Quality of sexually transmitted disease services in Jamaica: evaluation of a clinic-based approach

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As part of a larger strategy to develop global indicators of HIV (human immunodeficiency virus) infection prevention programmes, a clinic-based method for the assessment of sexually transmitted disease (STD) service quality was developed and field tested by trained observers who visited a random sample of public-sector clinics in Jamaica in October 1991. The assessment included an inventory of equipment and drugs, interviews with clinic staff, and observations of 27 health workers in 15 clinics as they provided services to 115 patients presenting for STD care.

This observation-based method provided Jamaican programme managers with descriptive data on STD case management in public clinics within a one-month study period at an approximate local cost of US$ 5000. Based on weighted estimates, 91% of public-sector STD patients in Jamaica were seen in clinics whose staff had received some training in STD case management during the preceding 12 months. The correct treatment rate was estimated to be 82% for those diagnosed with gonorrhoea, and 70% for those diagnosed with syphilis. Based on 98 observed encounters for first-time-for-episode patients, counselling included sex partner referral (57%), partner reduction (48%), and condom use (59%). Although 61% of STD patients were seen in clinics with condoms in stock on the day of the assessment, only 23% were offered condoms during their visit. The clinic-based assessment method can be adapted to the programme management and reporting needs of countries at all stages of STD service development, and can provide data needed to improve programme operations and meet international reporting standards.

Introduction

Sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) infection and STD-related female reproductive tract infections, are a leading cause of morbidity and mortality worldwide (1–3). The consequences of unchecked STD transmission are particularly severe in developing nations. Good STD case management is a promising strategy for HIV prevention (4); this includes prompt recognition, effective treatment, and provision of education and counselling to STD patients about how to prevent further infection. Experience in STD control and family planning programmes indicates that the assessment and improvement of service quality is an essential part of programme management, leading to more effective and efficient use of resources (5–7). Recent efforts to assess the quality of STD services in the USA have relied on reviews of patient records (8) and simulated patients (9) as data sources. These sources are unavailable in most less-developed countries which need valid, reliable,

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and cost-effective methods for the assessment of STD service quality.

One popular approach to programme assessment is the use of indicators. Indicators, which are quantitative measurements of programme processes, outcomes or impact on health status, should be:

- valid, i.e., giving a true and accurate measure of the phenomenon under study;
- reliable, i.e., the measurement is consistent and dependable across applications or time;
- and directly related to programme activities and anticipated outcomes, such that a change in the indicator can be attributed to programme interventions.

Indicators should be limited in number, readily interpretable, and operationally useful. Their selection and use promote standardization of measures, permitting both tracking of the programme's progress over time and comparisons of programme strategies. Limitations in the use of indicators include the danger that programme resources will be directed to activities likely to drive indicator levels to the exclusion of other programme needs, and that the data needed to report on indicators will supplant the more complete information necessary for effective health programme management.

This paper reports on an effort to identify a limited number of indicators that can be used by programme managers and international technical assistance agencies to monitor public-sector STD control programmes, and to develop and test a quality assurance method for the measurement of those indicators. This field test was part of a larger collaborative effort to develop comprehensive HIV/STD programme indicators involving the United States Agency for International Development, the Global Programme on AIDS of the World Health Organization, the U.S. Centers for Disease Control and Prevention (CDC), the AIDSCOM project of the Academy for Educational Development, the AIDSTECH project of Family Health International, and The Futures Group, and was carried out in collaboration with the Ministry of Health in Kingston, Jamaica.

**Materials and methods**

The method of clinic-based assessment (CBA) combines observations of health care service provision with an inventory of clinic resources in a representa-

dive sample of service sites. These methods have been used for health programme monitoring in both developed (e.g., 15) and less-developed (e.g., 16–18) countries.

We established a working group of experienced STD and international health professionals (epidemiologists, trainers, public health advisers, and social scientists) who drafted the assessment instruments by abstracting key elements of STD case management from the clinical practice guidelines of both CDC and WHO (4, 7, 16). Draft instruments were pre-tested in STD clinics in Atlanta (GA, USA) and in Kingston, and revised as needed. The final observation checklist measured the behaviour of health workers in four performance areas: (1) history-taking and physical examination; (2) use of available laboratory tests; (3) prescription of treatment for specific diagnoses; and (4) education and counselling of STD clients. The instrument used for the assessment of clinic resources relies on direct observation of the facilities and interviews with staff to collect information on their working hours, the number and specialized training of staff, the use of treatment guidelines and laboratory services, and the available basic equipment, drugs and supplies. The protocol was reviewed and approved by the Institutional Review Board of CDC and by the Ministry of Health in Jamaica.

**Description of field test site.** Jamaica was selected as the field test site because the leadership within the Ministry of Health (MOH) was committed to the activity and its international significance, and for its potential to allow timely completion of the field test. Jamaica is the largest of the English-speaking Caribbean islands. In 1990, the population was estimated at 2.4 million (19) and the infant mortality rate at 16/1000 (20). Public-sector primary health care (PHC) is delivered through a network of 168 public health clinics ranging from basic PHC centres in rural areas (without full-time staff) to specialized clinics located in comprehensive outpatient health centres in urban areas.

Since 1988, CDC and USAID have collaborated with the Jamaican MOH to strengthen STD control activities. The majority of clients seeking public-sector care for STDs are seen in the two comprehensive outpatient centres with specialized STD clinics: one in Kingston and one in Montego Bay. At the

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Assessing STD service quality

next level of care are 73 district health care centres. STD contact investigators (CIs) who provide specialized services in STD client counselling, partner notification, and surveillance are assigned to 13 of these 73 centres. In 1990, seven district health centres with CIs and the two specialized clinics accounted for approximately 82% of the STD caseload seen in public-sector clinics (A.R. Brathwaite, reporting unpublished records of the STD Control Programme, 1990). These clinics provide drugs for STD treatment free of charge.

In 1991, the estimated rate of reported syphilis in Jamaica was 103.6 per 100,000 population and the rate of reported gonorrhoea was 488.5 per 100,000. As of November 1992, the Jamaican Ministry of Health had received reports of 419 cases of AIDS, of whom 64% were male. Among 1006 STD clinic attendees assessed between November 1990 and January 1991, 3.1% were found to have antibodies to HIV-1.

Sample. The sampling frame for this assessment was a 1988 list of all public health clinics provided by the Health Information Unit of the Ministry of Health. After including both specialized clinics (Kingston and Montego Bay) in the sample, we stratified the remaining clinics by type of STD service and randomly selected 6 of the 13 district centres with contact investigators, 5 of the remaining 60 district centres without CIs, and 5 of 93 basic PHC centres. A purposive sample of 7 additional basic PHC centres in the Kingston area was added during data collection because only 2 of the 5 originally sampled were open on the day of the assessment. Within each sampled clinic, as many patients as possible were observed sequentially on the day of the assessment visit. In the specialized clinic in Kingston, data collection extended over two days to allow completion of observations for patients unable to finish their initial treatment before the end of service hours on the first day of observation.

Procedures. The Ministry of Health identified five nurses and one physician to serve as research assistants, three of whom had previous experience in research design and data collection. After three days of training, we divided the research assistants into three teams of two. Each team visited one clinic per day. The MOH notified the health district admini-

trators in advance about the assessment, and each research assistant carried a letter of authorization from the MOH.

Data were collected during two consecutive weeks in September and October 1991. CBA teams arrived at each clinic before service hours began. After meeting with the staff member in charge and providing a general explanation of the CBA goals, team members stationed themselves in the clinic to observe clients from the time of their meeting with the first provider until their departure. In some clinics, patients were seen by more than one provider. The first provider read an informed consent statement to each client and obtained verbal agreement before observations began. Only one patient refused to participate (a 28-year-old female who refused observation only during the physical examination portion of the clinic visit).

Each element of the case management process was operationally defined. For example, inspection of the male genitals was assumed to have taken place if the penis was visually exposed to the provider. A patient was considered to have been checked for rashes if the provider asked about the presence of a rash. Observers recorded all drugs prescribed or administered by the clinician. These were then compared with national treatment guidelines and classified as "in accordance" or "not in accordance", based on the drug and dose. The patient was considered to have received a specific educational message if the pertinent information was offered by any one of the providers seen during the clinic visit.

After completing their observations, the teams took an inventory of clinic supplies and drugs and conducted interviews with staff. Availability of supplies or drugs was based on visual confirmation; verbal reports from staff were not accepted as evidence of availability. We assessed inter-observer reliability by having two members of the research team independently record their observations for approximately 20% of provider-client interactions (21). For the inventory and staff interviews, one research assistant administered the instrument while another observed and recorded. Results were then compared and differences reconciled through discussion.

Data entry and analysis. Survey personnel reviewed and corrected each completed CBA instrument before leaving the clinic and at the end of each day when the data were submitted to the study coordinator. We entered and analysed data on a laptop microcomputer using EpilInfo, a standardized data entry, analysis and reporting package for field epidemiology (22). Data cleaning included a review of all variables for out-of-range values, and an item-by-item review of a 10% sample of the questionnaires. We

\[d\] Reported annual incidence of syphilis and gonorrhoea, Jamaica, Kingston: Epidemiology Unit, Ministry of Health, 1992.


\[f\] Epidemiology Unit, Ministry of Health, Jamaica, unpublished data.
found data entry errors in fewer than 1 in 100 computer fields.

Preliminary analyses included frequency distributions for all variables, cross-tabulation of performance measures by type of clinic, and selected analyses for client subgroups (e.g., those with specific diagnoses, those seen at clinics with and without condoms or gloves in stock, etc.). All results were initially presented by clinic type for use by Jamaican programme managers.

Results from the different types of clinics (i.e., specialized clinics, district health centres with and without contact investigators, and basic PHC centres) were combined to provide an overall estimate of the quality of STD service delivery in public clinics in Jamaica. We weighted the CBA data (both observations and data on clinic resources) based on the estimated annual STD caseload within each clinic type (Table 1). Weights were calculated separately for data on drug availability, to account for missing data in clinics where pharmacies were locked and therefore unavailable for inspection on the day of the assessment. Although the presence or absence of drugs on a single service day cannot be used as a measure of their availability throughout the year, the results can indicate whether a problem exists. If drugs are not available on the day of the assessment, the programme managers need to conduct a more thorough investigation of the situation to determine the nature and extent of the problem and to take appropriate remedial action.

Results

Among the 18 clinics in the original sample, 15 were open for services on the day of the CBA team visit. The closed clinics were all basic PHC centres. A total of 115 patients were observed while receiving care from 27 different providers in 10 clinics. They were observed in both specialized clinics and in five of the six district clinics with contact investigators. In two of the five district health clinics without CIs, and in both of the basic PHC centres without CIs, no patient presented for STD care on the day of the CBA visit. The lack of STD clients in basic PHC centres was confirmed through visits to seven additional centres. Only two of the nine centres were open for service on the day of the visit, and neither had seen a client presenting with STD symptoms in the previous month.

Of the observed patients, 47% (54/115) were male. The mean age of all patients was 25.4 years (S.D. 9.34), and ranged from 13 to 72 with a median of 23 years. The clinic visit was reported to be the first for a current symptomatic episode for 85% (98/115) of persons observed. Among the remaining patients, 4% (5/115) were asymptomatic contacts of previously identified cases and 10% (12/115) were seen for follow-up. The results reported below are limited to "first visit for episode" patients (n = 98).

The most frequently presenting complaints among patients with a new episode of STD included urethral discharge (71%), dysuria (40%), and genital ulceration (21%) among men, and vaginal discharge (87%), lower abdominal pain (56%), and dysuria (50%) among women. Genital ulceration was reported by 6% of women presenting with a new episode of STD. Distributions of presenting complaints were evaluated using a Mantel-Haenszel summary chi square and found not to be significantly different for all clients vs. clients presenting with a new episode of STD among men ($\chi^2 = 0.03, P = 0.87$) or women ($\chi^2 = 0.05, P = 0.83$). Approximately one-third (36.5%) of all patients presented with multiple complaints.

Fig. 1 presents results on the availability of staff, treatment guidelines, and supplies at each clinic, weighted to reflect annual STD client volume by type of clinic. Clinics with high STD caseloads were more likely than those serving fewer STD patients to

<table>
<thead>
<tr>
<th>Clinic type</th>
<th>All clinics (n = 15)</th>
<th>Clinics examined for drug stocks (n = 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of visits</td>
<td>Weighting</td>
</tr>
<tr>
<td>Specialized</td>
<td>42 250</td>
<td>0.751</td>
</tr>
<tr>
<td>District, with contact investigator</td>
<td>10 764</td>
<td>0.191</td>
</tr>
<tr>
<td>District without contact investigator</td>
<td>3 224</td>
<td>0.057</td>
</tr>
<tr>
<td>Total</td>
<td>56 238</td>
<td>0.999</td>
</tr>
</tbody>
</table>
have the necessary resources and training for appropriate STD case management. For example, while only 12 of 15 clinics had one or more staff members present who reported that they were qualified to treat STD, these 12 clinics accounted for 99% of the estimated annual public-sector STD caseload. Staff were able to produce treatment guidelines in 13 of the 15 clinics, representing 96% of the annual STD caseload in public-sector clinics. Nine of the 13 clinics with treatment guidelines were able to show the interviewer the manual recommended by the Jamaican MOH (23), and the remainder offered a variety of published and unpublished handbooks.

Every clinic had at least one speculum. One district health clinic had no gloves in stock on the day of the assessment (accounting for 3% of annual public-sector STD caseload), and the specialized clinic in Montego Bay and two district health clinics had no condoms (accounting for 39% of annual caseload). Some STD clinics obtained condoms for distribution from family planning service providers; shortages of condoms were more likely to be documented in clinics that did not also offer family planning services.

Estimated proportions of public-sector STD patients seen in clinics with on-site capacity to perform Gram stains and wet preparations are presented in Fig. 1; all other tests (including serology) were sent for processing to a laboratory outside the clinic. Staff in each clinic where observations were conducted were asked to describe the drugs used in treating adult men or non-pregnant women for each of five common STDs, the routes of administration, the dosages, and to show the interviewer stocks of the first-choice drugs sufficient to treat one client. Stocks were inspected in 11 clinics; in the other four clinics (three district centres and one basic PHC centre), stock inventories could not be taken because pharmacies were locked and no staff member present had a key. CBA observations were conducted in only one of the four clinics where drug stores were unavailable; clinics where inventories were taken accounted for 98% (113/115) of CBA observations. Among the clinics inspected, eight had available the first-choice drug they identified for gonorrhea (accounting for 58% of the annual public-sector STD caseload), ten had the drug for primary syphilis (100% of annual caseload), seven the drug for chancroid (52% of annual caseload), seven the drug for non-gonococcal or non-specific urethritis (49% of annual caseload), and six had the drugs for pelvic inflammatory disease (9% of annual caseload, with neither of the two comprehensive clinics having

Fig. 1. Characteristics of public-sector STD clinics, with weighted percentage of patients, Jamaica, 1991.

Fig. 2. Details of history-taking and examination of patients in public-sector STD clinics, with weighted percentage of all STD patients, Jamaica, 1991.

<table>
<thead>
<tr>
<th>Characteristics of public-sector STD clinics with</th>
<th>Weighted percentage of patients, Jamaica, 1991.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff able to prescribe treatment</td>
<td>99</td>
</tr>
<tr>
<td>Treatment guide</td>
<td>96</td>
</tr>
<tr>
<td>Counselling guide</td>
<td>86</td>
</tr>
<tr>
<td>Trained staff</td>
<td>91</td>
</tr>
<tr>
<td>≥ 1 speculum</td>
<td>100</td>
</tr>
<tr>
<td>≥ 1 pair of gloves</td>
<td>97</td>
</tr>
<tr>
<td>≥ 1 condom</td>
<td>61</td>
</tr>
<tr>
<td>On-site Gram staining</td>
<td>81</td>
</tr>
<tr>
<td>On-site wet preparations</td>
<td>38</td>
</tr>
<tr>
<td>Patients clinically examined</td>
<td>94</td>
</tr>
<tr>
<td>Provider wore gloves</td>
<td>86</td>
</tr>
<tr>
<td>Checked for rash</td>
<td>70</td>
</tr>
<tr>
<td>Patients asked about:</td>
<td></td>
</tr>
<tr>
<td>STD symptoms</td>
<td>100</td>
</tr>
<tr>
<td>History of STD</td>
<td>75</td>
</tr>
<tr>
<td>Use of medications</td>
<td>48</td>
</tr>
<tr>
<td>Health of partner</td>
<td>39</td>
</tr>
<tr>
<td>Allergies</td>
<td>27</td>
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appropriate drugs available). Data on the distribution of STD diagnoses, by type of clinic, are not available for comparison with the results on drug availability.

Fig. 2 presents the weighted results on provider performance in client assessment. High proportions of public-sector STD patients were asked about their STD symptoms and history, and underwent clinical examination. Information on current use of medications, the health of sex partners, or allergies was requested from less than 50% of patients, and only 70% were asked about the presence of a rash. Providers wore gloves during 86% of physical examinations. Among the 13 patients who were examined without gloves, three were seen in a clinic where no gloves were available on the day of the assessment.

Judgements of correct treatment were based on either prescription or administration of appropriate drugs for the provider's diagnosis, and were therefore independent of available drug supplies. However, some staff may have avoided prescribing drugs they knew were not available in the clinic or community. Of the patients diagnosed with gonorrhea, 74% (20/27) were prescribed or given treatment in accordance with Jamaican guidelines. When weighted to reflect annual STD caseloads at each type of facility assessed, the correct treatment rate for gonorrhea was 82% among public-sector STD clients. Similarly, six of nine (67%) patients diagnosed with syphilis were prescribed or given appropriate treatment, representing a weighted correct treatment rate of 70%. One patient was diagnosed with chancroid and prescribed appropriate treatment.

Fig. 3 presents observation-based results on the provision of specific education and counselling messages to patients. Weighted estimates are that 57% of public-sector STD clients were asked by providers to refer their partners for treatment, 48% were told that having fewer partners can be an effective STD risk-reduction strategy, and 59% were presented with condom use as a risk-reduction strategy; 30% of patients were asked by the provider whether they had any questions. Condoms were offered to 23% of patients during their clinic visit. Among the 80 patients not offered condoms, 15 were seen in clinics with no condoms in stock on the day of the assessment.

We completed independent dual observations for 21 of 115 observations (18.3%). There were 24 discrepancies among a total of 1008 checklist items, yielding an inter-observer reliability rate for the period of data collection of 98 per 100 observations. Error analysis revealed clustering of discrepancies on checklist sections related to the identification of presenting symptoms (6 discrepancies) and the provision of specific educational messages (7 discrepancies).

### Discussion

The CBA results indicate that the infrastructure for public-sector STD service provision in Jamaica is generally strong. Most clients seeking care for STD in these clinics will find that the needed equipment and first-choice medicines for common STDs are available, and that the treatment prescribed conforms with national (and international) standards. Aspects of provider performance that need improvement include in-depth history-taking, treatment of syphilis, the provision of education and counselling, and the distribution of condoms. Of particular note is the discrepancy between the availability of condoms (61% of STD clients are seen in clinics with available stocks of condoms) and their distribution (only 23% of STD clients were offered a condom during their clinic visit).

MOH staff in Jamaica put the findings of the assessment to immediate use in improving their programmes. The results have been used in the preparation of revised clinical practice guidelines, in training sessions for MOH personnel, and as the basis for an intersectoral meeting to assess programme operations and develop revised programme plans.

This observation-based method provided Jamaican programme managers with descriptive data on STD case management in public clinics within a one-month study period at an approximate local cost of US$ 5000. Roughly two-thirds of the in-country costs were salaries for the research assistants. The remaining funds were spent for transportation of field teams and reimbursements for their hotel and...
meal expenses during required overnight stays. Although considerable technical assistance was offered during this first field trial of the method, representatives of the Jamaican MOH report that the CBA would be replicable at the cost of US$ 5000 with only minimal external technical assistance in data analysis and reporting.

The CBA results are limited in two ways. First, we assessed case management only in public health clinics. The original STD service assessment proposal recommended a sampling frame including the full range of STD care providers: public, private (e.g., nongovernmental clinics, pharmacists, physicians in private practice, hospital emergency rooms) and informal (e.g., traditional healers, street vendors). Data on the distribution of care sources were to be collected through a population-based survey. However, a preliminary survey obtained little information on sources of STD care other than medical professionals, and the number of respondents reporting STD symptoms was very small.9

Second, there are a number of STD programme elements that were not addressed in the assessment. These include: (1) the quality, accessibility, and responsiveness of laboratory services; (2) correctness of the diagnosis; (3) case follow-up to determine the response to therapy; (4) partner notification services beyond the provision of client education or counseling during the single clinic visit; (5) demand for and access to services; and (6) clinic management and staffing. Cost-effective methods to evaluate these elements are needed to complement data on health worker practices and clinic resources provided by the CBA method.

As a result of the field test, we are able to make several proposals for future applications of the CBA method. First, a revised CBA protocol should include a more general review of national STD programmes conducted by STD programme managers as a first step. This programme review should include a qualitative assessment of national policy and practice guidelines, sources of STD care in both the public and private sectors, preservice and in-service training systems for STD service providers, laboratory facilities and associated quality-control strategies, the availability (to providers and the public) of affordable condoms and drugs for STD treatment, and the health information system. Review of the health information system is particularly important, as some information on diagnosis, testing and referral practices can be abstracted from records if adequate data are available. Assessments at the national level will help programme managers decide when public STD services are sufficiently developed and available to warrant a clinic-based study of service quality, and can serve as a basis for the development of an appropriate sampling frame.

Second, complementary methods should be developed to assess the quantity and quality of STD services in private and informal settings. Quality assurance in public clinics is recommended as a starting point for most STD control programmes in developing countries, where health services of any type are limited and the public sector is the primary source of care.

Third, in settings where data on STD client visits are available by type of clinic, stratified random sampling can be used to select self-weighting samples of clinics based on the annual number of STD clients seen at each clinic type. This would simplify the method, ensuring that observations are conducted in clinics proportional to their STD service volume and avoiding the need to weight the data during analysis.

Fourth, the procedure for recruiting clients for observation should be modified slightly, so that individuals presenting for STD services are identified at the time they present at the registration desk, rather than during their first contact with a provider. This would ensure that clients who present but fail to obtain service are documented as part of the assessment.

Finally, although use of a limited set of indicators provides a meaningful and valid overview of the quality of STD case management, some difficulty arises in selecting a small set of indicators that is sufficiently comprehensive to provide a valid profile of the STD service system. By definition, indicators are designed to serve as a sensitive signal to problems in programme operations, and cannot substitute for fuller, in-depth operational research or supervisory systems that provide complete management information. Cross-national standardization of indicators will require further field tests and the adaptation of internationally accepted case management protocols (e.g., 4, 15) to the needs and constraints of specific country settings. Based on this first field test, we recommend that multiple discrete indicators be retained for use by district and national programme managers, and that cross-national reporting of indicator data be accompanied by full descriptions of sampling procedures and CBA methods used in each country.

Quality assurance methods like those described here can contribute to the public health goal of reducing the transmission of STDs, including HIV infection, by alerting programme managers to the

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9 We used two supplementary methods (focus groups and exit interviews with STD clients) to assess the range of STD care providers other than public clinics; full descriptions of these efforts are available from the authors.
needed improvements in STD service provision. This field test has demonstrated that clinic-based assessments of the quality of STD case management in public health facilities in developing countries are feasible, and that they can provide information which STD programme managers need for continued programme development. Monitoring of service quality indicators is an essential part of programme management, and further effort in refining indicators and methodologies for STD service assessment are urgently needed.

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Résumé

Qualité des services de lutte contre les maladies sexuellement transmissibles à la Jamaïque: évaluation d'une méthode fondée sur l'observation des services cliniques

Cet article rend compte d'une étude de terrain menée à la Jamaïque en octobre 1991 pour évaluer la qualité des services de lutte contre les maladies sexuellement transmissibles (MST). Les méthodes d'assurance de la qualité — comme celle qui est décrite ici et qui est fondée sur l'observation des services cliniques — peuvent contribuer à réduire la transmission des MST, y compris l'infection à VIH, en appelant l'attention des administrateurs de programmes sur les améliorations à apporter aux services de lutte. L'évaluation a porté sur les points suivants: inventaire du matériel et des médicaments, entretiens avec le personnel clinique et observation du travail de 27 agents de santé lors des soins prodigués à 115 patients atteints de MST dans un échantillon stratifié de 15 dispensaires de santé publique. Afin de donner une valeur plus générale aux résultats obtenus, ceux-ci ont été pondérés en fonction du nombre annuel de cas de MST observés dans chaque type d'établissement.

Il ressort de ces estimations pondérées que 91% des patients du secteur public atteints de MST ont été examinés dans des dispensaires dont le personnel avait reçu une certaine formation sur les MST au cours des 12 mois précédents. Tous les dispensaires possédaient des spéculums, 3% seulement des patients ont été examinés dans des dispensaires qui ne disposaient pas de gants et 61% l'ont été dans des dispensaires qui avaient des préservatifs en stock. Tous les patients ont été interrogés sur les symptômes de MST qu'ils présentaient, 48% sur la prise récente de médicaments, 39% sur la santé de leurs partenaires sexuels et 27% sur une éventuelle allergie aux médicaments. Un examen physique a été pratiqué sur 94% des patients et la présence d'un rash cutané a été recherchée chez 70% d'entre eux. Dans 86% des cas, le personnel qui pratiquait les examens portait des gants. Sur une base annuelle, le pourcentage de traitement correct s'établit à 82% pour les patients du secteur public chez lesquels une gonococcie a été diagnostiquée et 70% en cas de diagnostic de syphilis. Il a été conseillé à 57% des patients de demander à leurs partenaires sexuels de se faire traiter; 48% d'entre eux ont été informés que la réduction du nombre de partenaires pouvait réduire le risque de MST et 59% qu'ils pouvaient se protéger contre ces infections en utilisant des préservatifs; des préservatifs ont été proposés dans 23% des cas.

L'enquête a donné des résultats fiables qui se sont révélés utiles pour les administrateurs de programmes et elle a été bien acceptée par les patients. Lors des applications futures de la méthode, il est recommandé d'ajouter une évaluation du programme national de lutte contre les MST au protocole d'étude, d'utiliser des procédures d'échantillonnage autopondérées en fonction du nombre de cas de MST observés dans les différents types de dispensaires de santé publique, d'élaborer des méthodes complémentaires pour évaluer le traitement des MST par des praticiens privés ainsi que les modes de traitement non officiels et de continuer à utiliser des indicateurs multiples pour évaluer les performances des dispensateurs de soins. Cette méthode peut être adaptée aux besoins de gestion des programmes de tous les pays, quel que soit leur état de développement; en outre, elle peut fournir les données nécessaires pour améliorer le fonctionnement des programmes et satisfaire aux normes internationales en matière de notification.

References


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