4	80	120
Mzuzu	9	4	190	250
Nkhata Bay	6	9	75	150
Nkhata Bay (Kachere HC)	2	1	30	40
Nkhata Bay (Phirisimo HC)	2	1	55	45
Rumphi (Mhuju HC)	--	1	20	45
Rumphi (Mzokoto HC)	2	5	75	100
Likuni	--	--	--	--
Lilongwe Central	20	15	--	--
Mchinji FP	--	4	--	15
Mkanda	4	2	50	100
Nkhwazi	1	1	50	100
Mchinji STD	2	5	--	--
Ntcheu FP	--	1	--	5
Kasinje	1	1	50	150
Ntcheu STD	4	6	--	--
Mangochi FP	--	1	--	16
Monkey Bay	3	4	60	90
Mangochi STD	10	15	100	150
Mulanje FP	--	--	5	20
Mulanje STD	5	2	39	48
QE FP	--	3	--	--
QE STD	50	40	--	--
Thyolo FP	--	1	--	30
Thyolo STD	10	8	100	150
Trinity	4	1	50	100

Fall-off rates in staff trained

The numbers of staff that had been trained in Syndromic Management at each unit were also recorded, and compared with the numbers of staff currently practising Syndromic Management at the units. It was very noticeable that the **fall off rate of nursing staff was very high**, whilst trained other staff remain very stable. This fall-off was often due to lack of agreement that the nurses could prescribe the necessary drugs.

Table 3 Staff Fall Off

	Clinical Officers		Med Assistants		Nurses	
Facility Name	trained	doing	trained	doing	trained	doing
Ekwendeni Hospital	2	2	3	3	**13**	**0**
Kachere Health Centre	0	0	1	1	**0**	**0**
Kasinje Health Centre	0	0	1	1	**2**	**0**
Likuni Hospital		2	2	2	**30**	**0**
LLW Central Hospital	0	3	0	2	0	3
Mangochi D. Hospital	0	0	0	0	**2**	**2**
Mangochi Std Clinic	3	3	3	3	**7**	**2**
Mchinji D. Hospital	7	7	4	4	0	0
Mchinji D. Hospital	0	0	0	0	**6**	**4**
Mhuju Health Centre	0	0	1	1	1	0
Mkanda Health Centre	0	0	0	2	**0**	**2**
Monkey Bay Health Centre	0	0	1	1	1	1
Mulanje D. Hospital	0	0	0	0	5	5
Mulanje D. Hospital	5	5	2	2	1	0
Mzokoto Health Centre	0	0	1	1	1	1
Mzuzu Health Centre	0	0	1	1	5	4
Nkhata Bay D. Hospital	5	5	3	3	3	0
Nkhwazi Health Centre	0	0	0	1	0	1
Ntcheu D. Hospital	6	4	2	2	**8**	**3**
Ntcheu D. Hospital	0	0	0	0	**3**	**0**
Phirisingo H. Centre	0	0	1	1	0	0
QECH	0	0	0	0	3	3
QECH	0	0	0	2	**0**	**4**
Thyolo D. Hospital	0	0	1	1	3	3
Thyolo D. Hospital	2	1	1	1	**6**	**5**
Trinity Hospital	0	1	1	1	13	13
TOTALS	32	33	29	36	113	56

Lack of drugs

With respect to any lack of drugs during the past three months, 43% of pilot sites and 28% of non-pilot sites had had a shortage of one or more STD drugs during the past three months. At the time of observation, **only 68% of pilot sites and 70% of non-pilot sites had all the 7 STD drugs present**. The drugs most often absent were Gentian Violet (in 61% of units), Nystatin (in 55% of units) and doxycycline (in 25% of units). There was no essential difference between pilot sites and non-pilot sites in this regard. These observations were taken into account in assessing the accuracy of treatment by the service providers.

Lack of reference materials & other resources

Desk reference cards for Syndromic Management were present in only 54% of units, training manuals in 65% and STD management guidelines in only 42% of the units visited.

The presence of diagnostic equipment, condoms, education materials and reference materials was checked: these will be commented on in the section on observation of client/provider interaction *[see page 29]*. The presence of sterilising facilities (bucket & bleach, autoclave, cookers and methods of boiling) were also checked, but apart from noting that all had at least one method and that 6 of the 7 pilot sites and 11 of the 18 non-pilot sites had no bleach, no further analysis is made of these.

Clinical Staff Questionnaire

A questionnaire was issued to 158 staff, 154 of whom had been trained in Syndromic Management. 58% of the respondents were women 42% men.

The purpose of this form was to establish:

- other training they had received;
- aspects of their work they liked or disliked, with reasons;
- the extent to which they were supervised and their needs in supervision;
- their beliefs about and attitudes to the value of the training they received in terms of methodology and content;
- the areas of syndromic management in which they experience difficulties;
- whether they check their diagnoses by obtaining laboratory results;
- the extent to which they are comfortable in dealing with sexual issues;
- their values with regard to adult and teenage clients of both sexes;
- their beliefs about the extent to which their clients understand and follow their advice, education and treatment;
- the extent to which they see clients for follow-up or their partners.

Other training

98% of the respondents had received training in subjects other than syndromic management. 66% had had experience of managing STDs prior to their training. The training broke down as follows (ranked in descending order of frequency):

Table 4: Other training of providers by sex

Male n=96	%	Female n=93	%
Other	40	Family Planning	41
Family Planning	32	Other	18
HIV	29	Breast Feeding	14
Acute Resp Infection	25	Safe Motherhood	9
Diarrhoeal Disease	17	Diarrhoeal Disease	6
Breast Feeding	2	Health Education	6
Health Education	2	HIV	6
Safe Motherhood	2	Acute Resp Infection	4

In view of the considerable amount of other training, it would be useful to examine the various curricula **to see if there was mutual reinforcement of approaches**, especially in relation to communication, education and counselling, or if there were areas of potential conflict.

One of the factors that influence the outcome of work is the extent to which staff like or are interested in the work. In this respect it should be noted that 96% of respondents said they liked their general work a lot (as opposed to a little or not at all).

Supervision

The extent to which supervision is carried out is very low. There were slight differences between the men and the women, but overall only **45** (28.8%) of respondents said they had any supervision at all, and **only 5 of these felt their supervision was adequate**. There was almost no difference in responses between pilot sites and non-pilot sites (27.6% of the 58 pilot site staff and 29.6% of the 98 non-pilot site staff said they had received any supervision).

Those that had any supervision at all had the following frequency of supervision:

Table 6: Frequency of supervision amongst those with supervision

Male n=20		Female n=23	
	%		%
Daily	20	Daily	30
Weekly	5	Weekly	26
monthly	45	monthly	9
3-Monthly	15	3-Monthly	17
Other	15	Other	17

The questions regarding supervision covered knowledge, practice, problems, availability of resources, appraisal, demonstration of correct skills, monitoring of clinic activities, data collection, diagnosis, treatment protocols, counselling & education, follow-up care, infection control and record keeping. Only those that did have supervision (43, or 28% of the total) answered these questions. Of these 43 between half and three quarters had received supervision in these areas [bearing in mind that only 5 of these 43 said they felt their supervision was adequate].

Amongst those observed with clients, 12 of the 62 whose questionnaires could be linked to the observation forms had said they received supervision. Unfortunately there seemed to be no consistent correlation between performance and stated supervision that could be detected (some parameters of performance were slightly better, others slightly worse). This may substantiate the statement above that so few of those supervised felt they had adequate supervision, and may imply that the type of supervision offered differs in some substantive way from the support offered by the STAFH project.

Attitudes to training in Syndromic Management

A series of questions were asked to elicit provider attitudes to the training they had received.

97% of respondents valued their training very highly in preparing them for syndromic management, assisting them to start with confidence and in providing them with relevant theoretical content. This dropped to 76.8% who said they had been provided with sufficient practical experience, and 87% who felt they had been given sufficient skills.

90% felt they had been assisted in training to provide counselling, and 82% to provide education.

It is possible that the questions were misinterpreted as concerning areas the training had covered, rather than the extent to which they were of value to the trainee. ***The report of the observers and evaluation supervisors was that they thought that in fact most people felt their training had been inadequate in terms of practical experience, counselling and communication — see the detailed remarks on page 8.***

Thus while 78% felt they had been assisted to help clients notify partners and to return for follow up, it is clear from the written comments of the providers (see pages 14 through to 17) that these remain areas of great difficulty.

Training methodology

The respondents were asked about what they most liked and least liked about the training methodology. Group discussions were clearly liked by all, and much more than other methods. *[For a better analysis of training content and methodology see the remarks made to the observers by the service providers on page 8].*

Table 7: What providers liked most about methodology in training

Males n=78	%	Females n=107	%
Group Discussion	**60**	**Group Discussion**	**59**
Slides	18	Role Play	22
Role Play	13	Case Study	15
Self-directed	13	Slides	11
Lecture	10	Demonstrations	8
Plenary	7	Self-directed	6
Case Study	3	Lecture	5
Posters	3	Video	5
Demonstrations	2	Posters	3
Video	1	Plenary	1

Just as lectures scored low in what providers liked most, so lectures scored high in what providers liked least.

Table 8: What they liked least about methodology in training

Male n=63	%	Female n=72	%
None	32	None	33
Other	22	Lecture	18
Inadequate time	12	Other	18
Lecture	12	Inadequate time	13
Individual reading	8	Role play	10
Role play	7	Reading manual in class	4
Too much content	5	Use of slides	4
Demonstrations	3	Individual reading	3
Reading manual in class	3	Demonstrations	1
Use of slides	2	Too much content	1

Training content

Providers were asked about their likes in training content. This did not produce as clear a response as the question about methodology, presumably because people have no particular feelings regarding content — which is, after all, what they are there for. *[For a better analysis of training content and methodology see the remarks made to the observers by the service providers on page 8].* Nevertheless it is interesting that the females preferred health education overall, while the males preferred the diagnostic or clinical aspects.

Table 9: What providers liked about content

Men n=80	%	Women n=106	%
Syndromic diagnosis	26	Health education	26
Syndromic Management	22	Case management	24
Counselling	21	Counselling	24
Health education	19	Syndromic diagnosis	19
All	16	All	18
Case management	16	Other	11
Other	10	Infection control	8
Genital Ulcer Disease	5	Syndromic Management	7
Infection control	2	Genital Ulcer Disease	4
Urethral Discharge	2	Urethral Discharge	3

Table 10: What providers disliked about content

Men n=69	%	Women n=75	%
None	48	None	56
Other	20	Other	13
Counselling	13	Condom use	9
Condom use	10	Too much content	9
Too much content	8	Counselling	7
Health Education	7	Physical Examination	7
Physical Examination	5	Anatomy	4
Anatomy	3	Health Education	4

Overall observations by the observer teams

The discussions between the providers and the observers gave better information than the questionnaires on training content. The team from the Northern region noted that most of the service providers felt that:

- They had too much content in a short period of time.
- Most of them spent time reading the training manual instead of being directed in certain areas.
- They felt that although they were given group work and activities, there was no time for the trainer to process, summarise or have conclusions from the group activities. All these were attributed to inadequate time.
- Some providers indicated that confusions arose when there was a difference of opinion between service providers in certain content areas. These were never resolved and the trainees never found out what was the correct view.
- Most said that the lack of practical experience during the four days of training was a great limitation.

The team from the Central region noted in addition that there was considerable confusion between GUS and PID. The providers expressed great concern about the lack of practicals which would have allowed them to understand this area better. This is quite important for Medical Assistants, who do very little or no pelvic examination in their other clinical practice.

Difficulties in practice

Providers were asked about the difficulties they face in particular aspects of Syndromic Management. Interestingly only a quarter said they had difficulties in providing a **private environment**. This relates to the observations of interactions in which privacy was established with clients in 88% of pilot sites, and in 65% of non-pilot sites *[see page 20]*. It is more generally assumed that **privacy** is a greater problem *[see especially the notes of the observers on page 28]*, so perhaps the definition of privacy needs to be reviewed. It is also surprising that only a quarter of providers said they had difficulties with partner notification, given the difficulties they listed in another part of the questionnaire *[see pages 14 to17]*.

Table 11: Difficulties in practical aspects (n=138)

Do you have any difficulties in:	Yes (%)
Establishing rapport with client	11
Providing a private environment	**24**
Performing Syndromic diagnosis (Treatment)	9
Treating with correct antibiotics	15
Communicating in a culturally sensitive manner	21
Arranging partner notification	**25**
Arranging patient follow up	**28**

In checking on the difficulties they might find in health education, it was interesting that very few said they had any difficulties at all. This may partly be because the notion of health education is as a pre-determined provision of information on a certain topic.

Table 12: Difficulties in providing health education (n=138)

Do you have difficulties in providing health education on:	Yes (%)
Nature of infection	4
Prevention of re-infection	7
Treatment compliance	11
Abstinence	**18**
Use of condoms	**14**

In order to check on the difficulties providers might face that influence their ability to carry out Syndromic Management, a number of questions were asked in relation to a variety of possibilities. Very few mentioned any difficulties, although lack of **drugs** or **equipment** were mentioned in about a quarter of all cases. This roughly correlates with the stated availability of these resources by the unit managers.

Table 13: Difficulties influencing ability to provide Syndromic Management

Male n=84	%	Female n=87	%
Lack of drugs	26	Other	23
Other	21	Lack of equipment	20
Nothing	16	Nothing	20
Lack of equipment	11	Follow up	7
Too much work	11	Lack of drugs	7
Lack of privacy	10	Patients can't afford to buy drugs	7
Follow up	6	Gender difference between client and provider	6
Partner notification	6	Lack of practical skills	6
Non-compliance with drug therapy	5	Lack of privacy	6
Patients can't afford to buy drugs	5	Language	6
Gender difference between client and provider	3	Partner notification	4
Lack of practical skills	3	Staff Shortage	4
Lack of room	3	Too much work	4
Lack of slips or cards	3	Multiple partners	3
Language	3	Lack of room	1
Multiple partners	2	Lack of slips or cards	0
Staff Shortage	0	Non-compliance with drug therapy	0

Checking with the laboratory

It is highly important to note the simple fact that 25% of all the respondents (29% pilot, 24% non-pilot) said that they checked their diagnoses with the laboratory (this being observed in practice as well).

Sexuality

A range of questions were asked of the providers to establish their level of comfort on particular issues related to sexuality. The differences between the responses of the men and the women are interesting. Thus it is clear that *nearly a third of male providers are uncomfortable in talking about sexual issues with female clients, and about the same proportion or more of female providers are uncomfortable in talking about sexual issues with male clients [table 14].*

In this regard, it is important to note that the observers remarked on the common practice of getting clients to expose their genitals without the service provider touching them — especially with older male medical assistants and female clients, and of male clients in general *see notes under Examination, page 22].*

The team of observers from the Central region also noted that counselling in relation to PID was especially bad in that *some providers force clients or their partners to believe that PID was contracted by being promiscuous* even if some clients denied this behaviour, and then did not recognise that the clients were offended by this.

The existence of the different viewpoints between service providers points to the need for clarification and review of attitudes and values during training, as well as for improving knowledge.

Table 14: Comfort in knowledge and discussion of sexual issues

	Men (%) n=65			Women (%) n=86		
	Fully	Partly	Not at all	Fully	Partly	Not at all
Do you feel comfortable in your knowledge of **male** sexual & reproductive function?	86	14		40	57	3
Do you feel comfortable in your knowledge of **female** sexual & reproductive function?	86	14		73	27	
Do you feel comfortable in talking about sexual issues with **adult male** clients?	86	12	2	54	37	9
Do you feel comfortable in talking about sexual issues with **teenage male** clients?	88	9	3	71	27	2
Do you feel comfortable in talking about sexual issues with **adult female** clients?	71	26	3	88	11	1
Do you feel comfortable in talking about sexual issues with **teenage female** clients?	72	25	3	92	8	

There was a series of questions designed to test the values of the providers. This type of questioning is far better done in a workshop environment together with role plays. Nevertheless, some indications of attitudes are shown by analysis of the following four tables. Again, the variations between male and female providers should be noted.

Table 15: Attitudes to adult male clients with STDs

What is your opinion about **adult male clients** with STDs	Men (%) n=65 Yes	Women (%) n=86 Yes
They deserve their illness for being promiscuous	18	27
I should give them condoms	92	94
I get irritated by seeing the same men again and again	32	28
STDs are shameful in men, they show they are promiscuous	35	41
STDs are like any other illness in men	52	53
I feel ashamed when examining men with STDs	5	21
Men with STDs require sympathy and advice in addition to treatment	99	97

Compare to feelings about women in Table 17

Table 16: Attitudes to teenage boy clients with STDs

What is your opinion about **teenage boy** clients with STDs	Men (%) n=65 Yes	Women (%) n=86 Yes
I should stop them having sex	38	35
I should give them sex education and condoms	94	98
I get irritated by seeing the same boys again and again	42	29
STDs are shameful in boys, they show they are promiscuous	45	45
STDs are like any other illness in teenage boys	41	44
Boys with STDs require sympathy and advice in addition to treatment	97	98
I feel angry when examining boys with STDs	8	7

Compare to feelings about girls in Table 18

Table 17: Attitudes to adult women clients with STDs

What is your opinion about **adult women** clients with STDs	Men (%) n=65 Yes	Women (%) n=86 Yes
They deserve their illness for being promiscuous	14	26
Men are at fault for not sticking to their partner	42	48
I get irritated by seeing the same women again and again	36	25
STDs are shameful in women, they show they are promiscuous	31	30
STDs are like any other illness in women	45	55
Women with STDs require sympathy and advice in addition to treatment	95	93
I feel ashamed when examining women with STDs	14	6

Compare to feelings about men in Table 15

Table 18: Attitudes to teenage girl clients with STDs

What is your opinion about **teenage girl** clients with STDs	Men (%) n=66 Yes	Women (%) n=86 Yes
I should stop them having sex	39	43
I should give them sex education and condoms	99	97
I get irritated by seeing the same girls again and again	43	28
We should stop older men from seducing young girls	89	87
STDs are like any other illness in teenage girls	43	55
Girls with STDs require sympathy and advice in addition to treatment	97	97
I feel angry when examining girls with STDs	22	7

Compare to feelings about girls in Table 16

It is unclear about the extent to which such attitudes do in fact interfere with good client management. Experience elsewhere suggests that examination, counselling, education and advice are all affected in a variety of ways. At the very least, the answers are an indication of continuing issues related to gender.

A particularly interesting point in all the previous four tables is that around half of all providers believe that STDs are ***not*** like other illnesses, and about 40% believe they should stop teenagers having sex.

What providers believe clients do

There was a series of questions on the beliefs of the respondents concerning the effect of their work on clients. This carries no serious weight as far as an analysis is concerned, but it shows that about a third of providers believe education on the importance of abstinence is *not effective*, and the *female providers are more sceptical of the value of education concerning abstinence, condoms, partner notification and follow up.*

Table 19: Provider beliefs re client understanding and action after education

Do clients understand and take action on	Men (%) n=65 Yes	Women (%) n=86 Yes
Nature of infection	91	82
Prevention of re-infection	89	86
Treatment compliance	92	81
Importance of abstinence	73	68
Importance of use of condoms	94	79
Importance of partner notification	95	75
Importance of patient follow up	91	76

Partner Notification

Interestingly, when asked how frequently they see the partners of clients, 20% said they frequently saw partners, 55% said sometimes, 17% said rarely, and 5% said never. Unfortunately, these are vague terms, but there was a wide range of written responses (detailed below) concerning the experience with partner notification, which revealed the difficulties providers face in contacting partners. Many of the reasons are very simple ones (such as the sheer distance involved) whilst others are attitudinal and reflect problems such as shame. The answers here underline the poor response to the earlier part of the questionnaire where respondents implied they did not have so many problems in this area.

The same range of difficulties were experienced with attempts to bring spouses for treatment, although in this instance the difficulties were more to do with shame.

Experience of Partner Notification *(direct providers' quotes)*

Difficult to experience.

Partners do not come.

Coerced to come to hospital.

Not using notification cards.

Few bring partners.

Not sure.

Understand importance of Partner Notification.

Lack of understanding of importance of Partner Notification.

Difficult if spouse has no evident symptoms.

Problems convincing clients with asymptomatic STD.

None.

Some come.

Some report to another clinician elsewhere because they are ashamed to report at that clinic.

Some go to traditional healers.

Reluctant to tell partner.

Men bring partners easily.

Women have fear/problems bringing their partners.

Partners response positively.

Men difficult - they disagree.

Teenage pregnant women do not bring partners.

Feel shy, bad, guilty.

Fear of partner knowing promiscuity.

Sometimes it creates a problem.

Good response.

Comfortable.

Do not accept responsibility for the disease.

They say they have no spouses but after counselling they bring their partners.

Poor communication between partners.

Rarely notices them and do not use notification slips.

Do not inform partners.

Have difficulties to inform partners.

Clients do not give notification to partners.

Denies the disease.

Complies after careful explanation.

Lied.

Never bring partner of contact.

Women respond better than men.

Has helped in complete management of STDs.

Especially commercial sex workers.

Difficult to catch the contact especially in married men.

Some partners hide.

Communicate with partners by letter to come for treatment.

If sex partner is wife or husband response is positive. If another partner response is poor.

Partners are far away.

Helps them to come for treatment.

Afraid to notify partners.

Initially angry and embarrassed but later understood.

Some partners do not come.

Denial.

Fear of charges.

Men give notification to their wives only but not other extra partners.

Gives excuses.

Brings spouses for fear of complications.

Women fear husbands.

Some ignore to give partner notification on slip.

Do not remember partner due to the influence of alcohol.

Use of card without a name.

some men with multiple partners.

One is brought for treatment.

Difficult in terms of hit and run relative slips.

Easy for married couples.

Use of diagnosis less stigmatising as most people do not understand the diagnosis e.g. UD.

Fear to tell partners prefer to bring girl friends not wives.

Difficult to bring casual partner.

Dishonest in case of multiple partners.

Ashamed to carry notification slips.

Husband refusing to go for treatment.

If pregnant no problem (males).

How clients respond if asked to bring *spouse* for treatment *(direct providers' quotes)*

Respond well.

Some come/bring.

Some do not come.

Failure to disclose marital status.

Difficulties with transport.

Shy to tell spouses.

Spouses very far away.

Do not know how to bring the matter to spouse.

Negative response.

Give excuses for not bringing spouses.

Women have difficulties bringing husbands for treatment.

Women show signs of fear.

Men look carefree.

They feel happy.

They need notification letter to show to their partners.

Respond well but bringing spouse is difficult.

Afraid to tell spouse.

Initially they say they have no spouse and bring later after discussing.

If index is single then difficult to bring spouse.

Positive response after understanding dangers of treating one partner.

Women come for treatment, men do not.

Very few bring spouses.

Need notification card and not bringing them together.

Men feel ashamed.

Difficult to bring spouse .

If pregnant no problem.

Negative later responds.

Spouse difficult to be informed.

Difficult to notify since spouse has no evident symptom.

Ashamed.

Afraid of physical abuse.

Unwilling to convey message.

Female clients responsible positively other than males.

Feel embarrassed.

They feel uncomfortable and lie that they have not slept with their wives for several days.

Provider to inform spouse.

Clients nervous to break news to spouse.

Give assurance to coerce partners to come.

In clinics which are manned by more than one person experience is difficult because no explanations are given for partner notification and partner feels embarrassed to learn about the problem at the clinic.

Not happy.

Spouses refuse.

Good responses in female spouses.

If index is male they easily convince wife/spouse to come.

If index is female it is difficult to bring spouse.

Fear to be exposed.

Spouse reluctant.

Fear for marital instability/divorce.

Spouse threatened to divorce but then accepts after explanation.

Afraid to bring spouse.

Do not want spouse to know.

If index is married it is easy to bring spouse.

How do clients respond when you ask them to bring their *other sexual partners* for treatment? *(direct providers' quotes)*

Some come/willing to receive treatment.

Some can not convince partner to come.

They do not come.

Sometimes unwilling or reluctant.

Had a casual sexual relationship.

Male clients have problems bringing partners.

Female clients have problems bringing partners.

Use of excuses for not bringing partner for treatment.

No casual partners anymore.

Respond positively.

Very easy.

Lie to have not partner.

Sexual partner living far away.

Respond negatively.

Feel ashamed to bring a casual sexual partner.

Sexual partner very young.

Lack of responsibility for casual sex.

Married men have no problems.

Single men have problems.

Blame the sexual partner for STD therefore does not feel responsible to bring her/him.

Very few sexual partners show up for treatment.

Cannot trace other sexual partners.

Commercial sex workers cannot bring their sexual partners.

Partners refused to come.

Initially difficult to convince but after counselling there is favourable response.

Females afraid to bring males for treatment.

Angry.

Uncooperative partner.

Poor.

Difficult to get partner.

Uncomfortable.

Deny having other sexual partners but accept after good counselling.

Client willing to have other sexual partners notified.

Difficult to identify which of other sexual partners was infected.

Do not accept to notify partners.

Few accept to notify partners.

Afraid.

Shy/ashamed.

Varied responses from clients.

Relationship had been dissolved.

Difficulties approaching sexual partner.

Blame the sexual partner for the infection.

Regret having had casual sex.

Will not go back to the partner therefore does not care about partners fate.

Prefer to bring spouse than casual sex partner for treatment.

Too many sexual partners therefore not sure of which are to bring.

Respond well but request to be treated in confidence.

Preferable at a different clinic.

Positive response but do not bring partners.

Fear of causing marital problems.

Men more comfortable to bring girl friends.

Fear of terminating their relationship.

Difficult because sexual partner is somebody's wife/husband.

Their partners already received treatment.

Follow up

Only half the respondents (both in pilot and non-pilot sites) said they had a method to *check whether clients return for follow up*, and that they do check whether clients return. Slightly fewer (41%) said that they had a method to check whether the same clients were returning with re-infections or new infections, and said that they did check this.

It is important to note that the above findings imply the need for a standardised method of providing slips for people to return, and emphasis in all sites that this is an important aspect of syndromic management.

In estimating the frequency of return with new infections, the answers were as follows:

Table 20: Provider beliefs concerning return of clients with new infections

% clients returning in last 3 months	Male providers (%) n=54	Female providers (%) n=50
Up to 25%	69	74
Up to 50%	29	19
Over 50%	2	2

These answers are of course not accurate evidence concerning real rates, but since so many providers believe that they are seeing a substantial number of people returning with new infections, it implies that a substantial proportion of education and counselling efforts are ineffective. This would require further investigation, because if the education is truly ineffective then either it would have to be modified or other efforts would have to be made to change the situation.

Observations of client-provider interactions

129 observations were made of client-provider interactions. Of these, only 97 were linked to the sex and background characteristics of the service provider because of the failure of 31 providers to complete questionnaires. Linking of the sex of the client to that of the service provider was impossible in the cases of 5 FP clients whose sex was not recorded.

Table 21: Types of client by type of site

	Pilot sites	Non-pilot sites	
STD Clients	25	40	65
Family Planning clients		30	30
Other	4	30	34
TOTAL	29	100	129

Table 22: Types of client by sex of provider

	Male service providers	Female service providers	
STD Clients	34	12	46
Family Planning clients	1	12	13
Other	25	4	29
TOTAL	67	28	95

Table 23: Type of client by sex of client

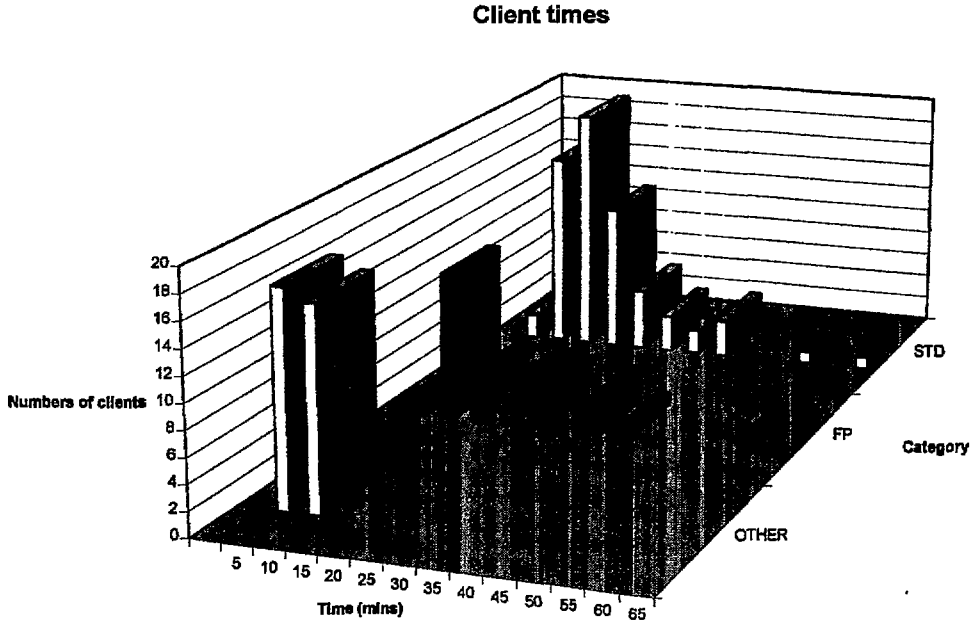
	Male Clients	Female clients	
STD Clients	34	31	65
Family Planning clients	1	24	25
Other	13	21	34
TOTAL	48	76	124

Table 24: Sex of client by sex of service provider

		Service providers		
		Male	Female	
Clients	Male	34	6	40
	Female	33	19	52
	TOTAL	67	25	92

Consultation times

The first comparison to be made was to check the length of time for which each client was seen. The following is a chart that illustrates the range of times for each category of client.



This is based on the following figures, which show that more time is spent with STD and FP clients than with other clients (*no 'other' clients were seen for longer than 10 minutes*). This is because of the extra time in counselling and education. Overall, the mean time with both STD and FP clients was 18 minutes, as opposed to a mean of just over 6 minutes for other clients — a difference of 12 minutes per client *[see table 26 overleaf]*. The excessive times spent with three of the cases were because of considerable anxiety of the service providers at being observed.

Table 25: Time spent with client (mins) by type of client

Time	STD	%	cum %	FP	%	cum %	OTHER	%	cum %
5	2	3%	3%	2	7%	7%	17	52%	52%
10	16	25%	28%	12	40%	47%	16	48%	100%
15	20	31%	58%	4	13%	60%			
20	12	18%	77%	3	10%	70%			
25	5	8%	85%	4	13%	83%			
30	3	5%	89%			83%			
35	2	3%	92%	3	10%	93%			
40	3	5%	97%	1	3%	97%			
45			97%			97%			
50			97%			97%			
55	1	2%	98%			97%			
60			98%	1	3%	100%			
65	1	2%	100%						
	65			30			33		

Table 26: Analysis of times with clients by type of client

Clients	Mean	Standard Deviation	Standard Error	25th centile	Median	75th centile	Mode
STD	18.0	11.2	1.4	10	15	20	10
FP	17.5	12.7	2.3	10	13.5	22	10
Other	6.2	3.0	0.5	4	5	10	5

General interaction

The following tables suggest that in general **rapport** *[tables 27 & 28]* was well established in pilot and non-pilot sites (although as usual pilot sites performed better in all cases) as well as for FP and STD clients. However **privacy** and **confidentiality** were less frequently observed, and this is in agreement with some observer remarks on counselling *[see page 28]*.

In terms of **use of diagnostic algorithm** *[table 29]* the differences between pilot sites and non-pilot sites were much greater. **In 30% of the non-pilot site observations staff did not follow the algorithm at all in diagnosing their clients**, and this may be part of the reason for the very poor performance of the non-pilot sites in terms of accuracy of treatment.

Although **attentiveness to the client** *[table 30]* seemed to be good in both pilot and non-pilot sites, and the observed **attitudes and reactions of the clients** *[table 31]* revealed that a much better rapport and openness had been established in the pilot sites, observers made several remarks about the absence of **active listening** that would allow more relevant education *[see page 26 on Education]*..

History taking *[see table 32]* was of greater thoroughness and accuracy in the pilot sites, but even so, only **56%** of pilot sites achieved accuracy or thoroughness and accuracy in their history taking. The pilot sites achieved only an overall **25%** in this respect. This is an area that therefore requires considerable improvement.

Table 27: Was rapport established? (By type of client)

	Rapport established with client	Privacy established	Confidentiality Established
STD client n=64	80%	70%	67%
FP Client n=30	69%	80%	63%
Other client n=34	77%	68%	65%

Table 28: Was rapport established? (By type of site)

	Rapport established with client	Privacy established	Confidentiality Established
Pilot sites n=25	100%	88%	72%
Non-pilot sites n=51	71%	65%	64%

Table 29: Was a diagnostic algorithm used? (STD cases only selected)

	Use of algorithm		
	With book	Without book	Not used
Pilot sites n=23	17%	83%	
Non-Pilot sites n=47	32%	38%	30%

Table 30: Was there attentiveness to the client?

	Attentiveness to client		
	Attentive	Missed points	Not attentive
Pilot n=24	100%		
Non-Pilot n=52	90%	8%	2%

Table 31: What was the attitude of the client? (by type of unit, STD cases only)

	STD cases only	Pilot Sites (%) n=25	Non-Pilot (%) n=52
Good inter-action	Openly discusses symptoms	24	44
	Openly discusses sexual practice		4
	Open re both symptoms & sexual practice	64	23
	Open re symptoms but not sexual practice	4	2
	SUB-TOTAL	**92%**	**73%**
Poor inter-action	Embarrassed	4	13
	Silent		2
	Does not discuss sexual practice		
	Responds with minimal answers		8
	Embarrassed & responds with minimal answers		2
	Does not discuss sexual practice and responds with minimal answers	4	
	Embarrassed but openly discusses symptoms		2
	SUB-TOTAL	**8%**	**27%**

Table 32: How was the history taken?

STD cases only	History taking	
	Pilot n=25	Non-Pilot n=52
Thoroughly	40%	33%
Thoroughly & Accurately	**40%**	**15%**
Accurately	**16%**	**10%**
Skipping stages		23%
Skipping stages & Inaccurately	4%	4%
Inaccurately		15%

Examination

The observation of examination of the STD clients showed that in general this was satisfactory *[see table 33]* but that **detailed genital examination was unsatisfactory**. This was attributed by the observers partly to a fear of AIDS, partly to gender considerations, and partly to an embarrassment concerning genitals. It was noted that in some units clients are asked by the providers to expose themselves (especially male clients who are also often asked to retract their own foreskins), while the service providers do not touch the clients. The observer from the northern region noted that older male medical assistants felt uncomfortable in performing genital examinations and would usually skip this.

In each case, except in the case of bimanual examination, the pilot sites scored better (often much better) than the non-pilot sites in examination of the client. It is notable that **none of the service providers in non-pilot sites washed their hands before examining male clients**, and only 61% before female clients.

It is also notable that while pilot sites used a speculum in only 1 out of the 9 times it was available, in non-pilot sites it was used 7 out of 8 instances in which it was available.

Beyond the general observations made by the observers (above), it was impossible to assess with any clarity the extent to which there was a difference between male and female service providers in examining both men and women. This was because the numbers of women service providers with completed questionnaires linking their details to the observations were too few (the details of only 3 female service providers could be linked with male clients, and 8 with female clients).

The observation form itself did not allow for some of the observations made. Thus observers correctly recorded "Genitals examined", "Foreskin retracted" and "Genitals exposed" *even if this meant that the clients did it themselves.*

The overall figures given in the following table still demonstrate to some extent the areas of weakness in examination.

Table 33	Male STD clients (%)		Female STD clients (%)	
	Pilot n=14	Non-pilot n=18	Pilot n=9	Non-pilot n=29
Hands washed	100 (but n=7)	0	75	61
Consent obtained	86	47	100	68
Explanation provided	86	50	100	71
Examination gloves used	43	18	89	82
Genitals exposed	100	82	89	86
Genitals examined	69	50	89	82
Foreskin retracted if present	79	47	--	--
Penis milked if discharge	57	41	--	--
Labia separated	--	--	89	79
Speculum used if speculum present	--	--	11	88
Light source adequate	--	--	44	19
Bi-manual examination	--	--	33	64

Treatment

The overall results for accuracy of treatment are generally **poorer than is to be expected**, except in the accuracy of the pilot sites for urethral discharge and genital ulcer disease (which is in line with previous assessments of pilot sites). In Pilot sites **67%** of all STD patients seen left with correct treatment, and in non-pilot sites this dropped to **only 17%** of all patients seen for STDs.

The accuracy of the diagnosis itself was not assessed by the observers, but for each diagnosis made, assessment was made on the basis of

- Whether the correct combination of drugs were prescribed (with account taken of whether the drugs were available in the clinic at the time of observation);
- If the correct combination of drugs was prescribed, then if the correct doses were prescribed;
- If the correct doses were prescribed, then if they were prescribed for the correct period of time;
- If all the above was correct, then if they offered or provided condoms to the client.

Only if all four criteria were correct was an accurate treatment recorded. In general, almost all the failures came from the wrong prescription of drugs (either incorrect drugs for the syndrome, or the incorrect mixture). Dosage of drugs was only seen to be a problem with Metronidazole where there was frequent confusion between the times it had to be administered as a 2gm stat dose (GUS), or as 2 tablets of 240mg bd for 10 days (PID). A few further errors resulted from the failure to offer or provide condoms. The **incorrect treatments are shown in table 34** (note that in any one case, more than one error may have been made, so the final column refers to the numbers of clients rather than total errors):

Table 34: Numbers of cases of incorrect treatment by type of error

	Total observed including correctly treated (numbers of clients)	Incorrect drug combination	Incorrect dose	Failure to offer or provide condoms	Total incorrect management (numbers of clients)
Urethral Discharge	15	5	--	8	9
Ulcer (non Herpes)	13	6	--	3	6
PID	9	7	2 (metro)	5	8
GUS	23	13	8 (3 metro)	7	17
Total	60	25	6	20	**40**

In cases of multiple diagnoses, each symptom was regarded separately and accuracy recorded accordingly.

Treatment accuracy

The tables for overall correct/incorrect management separated by type of site are as follows. They are in order of descending accuracy.

Table 35

	Treatment accuracy in Pilot Sites		
	Correct (numbers)	Total (numbers)	%
Urethral Discharge	5	5	100.0
Ulcer (non Herpes)	5	8	62.5
PID			
GUS	4	8	50.0
Total	14	21	66.7%

Table 36

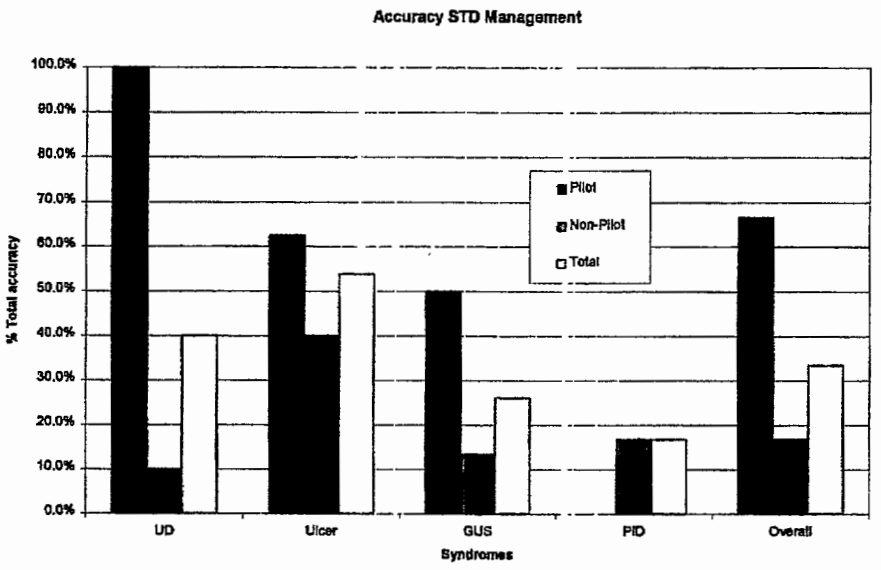
	Treatment accuracy in Non-Pilot Sites		
	Correct (numbers)	Total (numbers)	%
Ulcer (non Herpes)	2	5	40.0
PID	2	12	16.7
GUS	2	15	13.3
Urethral Discharge	1	10	10.0
Total	7	42	16.7%

Table 37

	Treatment accuracy in all sites		
	Correct (numbers)	Total (numbers)	%
Ulcer (non Herpes)	7	13	53.8
Urethral Discharge	6	15	40.0
GUS	6	23	26.1
PID	2	12	16.7
Total	21	63	33.3%

In each instance the pilot sites performed better than the non-pilot sites.

The pattern is better seen in the following chart.



Education

In order to test the listening skills of the providers, the observers noted whether the provider checked the client's knowledge on the following topics before giving education to STD clients:

Table 38 Providers reviewing client's knowledge before education of:

	Nature of the infection		Prevention of reinfection		Treatment compliance		Abstinence		Use of condoms	
	Pilot n=25	Non-Pilot n=51	Pilot n=25	Non-Pilot n=50	Pilot n=25	Non-Pilot n=49	Pilot n=25	Non-Pilot n=47	Pilot n=25	Non-Pilot n=45
Well	60%	28%	72%	18%	60%	29%	60%	19%	64%	22%
Not well	12%	8%	4%	20%	12%	6%	4%	13%	8%	22%
Not at all	28%	65%	24%	62%	28%	65%	36%	68%	28%	56%

60%-70% of pilot sites performed well (i.e. 30-40% of pilot sites did not perform well), and considerably better than the **non-pilot sites** whose **scores were very low**. This may be attributable to **problems of privacy**. The team from the Northern region noted that "there was a general lack of privacy in clinics which were not Pilot centres such that counselling and health education were minimal".

It is a necessary part of Syndromic Management to provide education on certain key areas. This was measured by observation. In simple terms of actual transmission of education, the pilot sites performed well and again considerably better than the non-pilot sites. Caution should again be taken in light of the findings that **little attempt was made to check the extent to which this was relevant to the client's situation, knowledge and potential for action.**

Table 39 Education was provided on:

	Nature of the infection		Prevention of reinfection		Treatment compliance		Abstinence		Use of condoms	
	Pilot n=24	Non-Pilot n=50	Pilot n=24	Non-Pilot n=49	Pilot n=23	Non-Pilot n=48	Pilot n=24	Non-Pilot n=48	Pilot n=24	Non-Pilot n=48
Well	88%	40%	88%	35%	96%	56%	96%	40%	83%	30%
Not well	8%	18%	8%	25%	5%	17%		13%	13%	28%
Not at all	4%	42%	4%	40%		27%	4%	47%	4%	42%

An attempt was made at assessing the extent to which the client was interested in the education and whether this education was provided in an interactive way. The providers in the pilot sites were more interactive with clients than in non-pilot sites, although even in the pilot sites the **scores for interaction were not high**. This is reflected in the remarks by the observers (see below) and in the results of the interviews with clients 40% of whom complained they could not ask questions they wanted to *[see page 33]*. In terms of interest, it is clear that in all cases clients are very interested in what is being said, whether they are in a pilot site or not.

Table 40 Client's response to education on:

	Nature of the infection		Prevention of reinfection		Treatment compliance		Abstinence		Use of condoms	
	Pilot n=22	Non-Pilot n=30	Pilot n=22	Non-Pilot n=30	Pilot n=22	Non-Pilot n=30	Pilot n=22	Non-Pilot n=30	Pilot n=23	Non-Pilot n=29
Interactive	35%	19%	27%	16%	46%	38%	22%	22%	35%	35%
Interested	57%	78%	68%	80%	54%	56%	74%	70%	52%	48%
Not interested	8%	3%	5%	4%		6%	4%	8%	13%	17%

Finally, there was a check to ensure that the language and education used were appropriate and easy to understand. The figures from the observation forms at first suggest that this seemed to be the case.

Table 41 Education

	Language same as client's	Education appropriate	Simple to understand
Pilot n=24	100%	96%	100%
Non-Pilot n=36	100%	78%	75%

However, the observations made by the observer teams put this in context. Most felt that there was in fact **very little testing to check whether the education was relevant to the particular situation, knowledge or potential for action of the client**. In this case, it is clear that listening skills and educational skills need some improvement, and that this needs the right emphasis in training.

Partner notification

In looking at the extent to which providers tried to obtain partner notification *[see table 4]*, again it is clear that pilot sites performed far better than non-pilot sites, especially when giving slips for notification of partners. However, the questions concerning the extent to which providers check the comfort of the client in discussing such issues with their partners show that some improvements could be made (as with all aspects of client interaction). It is noteworthy that the reaction of the client was regarded as being positive in 76% of cases.

The statements made in the responses to the questionnaires by providers *[see page 14]* regarding partner notification should also be looked at as they demonstrate the difficulties in this area.

It is important to note the differences between men and women clients. Men on the whole would feel a bit more comfortable in arranging for their spouses to come as the observers said they would "order them to do so". However, women were very wary of asking husbands to come.

Table 42 Partner notification	Asked re comfort on discussing sexual issues	Asked re embarrassment, anger or shame	Asked re comfort in talking with sexual partners	Asked re comfort in seeking partner treatment	Asked re action client will take	Suggestions appropriate to client	Slip given for partner
Pilot n=24	63%	13%	58%	71%	79%	79%	87%
Non-pilot n=46	58%	7%	55%	61%	62%	71%	43%

Follow up

Follow up of clients was again pursued well in pilot sites, and reasonably in pilot sites, with cards or stamps being given in 92% of cases in pilot sites, and 63% of cases in non-pilot sites. However, this contrasts with the fact that **only half of the providers check whether clients do in fact return** *[see page 17]*.

Table 43 Follow-up	Client asked to return	Client given explanation why important	Client given card or stamp
Pilot N=25	100%	100%	92%
Non-pilot N=50	82%	77%	63%

Counselling

The performance in counselling of both pilot sites and non-pilot sites was good in some aspects if only the forms filled by observers are taken into account — again with the pilot sites performing better. However, **processing**, **paraphrasing** and **probing** scored less well, and the observations by the observer teams again put this in a different light. As was noted earlier, the team from the Northern region stated that "there was a general lack of **privacy** in clinics which were not Pilot centres such that *counselling and health education were minimal*". They also said that "For most of the providers, in giving health education or counselling there was *very little consideration about the client's knowledge of his/her STD condition*". Overall they noted that "*providers did not give appropriate counselling.*"

The team from the Central region noted that "*providers are not adequately prepared to manage clients with PID, especially on counselling. Some providers forced clients or their partners to believe that PID (their disease) was contracted by being* ***promiscuous*** *even if some clients denied this behaviour. Some clients were offended by this approach yet the providers never picked this up.*"

Table 44 Counselling	Language same as client's	Active listening	Eye contact	Responses processed	Answers paraphrased	Probing
Pilot n=26	100%	92%	100%	74%	70%	70%
Non-pilot n=50	96%	88%	84%	57%	57%	53%

Condoms

The pilot sites scored highly in the provision of condoms (though not so highly in checking whether the client uses them or knows how to use them — both areas that require attention in future training). On the other hand, the **performance of the non-pilot sites was extremely poor in all aspects of condom provision.**

Table 45 Condoms

	Available	Offered	Given	Check client knows how to use	Checks if client uses with spouse	Checks if client uses with other partners
Pilot n=23	96%	94%	86%	79%	55%	58%
Non-pilot n=45	89%	46%	44%	30%	20%	16%

Presence of materials

A flowchart was present only in only 40% of pilot site observations (12% non-pilot), and a manual on syndromic management in only 52% of pilot sites (60% non-pilot). It makes it difficult for providers to perform well in the syndromic approach if they have no materials to remind them of their training.

Table 46

	Flowchart present	Syndromic Management book present	Patient registry present	Registry filled correctly
Pilot n=25	40%	52%	100%	87%
Non-Pilot n=49	12%	60%	78%	62%

Trainers' experience

There is little to report of note from the questionnaires filled out by 9 trainers. 2 of the 9 reported that other training they had received conflicted with the Training in Syndromic Management, but this was not detailed. It may be, for example, the requirements concerning STDs are not yet standardised throughout the system, or that the approaches to counselling advocated in specialised HIV counselling are at variance with the methods for counselling of STD clients.

All seemed satisfied with their training to train others, in practical and theoretical terms.

Aspects the training covered best

The trainers believed the following was covered best in training:

1. Presentation of all syndromes and their flow charts
2. Syndromic Management
   - Diagnosis
   - History taking
   - Examination of all conditions
   - Counselling
   - Health Education
   - Management of GUD
3. Theory and practice
4. All content

Aspects the training covered worst or not at all

The trainers provided the following written answers:

1. None
2. Communication
3. Counselling skills

Other aspects that make provision of training difficult

The trainers provided the following written answers:

1. Time factor - too short a period
2. Shortage of staff
3. Lack of enough funds
4. Environment - some hospitals have no proper rooms for Training and practice
5. Adaptation of SM, by some doctors and clinicians - difficult
6. None

Skills needing improvement

Of the 9 trainers, the following said they needed improvement in skills

- 5 in communication with trainees;
- 7 in teaching people to communicate;
- 3 in their comfort in discussing sexuality;
- 1 in teaching people to listen;
- 4 in teaching people practical skills;
- 8 in teaching people theoretical skills.

Interviews with clients

85 clients were interviewed both before and after their consultation. 28 (33%) were male, and 57 (67%) were female.

Clients who were for Family Planning and did not have an STD were excluded from the pre-diagnosis interview.

Of those who believed they had an STD, 12 were male, 8 were female. 5 of the 8 women listed themselves as housewives.

5 of the 8 women thought they had got the STD from their spouse, and 2 from another partner.

11 of the 13 men thought they had got the STD from a partner other than their spouse, and the remaining 2 said they "didn't know".

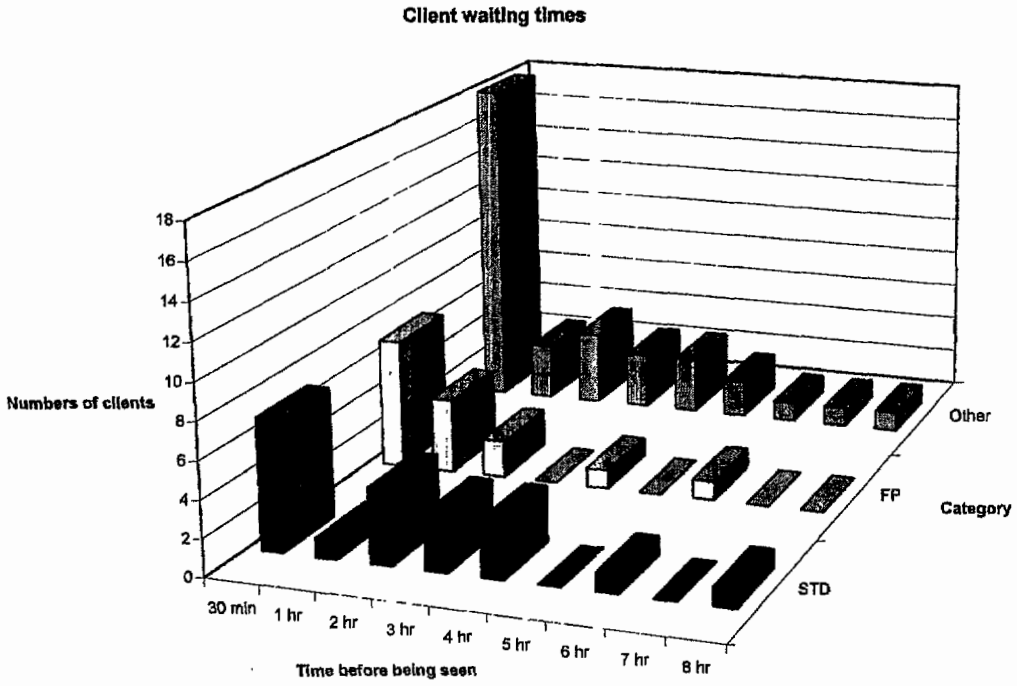
Waiting times

The times the clients had to wait were often excessive, and there was not much difference between STD clients and others in this respect. Of the 71 clients whose time was estimated by them, **30% had to wait between 3 hours and 8 hours** before being seen by a service provider.

Table 47: Frequency analysis of waiting times in minutes

Waiting time	STD Client Numbers	Cum %	FP Client Numbers	Cum %	Other Client Numbers	Cum %	All clients	Cum %
30 mins	7	35%	7	47%	18	50%	32	45%
1 hour	1	40%	4	73%	3	58%	8	56%
2 hours	4	60%	2	87%	4	69%	10	70%
3 hours	3	75%		87%	3	78%	6	79%
4 hours	3	90%	1	93%	3	86%	7	89%
5 hours		90%		93%	2	92%	2	92%
6 hours	1	95%	1	100%	1	94%	3	96%
7 hours		95%		--	1	97%	1	97%
8 hours	1	100%		--	1	100%	2	100%
Total	20		15		36		71	

This is graphically illustrated as follows:



Self-medication

Of the 20 people who believed they had an STD and who admitted trying self-medication

- 60% had tried self-medication, and of this number half had tried herbal medication.
- 60% of the 20 had been ill for **12 days** before attending the clinic.
- 65% had concerns about confidentiality.

If this sample is representative, it shows that considerable efforts have to be made in communities to increase the trust and use of the clinics.

Selecting the clinic

40% of those thinking they had an STD selected the clinic because it was near, and 37% because the services offered were free. 6% did so because they thought the staff were helpful. 17% gave a variety of other reasons.

However, 35% of those thinking they had an STD said that they thought that others in the community are worried about attending the clinic for treatment. This reinforces what was said above concerning the need to increase trust in the services.

65% of those thinking they had an STD thought the services at the clinic were adequate and of good quality. 75% thought the staff friendly.

Post-diagnosis

All the clients thought they had been treated with respect. Whether this was due to the presence of observers is of course unknown. The opinion of the observers was that this was unusual in their experience.

The observers checked what was handed to 20 of the 'STD' clients. Of these

- 18 understood the drug instructions
- 16 understood the follow up card (16 received cards)
- Only 14 had been given a notification of partner slip or a stamp
- 13 had been told about abstinence;
- Only 12 had been told about the use of condoms
- 17 had been told about the nature of infection, prevention of re-infection and treatment compliance;
- 15 had been asked to return for a check-up, and they all said they would be able to do so.

19 felt they would be able to put into practice what they had been advised, and 16 said they would have no difficulties. Of those that said they had difficulties, they said:

- Not clear on my condition
- Not sure if husband will use condoms
- Was after treatment and not condoms
- Very mobile unable to maintain follow up advice.
- Difficult to get other partner.
- Well understood.
- Some of the medical terms were not clear.
- I don't need condoms

8 of the clients said they were not given a chance to ask questions. The things they would like to have asked about were:

- Follow up if it is necessary
- Cause of illness/ mode nature of illness
- Treatment/duration
- Why he has to be tested for VDRI 3 times
- Advise and not to get re-infection
- What to do if no improvement
- Type of illness
- Main Problem
- What would happen with drugs finish before follow-up

In relation to talking with partners, 13 of the 20 had already talked with their partners about the STD. All 8 of the women had done so, but only 5 of the 12 men had done so. Interestingly, 19 said they would be able to talk with their partner in the future, so presumably the men found new courage or fear.

Interviews with non-clinical staff

The interviews with the 25 non-clinical staff were extremely valuable, as this category of staff is not often interviewed — despite the fact that it is likely that they have the highest client contact of all staff in a health unit.

The point of the interviews was to establish if there is an important need for education in this category of staff in relation to STDs. It seems quite clear that there is such a need, and that it is of great importance.

20 of the 26 were men (2 respondents did not have the sex entered on the form), so it is not useful to try to compare the sexes for response and level of client interaction.

What others ask or talk to them about

When asked "Do patients or other staff ever talk to you or ask questions" a very high proportion said that they did.

- 88% were asked about STDs;
- 92% were asked about AIDS;
- 87% were asked about treatment;
- All of them were asked about using condoms;
- 84% were asked about safer sex.

In each case, they were asked to give one example of what they were asked. The answers were as follows:

STDs

- What will happen to STD contacts. Where to get treatment in confidence. How to prevent getting STD.
- Women ask how they will explain their STD situation to their partners. Signs and symptoms of Gonorrhoea/ Bubo.
- Do all people even the elderly who visit the clinic have STDs.
- Ask about treatment.
- They ask if STDs e.g. Gonorrhoea is equal to AIDS.
- Transmission of STDs and nature of their disease if infected.
- Why are clinics designated as STDs not general.
- How many married people can avoid STDs.

AIDS

- If it is true that there is no cure for AIDS.
- Transmission of HIV among married couples.
- What should they do if a sexual partner dies of AIDS.
- Can AIDS be cured.
- Why medical staff do not tell patients about their HIV status.
- Can people contract HIV from mosquitoes.
- How can HIV/AIDS be prevented.
- Is it true that a person who loses weight has contracted HIV?
- Treatment of AIDS.
- Mode of spread.
- How someone can live better if infected.
- Why mosquitoes cannot be spread.
- Is it true that if you have TB you have AIDS.
- How to avoid contracting HIV.
- How a baby can be born with HIV/AIDS
- Signs and symptoms
- How long can a person with full blown AIDS can survive?
- Procedure of getting an HIV Test.
- Do hospital and personnel who touch AIDS patients also contract HIV?

TREATMENT

- Dosage.
- Counter-checking if drugs given are correct for their illness.
- Type of medication e.g. injections, tablet or capsule.
- Ask if some drugs kill people.
- Specific drugs/medicine used for treating STDs.
- If a person receiving STD treatment can be cured completely.
- Medications available in the shops for STD treatment.
- Why do STD clients experience leg pains when receiving medications.
- Assistance if one has contracted gonorrhoea.
- Are there medications that cure STDs.
- AIDS treatment if available.
- Could they be supplied with STD drugs without prescription.

CONDOMS

- Where to get them.
- Can they use two condoms for full protection.
- Whether condoms can be used for both family planning and STD/AIDS prevention.
- Female clients ask about female condoms availability and its use.
- It is true that you can not get AIDS by using condoms.
- Condom use.
- Where to buy condoms.
- Supply.
- They ask if it is safe to make a small hole at the tip of condoms so that only sperms can penetrate without direct contact.
- It is true that condoms cause infection/ irritation to genitalia as a result of the lubricant in the condoms.
- Whether it is true that condoms burst during sexual intercourse.
- Is it true that you get diseases even if you wear condoms.
- Advantages of using condoms.
- When condoms rupture can one contract diseases.
- Why do they contract STDs when they use condoms.
- What men can do when girl friends and bar girls refuse to use condoms.
- When can a married couple use condoms.
- What can they do because condoms break.

SAFER SEX

- Better way of not contracting AIDS/STDs.
- Effectiveness of condoms in prevention of condoms.
- Other methods of safer sex apart from using condoms.
- With polygamy it is very difficult to practice safer sex.
- Being faithful to partner.
- Whether using condoms can protect you from contracting STDs.
- If only men keep condoms for protection, what happens to their wives if they meet other men.
- Ways that they can use to ensure safer sex.

Asked to provide drugs

A very high proportion of the non-clinical staff are asked to provide drugs.

- 68% were asked by patients in the unit;
- 80% were asked at home;
- 80% were asked by other members of their communities;

Asked to provide condoms

A very high proportion of the non-clinical staff are asked to provide condoms.

- 76% were asked to provide condoms while they were in the health unit;
- 68% were asked at home;
- 76% were asked by others in their communities.

Formal Training or Informal Instruction

Although quite a few of the staff had received informal instruction on STDs, AIDS, condoms and safer sex, none had received any formal training or education. This might point to the need to formalise education in this regard so that the responses they give people can be consistent with what is said in the rest of the clinic.

Table 48 n=25	Formal training (%)	Informal instruction (%)
STDs	12	68
AIDS	12	72
Treatment	16	48
Condoms	12	67
Safer sex	8	60

In the family and community

They were asked "When you are at home, does anyone in the family, or does anyone in the community ask you about" the following categories. Again, it is noteworthy that such a high percentage are involved both in the communities and in their homes.

Table 49 n=25	Home (%)	Community (%)
For advice/ information about STDs	88	84
For advice/ information about AIDS	92	84
To give or sell them drugs	64	68
To give or sell them condoms	44	64
Safer sex	64	56

The non-clinical staff were then asked to provide examples of what they advise people if asked. The answers all show the importance of ensuring some formal in-unit education to ensure their answers are consistent with those provided by trained staff.

Their answers were as follows.

Advice given to people by non-clinical staff

STDs

- Advise them to avoid multiple partners.
- Use condoms.
- Go to hospital for treatment.
- Abstinence.
- Prevention and treatment.
- Mode of transmission.
- Contacts to come for treatment.
- Safe sex.
- Type of STDs treated at this clinic.
- That STDs can be cured completely except AIDS if one seeks medication early.
- What is STD?
- That STDs are dangerous because they can be transmitted.

AIDS

- Avoid multiple partners.
- Use condoms
- Go to the hospital.
- How to live longer with AIDS.
- Stop cultural practices that assist in transmission of HIV.
- Use different surgical blades during circumcision treatment.
- Mode of transmission.
- Avoid borrowing razor blades, tooth brushes..
- Avoid going to traditional doctors.
- Life span for people with AIDS varies.
- There is no treatment for AIDS.
- Women with HIV infection should not get pregnant.
- AIDS is fatal and incurable.

DRUGS

- Seek medical attention quickly.
- Not to buy medication from the shops.
- Importance of early treatment in STDs.
- Take drugs according to prescribed dosages.
- Importance of bringing a partner for treatment.
- Abstain from sex during STD treatment.
- No drugs for AIDS.
- Where to get drugs.

CONDOMS

- Use condoms to prevent STD/AIDS.
- Go to hospital for supply of condoms.
- Dispose of condoms in the pit latrine.
- One condom at a time.
- Condoms do not cause rash.
- If condoms burst wear two.
- Demonstrates condom use.
- If condoms burst they can contract disease.
- Supplies to other when he has a supply.

SAFER SEX

- Not good to practice polygamy.
- Stop or order men from indulging in sex outside marriages.
- Keep one partner.
- Learn from people dying from AIDS and not indulging in high risk sexual behaviour.
- If one partner has HIV and other has not, advises them to use condoms.
- To come to clinic for advice.
- Abstinence.
- Advises them to use condom .
- Is one of the methods of preventing STDs.

Comments from observers

Finally, the observers were asked to comment on their interviews, such as on the comfort of staff in answering questions. Their answers were as follows:

- Very comfortable.
- Knowledgeable.
- Expressed need for formal education in STD/AIDS.
- Open when answering questions.
- Shy.
- Satisfactory comments.
- Sensitive on question 15 (to give or sell drugs).
- Sincere in his comments.
- Uncertain.
- Confident.
- Alert.
- Very inquisitive to know.

All of the above answers in the interviews with the non-clinical staff point to their importance in the links between clients and health staff — especially with regard to STDs, and their importance as representatives of the health services in their families and communities.

Interviews with managers

21 managers of the 26 units were interviewed. 12 were men, 9 women. The mean age was 37. Their mean length of experience was 11 years (Standard Deviation = 6.98). 13 of them had had an orientation to the Syndromic Management of STDs.

9 felt there was adequate supervision and monitoring of the staff carrying out syndromic management, and 11 did not.

It was their qualitative responses to the questions that were of great interest, and these are reproduced as follows:

What factors have made it easy to adopt Syndromic Management?

- Availability of drugs.
- Training of Providers.
- Less need for lab investigations (reduces congestion in the clinic).
- Treatment of all symptoms at once.
- Availability of treatment guidelines; STD Management manual; desk STD management protocol.
- Availability of flowcharts even for those not trained in SM.
- Free medications for treating STDs..
- Availability of room.
- Privacy.
- Treatment is cheaper.
- Time efficient.
- Good communication with hospital management team.
- Flexibility of the institution for the first time to start distributing condoms on clinical grounds.
- Availability of syndromic in MSTG and prescribers' companion.
- Easy to diagnose.

What factors have made it difficult to adopt Syndromic Management?

- It is time consuming where there is only one provider.
- Drug shortages/at times.
- Difficult follow up of sexual contacts especially commercial sex workers.
- Lack of privacy in the hospital.
- Lack of training.
- Overcrowded consultation areas.
- Shortage of providers.
- Lack of support from management team.
- Lack of examination room.
- Lack of interest from prescribers.
- Limited time especially with counselling.
- None.
- Pressure of work combined with staff shortages.
- It is expensive to run the clinic in terms of time and staffing.
- Non compliance of patients.
- Lack of equipment e.g. speculum.
- Resistance to change.
- Cultural and religious beliefs.
- Drugs are expensive.
- Lack of necessary resources.

What changes have you noticed amongst staff as a result of the use of Syndromic Management?

POSITIVE

- Improvement in diagnosing, treatment and prescribing habits of providers by using counselling skills and treatment guidelines.
- Efficiency in counselling.
- Comprehensive management of cases, diagnoses are not missed.
- Reduced workload on clinicians as providers in FM and Maternity can manage STD patients on their own.
- Confidence.
- None.
- Good drug management amongst staff.
- Staff have developed interest in Health Education on STD.
- Job satisfaction amongst staff.
- Good management of cases even for untrained providers.
- Has not noticed any change because he has not interacted with service providers.

NEGATIVE

- Staff not trained in syndromic management refuse to assist/attend STD clients.
- Untrained staff are no longer taking proper history in the general OPD. As a result all patients with abdominal pain or any problems around the reproductive organs are referred to STD clinic. This causes congestion in STD clinic as providers spend some time treating these cases.

What changes have you noticed amongst clients as a result of the use of Syndromic Management?

POSITIVE

- Increased awareness about disease process, treatment and complications.
- Confidence in coming to STD clinic because of privacy.
- Clients are free to come for follow up.
- Patient satisfaction as a result of comprehensive treatment.
- Clients are free to talk about STDs because of good approach.
- Change in sexual behaviour (talk about it).
- Low attendance of STD Clients.
- Clients come to the hospital for treatment whenever they have STDs as a result of Health Education.
- Improved compliance.
- Free treatment without laboratory tests.
- No changes.

NEGATIVE

- Clients say its not effective especially with GU.
- Not all clients are bringing partners, some refuse.
- Reduced waiting time/delay in receiving treatment as a result of laboratory investigations.
- Clients support notifications slips, good return of partners for treatment.

What could be done in training to improve the syndromic management of STDs?

- Include information on counselling skills for clients who are not responding to Staff Members for HIV Tests.
- External training to non-medical staff as they are in contact with people in the community who are interested in STDs.
- Train all Clinical Officers and Medical Assistants as they are the main prescribers except in rural areas where nurses prescribe.
- Include practicals during trainings in STD clinics.
- More supervision/boost morale.
- Include latent, tertiary and congenital management of syphilis in training.
- After training, providers must be given all the necessary equipment and drugs so that they can perform efficiently (e.g. gloves, speculum, angle poise lamp).
- Train staff at health centres to avoid defaulters resulting from distance as these patients are referred from H/Centres.
- Train all health workers at each institution (training may be through in-service education).
- Stress on practice and more on counselling.
- Training to improve general attitude of staff.
- Create public awareness by training volunteers in the community who will inform members of the public about STDs and its complications and also where they can go for treatment..
- Use more video shows than group discussion as people tend to remember more what they see than hear.
- Concentrate more on signs and symptoms of STD and management..
- Refresher course to review some of the problems faced in clinical area and see how they can be improved.
- Lengthen period of training.

Why (or why not) is there adequate supervision and monitoring of Syndromic Management of STDs? _____

YES it is adequate because:

- A clinician in-charge of the clinic supervises the day to day running of the clinic.
- Periodic supervision.
- Monthly supervision.
- Monitor through monthly returns.
- Through asking questions.
- Manager checks on the staff to see how they are working.
- Through monthly statistics.
- STD Coordinator supervises.
- Through turn up of clients at the clinic.
- Through IEC.
- Through supervisory visits to the clinics.
- Through drug dispensing (Drugs are dispensed by one person).

NO **it is not adequate because:**

- Supervisors do not come to supervise.
- Manager not trained in Staff Members.
- No one has been trained about Staff Members.
- Transport problem for Managers to travel.
- Pressure of work.
- Lack of time.

What are the factors that influence the management of drugs related to syndromic management of STDs? _____

- None.
- Unavailability of drugs.
- Availability of drugs.
- Costs of drugs.
- Misuse of Staff Members drugs.
- Over-prescription due to poor supervision.
- No proper monitoring of drugs.
- Lack of knowledge about STD clinic by manager.
- Security of the drugs.
- Use of STD manual or STD guidelines.

*Do you have any other comments to make about the use of Syndromic Management in your unit?*_____

- If equipment and staff were adequate, staff members would have a very good approach to manage STDs.
- Basically a good idea, however implementation seems to be more difficult than initially assumed.

  Possible reasons:

  No real interest amongst staff – the workshop was especially interesting because of allowances.

  Counselling is not only time consuming but requires a positive attitude. I doubt if this attitude exists.
- It is an excellent initiative.
- Importance of compliance should be emphasised by charging index for partner so that partner is forced to come for treatment..
- Increase and maintain supply of drugs.
- Need for a structure/space for STD Clinic.
- Need for training managers and more providers.
- Frequent supervisory visits by STAFH Project staff.
- Orientation of other members of staff to SM approach include Doctors and Specialists.
- Potential for sexual abuse by male clients to female providers who are providing services alone and privately. Recommendation is to have 2 providers in a room to prevent this problem.
- Increase training period to one week.
- Need for refresher courses.
- Introduce register for follow-up and contacts.
- Messages to reach community as a special programme.