A CASE STUDY ON THE QUALITY OF CARE FOR SEXUALLY TRANSMITTED DISEASE PATIENTS: THE NURSING PERSPECTIVE

By

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Submitted in fulfilment of the requirements for the Degree of M.A. Curationis, Nursing Science Department, University of Zululand

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DEDICATION

This work is dedicated to:-

(1) The Students' Health Service and nursing personnel of the University of Zululand with the hope that it will help to improve the health service for students, particularly those presenting with sexually transmitted diseases.

(2) Community health and clinical nurse specialists as a motivation for further research work.

(3) My parents who laid in me the foundation of what I am today.

DECLARATION

I, BEQUIET NOMUSA VILAKAZI, hereby declare that "A CASE STUDY ON THE QUALITY OF CARE FOR SEXUALLY TRANSMITTED DISEASE PATIENTS: THE NURSING PERSPECTIVE" is my own work in conception and creation. All sources that have been used or quoted have been indicated or acknowledged by means of complete references.

MISS B.N. VILAKAZI

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ABSTRACT

This is a non experimental case study of nursing intervention in respect of students of a tertiary institution in Kwa-Zulu Natal. The overall aim was to assess and evaluate the quality of management and care of sexually transmitted disease (STD) patients. The study was anchored on the nursing process using structure, process and outcome of the Donabedian's model of Quality Assurance Process.

The target population was students residing at this institution's main campus in the 1995 academic year. Questionnaires and checklist schedules were used to examine and evaluate the Students' Health Service structure process, outcome and Health education regarding the management and nursing care of STD patients. A sample of 300 students was incidentally chosen, which constituted 10% of the target population. However, due to failure to return the research tools and the fact that some questionnaires were spoilt, ultimately 230 questionnaires were processed. All the objectives of the study were met. The findings were:

- Structure of the Health Centre is of good quality
- Process of management of STDs ranges from satisfactory to good quality
- Outcome of intervention is regarded as not so good
- Health education is seen as varying from satisfactory to good.

The findings of this study had implications for authorities of the institution under study, the nurses providing care in this institution, the consumers of health care at this institution, as well as for the government. Several recommendations were made in line with the findings.

OPSOMMING

Hierdie was 'n nie-eksperimentele gevallestudie van verpleegsbemiddeling ten opsigte van studente van 'n tersiêre opleidingsinstituut in Kwa-Zulu Natal. Die oorhoofse doel was om die gehalte van die bestuur en versorging van pasiënte met seksueel oordraagbare siektes (SOS'e) vas te stel en te evalueer. Die studie is op die verpleegproses gebaseer en maak van die struktuur, proses en uitslag van Donabedian se model vir Gehalte Versekering, gebruik.

Die teikenbevolking was studente wat gedurende die akademiese jaar 1995 op die hoofkampus van hierdie instituut woonagtig was. Vraelyste en kontrolelyste was gebruik om die Studente Gesondheidsdienste se struktuur, proses en uitslag asook die gesondheidsopvoeding met betrekking tot die bestuur en versorging van SOS pasiënte vas te stel en te evalueer. 'n Steekproef van 300 studente was willekeurig gekies, wat 10% van die doelgroep uitmaak. Daar is egter, as gevolg daarvan dat alle navorsingsmateriaal nie teruggestuur is nie en die feit dat sommige vraelyste bederf was, slegs 230 vraelyste geprosesseer. Al die doelwitte van die studie is nagekom. Die bevindings was:

- Die struktuur van die Gesondheidsentrum is van *goeie gehalte*.
- Die bestuurproses van SOS'e wissel van *bevredigend* tot van *goeie gehalte*.
- Die uitslag van die intervensie word as *minder bevredigend* beskou.
- Gesondheidsopvoeding wissel van *bevredigend* tot *goed*.

Die bevindings van hierdie studie het implikasies vir die owerhede van die bestudeerde instituut, die verpleegsters wat dienste lewer by hierdie instituut, die gebruikers van gesondheidsdienste by hierdie instituut, sowel as vir die regering, gehad. Verskeie aanbevelings was in ooreenstemming met die bevindings gemaak.

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CHAPTER 1

ORIENTATION TO THE STUDY

BACKGROUND INFORMATION

Sexually transmitted diseases (STDs) are a group of highly contagious diseases transmitted through sexual contact. A study undertaken by Caliandro and Judkins (1988) indicates that there are; at least twenty diseases considered to be sexually transmitted. Among these; syphilis and gonorrhea are the primary venereal diseases. In the Republic of South Africa; regulations under the Health Act No. 63 of 1977; classify syphilis, gonorrhoea, chancroid, urethritis, genital herpes and vaginitis as sexually transmitted diseases. These diseases are considered to be a major cause of morbidity and even mortality (Kassner, 1988).

STDs, especially syphilis and gonorrhoea are becoming a major health care priority in South Africa. A study conducted by Morton (1976) estimates that over one million patients seek medical treatment for STD each year at health care centres, doctors' private practices, hospital out-patient departments and primary health care clinics. The above author further states that in the United States of America; it is confirmed that someone develops gonorrhoea every fifteen seconds and the numbers are increasing. The World Health Organisation (WHO) states that over 250 million persons are infected with gonorrhoea and 50 million with syphilis (Bradley, 1987). These statements prove that STDs are a worldwide public health problem and are becoming a major health care priority all over the world.

There appears to be a strong belief that STDs are the diseases of the adolescents and the young adult population. A study conducted by Flemming (1993) confirms that women are infected more often and earlier in life than men. The age ranges between 15 and 24 years. Kassner (1988) in his report qualifies the main sufferers as young educated members of the community and university students become a good example.

It is essential to note that STDs in females are a cause of pelvic inflammatory disease, infertility, ectopic pregnancy, cervical cancer and endometritis. If the woman is pregnant; STD can result in premature labour, abortions and intra-uterine death. In males; these diseases may lead to urethral strictures, prostatitis and epididymitis (Schneider, 1995).

Alongside the serious complications of the STDs; is the incidence of Human Immuno deficiency virus (HIV) and the Acquired Immunodeficiency Syndrome (AIDS) infections. In South Africa, Flemming (1993) regards HIV to be as highly transmittable during adolescence stage; between 15 and 24 years of age. According to the first national survey (October/November, 1990) of women attending ante-natal clinics; the prevalence of these diseases by regions was the highest in the Natal/Kwa-Zulu at 2.87 percent; followed by Orange-Free State 1.45 percent and Transvaal to 1.11 percent and by population groups, Blacks were the worst affected at 1.84 percent (Flemming, 1993). Van Niftrich (1993) states that there is neither vaccine, nor cure for HIV and AIDS. While the WHO contends that there could be at least 30 million people around the world infected with AIDS and HIV by the year 2000; Van Niftrich (1993) puts the number even higher and predicts 110 million people.

STDs can be prevented to a large extent through; among other things, sex education. There seems to be no sex education in Government schools, technicons and universities in South Africa. Flemming (1993) indicates that there has been repeated pleas from highly placed professionals for sex education programmes to be introduced; but to date nothing is in place in government schools and universities. Sex education in schools and universities for Black people is perceived by the Black society to promote premarital and extramarital sexual intercourse (Flemming, 1993).

The rising incidence of STDs and the prevalence of HIV and AIDS makes it imperative that a study on the quality of nursing intervention to STD patients be undertaken. The study will look at the quality of nursing intervention in order to try and improve the care as well as its feasibility for patients coming forward for prevention and early counselling; which in turn can reduce the incidence of STDs.

STATEMENT OF THE PROBLEM

The institution under study will remain nameless for the purpose of anonymity. In this institution, the Students' Health Service renders health care for students including those with STDs. Records show that the incidence of STD is increasing. The noticeable increase is in those who come for repeat visits or who return for treatment of the same condition after the initial visit. The age of these STD patients ranges between 15 to 35 years. This arouses concern that the high number of repeat visits may be due to a low quality nursing intervention in the management of STD patients. The figures below indicate the incidence of STD patients as revealed by this institution's Health Service Annual Reports from 1990 to 1995.

TABLE 1.1: ANNUAL FIGURES OF STUDENTS WITH STDs FROM 1990 - 1995

YEAR	MAIN CAMPUS FULL TIME RESIDENT STUDENTS	INCREASE PER ANNUM	CLINIC VISITS BY STD PATENTS INCLUDING REPEAT VISITS	INCREASES PER ANNUM
1990	2,674	-	410	-
1991	3,150	476	520	110
1992	2,916	234 (decrease)	180	430 (decrease)
1993	3,172	256	420	240
1994	3,786	614	610	190
1995	2,790	996 (decrease)	810	200

The above statistics show the prevalence of STD patients visits to the Health Centre during the six successive years. The visits by these patients in 1991 were increased by 110. In 1992 the student body was decreased by 234 with a corresponding decrease of visits by 430. In 1993, there was an increase by 256 students; as a result STD patients' visits also increased by 240. In 1994 the number of students went up by 614; the

number of visits also went up by 190. In 1995 first semester; STD patients' visits were already 410; though students registered as full time had decreased by 996 to 2,790. The possibility of STD patients being doubled by end of 1995 academic year became a reality when the end of the year number of visits came up to 810. The increase has been 200 (Students' Health Service Reports, 1990 to 1995). This is unacceptably high.

Statistics from other institutions were not available owing to policies regarding management and treatment of STD patients. It was therefore, not possible to compare the seriousness of this issue among different institutions. It was established that in some of the institutions in Kwa-Zulu Natal; a community health nurse does not play a major role in the management of STD patients. Only a doctor decides to treat or refer STD patients to a special clinic for STD in town.

In the institution under study the researcher discovered that some of the students are diagnosed as having STDs and receive treatment; but it appears as if their sexual partners are not available for treatment. Some partners are at home; while others are employed elsewhere. Therefore, the problem being addressed in this study is what is the quality of STD care; to what extent does this type of care contribute to the unabating incidence of STD among students of this university?

MOTIVATION FOR THE STUDY

The researcher was motivated by a number of factors to conduct the study. These factors are:

- The researcher's involvement in the management and care of students at this institution's Health Service since 1985. The duration of this involvement constitutes a great deal of exposure in the field of students' health problems.

- The unabating number of students with STDs reporting at the Health Service.

- The close association of STD with HIV/AIDS which is not only highly contagious but also incurable and fatal.

- The high risk of STD patients among university students becoming HIV positive.

- Therefore; the quality of nursing care provided by this institution is questionable with regard to STD patients. The quality of care is manifest in the structure of the Health Service; the process of the management of STD patients and the outcome (evaluation) of the service rendered (Stanhope and Lancaster 1988; Brown, Franco, Rafeh and Hatzell, 1990).

SIGNIFICANCE OF THE STUDY

Assessing the quality of nursing intervention in the context of primary health care is a challenge to any community health nurse treating STD patients; especially because HIV is being transmitted alongside the STD at high rates in Africa in general and in Kwa-Zulu Natal in particular.

Another value of this study lies in its possible effect on the improvement in the quality of nursing care offered by this institution. Consequently, the problem, not only of STD; but of other ailments will be properly addressed.

A scientific research on the health unit of this institution will assist the university strategic planners to develop a comprehensive health policy that would cater for a growing university student community. Further, university students' health should be seen as part of the university's goal; by ensuring a sound and effective community health service; as well as effective nursing care which should be an ideal to be pursued.

A preliminary literature review revealed that studies in this area have been and are still being undertaken. There was a study undertaken in Jamaica that assessed the management of STDs at clinics by means of direct observation. This study had a number of STD programme elements that were not addressed during the assessment phase; such as service accessibility and partner notification services (Bryce, Verhan,

Brathwaite, Perry, Figueroa and Emerson, 1994). The study in progress will ensure that accessibility of service to students and the partner - notification system are addressed so as to improve the management of STD patients.

Another study was on the development of a strategic plan conducted by the National Aids Committee of South Africa (NACOSA). The aim of this study was to reduce the impact of HIV/AIDS and STD epidemic in KwaZulu Natal. Through this study; the Provincial AIDS Implementation Plan was developed. The plan is in the process of identifying preventive activities and all other activities aimed at reducing the impact of the epidemic of these diseases (NACOSA, 1994).

A current study by the McCoy and Coleman (1995) is focusing on an assessment of the management of STDs and how it may be improved in a Health Ward located in Northern Kwa-Zulu Natal. The main purpose of this study is to describe and assess all the health services and health care providers who manage STDs in this Health Ward.

Schneider (1995) states that it is not enough for STD services to continue concentrating on diagnosis and treatment of STD patients. A holistic approach is required; which will embrace prevention, accessibility to health care centres, diagnosis, treatment, counselling, contact-tracing, health education, data collection and the empowerment of individuals to protect themselves from infection. All this needs to be integrated into an appropriate sustainable Primary Health Care approach; which will form the basis for the future provision of South Africa's health needs.

An important factor in the successful implementation of a Primary Health Care service for STDs is the correct understanding and approach to STDs by all the health care providers themselves. These health personnel should have a sound understanding of public significance and importance of STDs. Ignorance, misinformation and misunderstanding about STDs must be identified and minimised amongst health personnel.

The study in progress focuses on university students who are probably our future community leaders. The intention is that findings of this study should make it possible to prevent the uninfected student population from becoming infected and to ensure that those who have the infection are diagnosed and treated adequately to prevent complications of STDs especially AIDS which is a killer disease. The concern is that;

university students are a group of young adults who are more sexually active and that HIV as well as AIDS infections continue to be more common especially in KwaZulu-Natal (NACOSA, 1994).

Therefore, this research study is related to the foregoing studies. However its significance lies in the fact that it is filling a gap created by the absence of research on the quality of STD service to university students. These students are a vulnerable target population especially in a permissive society where freedom of choice is receiving more emphasis than before. This research can form the basis for further research in this area.

OBJECTIVES OF THE STUDY

The overall objective of this study is to assess and evaluate the quality of management and nursing care of STD patients. The study should attain the following objectives:

- To establish health education content and methods used at this institution's Health Service to contain STDs.
- To establish the extent of counselling and tracing of sexual contacts of people diagnosed with STDs.
- To establish the extent to which the nursing process is applied for nursing care of STD patients
- To establish if early diagnosis is made and appropriate treatment commenced.
- To investigate the preventive and screening measures used to detect and eradicate STDs.

DEFINITION OF CONCEPTS

Sexually transmitted diseases

These are communicable diseases transmitted or spread by sexual intercourse - for example, syphilis, gonorrhoea, genital ulcers (Berkow, 1977; Caliandro & Judkins,

1988). In this study the concept sexually transmitted diseases will be used for all those infectious diseases that are spread by way of sexual contact between two people of opposite sex.

Quality

The concept "quality" refers to the degree to which something is excellent or the standard is good. Brown **et al** (1990) defines "quality" in the light of the provider's technical standards and patients' expectations by explaining "quality" as the extent to which care provided is expected to achieve the most favourable balance of risks and benefits. In the study; the concept "quality" will mean the effectiveness, efficiency and economy within which delivery services are rendered. The benefit of such services in the final analysis gives rise to patients' satisfaction as well as the providers of human and material resources; with the ultimate goal of reducing the disease incidence.

Nursing intervention

Pinnell and De Meneses (1986) regard nursing intervention as any action that prevents harm from occurring to a patient. This action needs to maintain and improve the mental, physical or psychological function of the patient. Balecheck and McCloskey (1985) define nursing intervention as an autonomous action based on the scientific method for the benefit of the patient. In the study, nursing intervention will mean all nursing care or action in the management of students with STDs aimed at lowering the incidence of these diseases

Health Service

Searle (1987) regards health service as the process of all the acts related to keeping the particular body function in action in any and every situation throughout the life span of each individual and these acts are undertaken by health care providers. In this study, the term: health service must be understood to refer to Students' Health Service of the institution that is being studied. The term Students' Health Service is used in most tertiary institutions. Further in this study, the term Health Service will be used interchangeably with Health Centre seeing that in a few Health institutions, the term Health Centre is used.

CHAPTER 2

LITERATURE REVIEW

INTRODUCTION

Literature reviewed on STDs show that these diseases are highly communicable and are a major public health problem in South Africa; not only in the university situation. This Chapter consists of an exposition of information gathered from published and unpublished literature. The researcher perused published books, journal articles, research reports, official reports and documents, media reports as well as institutional documents, policies and reports.

An attempt was made to consult both recent and not so recent documents and publications; local, regional, national literature as well as literature from other countries and in particular the World Health Organisation (WHO) and the Department of National Health and Population Development. Concepts that were used to guide reading were - STD and HIV/AIDS, role and function of a community health nurse as a clinical nurse specialist, Primary Health Care and nursing intervention. This Chapter is organised around the following subtopics:-

- Background of HIV/AIDS and the present statistics
- Incidence of STDs
- Types of STDs
- Aetiology, clinical features, complications, diagnosis and treatment of STDs
- Health Policy in the management of STDs
- Management of STDs using World Health Organization's (WHO) strategies
- The framework of concepts and Primary Health Care Approach (PHCA)
- The need for a clinical nurse specialist in community health nursing in general and STD management in particular
- Theoretical framework

BACKGROUND OF HIV/AIDS AND THE CURRENT STATISTICS

The major cause for concern in South Africa is the pressing need for health education in all spheres regarding HIV/AIDS - the silent epidemic. AIDS is discussed here because it is one of the serious and fatal types of STDs. Gomes (1995) indicates that AIDS is set to become South Africa's greatest killer but most unfortunately the virus causing such a disease cannot be tried or sentenced in court. According to the above author; in KwaZulu-Natal the virus is transmitted to 500 new victims almost every day. In ten years time it is believed that most of these people will be killed by HIV/AIDS. In the report of a study by Whiteside, Wilkins, Mason and Woods (1996) it is estimated that the number of AIDS burials per day in the year 2000 would be 574. By the year 2014, the number of burials would be three times the number expected with AIDS epidemic. In KwaZulu-Natal the Health Systems Trust (1996) points out that one in ten people are already affected by HIV and the incidence is high amongst fifteen to thirty year olds. Kristner (1994) reports that there were 750 AIDS victims in 1993 and 990 victims in 1994.

The Health Systems Trust (1996:7) indicates that 17 million people are estimated to be infected with HIV worldwide. The Director of the National AIDS Training and Outreach, Doctor Sher states that there could be 23 million HIV sufferers in South Africa by the year 2005. The Director further estimates 30,000 HIV infected babies to be born in South Africa in ten years to come. In other countries, for example Malawi, the Health Systems Trust (1996:8) estimates 2 million people to be infected with HIV and that 350,000 children will be orphaned by the year 2000. Malawi being one of the poorest nations of the world carries the heaviest burden of AIDS. Zimbabwe is considered by the Health Systems Trust (1996:13) as leading in AIDS infections. The life expectancy is expected to decline to 40 years due to AIDS. This is quite frightening.

Prevention programmes and intervention need to be planned, evaluated and revised according to more modern surveillance data and other studies. In support of this view, WHO is primarily concerned with public health and started setting up special programmes on AIDS since 1987. This special programme has played a major role in

mobilising International AIDS awareness. WHO (1995) hosted in December 1995 the last special programme on AIDS in Durban. The theme was "Shared rights - shared responsibilities" in order to highlight the impact of AIDS on families. According to WHO, every individual regardless of age, sex, race, sexual preference or social standing has the right; to avoid infection, to freedom of movement and to have a relationship. Health care providers at all health services have great responsibilities to help and guide students as the young adult population to share rights and responsibilities regarding their wellness.

The Department of Health at national level has made intervention against AIDS and STDs to be one of its top priorities. There are five intervention strategies that have been introduced by the Department of Health and these are:- improvement of life skills of the youth; distribution of condoms; improvement of communication around AIDS; caring for people with AIDS and improvement of the treatment of STDs (Health Systems Trust, 1996:2). These intervention strategies will only be a success if every individual and each organisation such as the church, the school play their part in helping the formal health sector. Personnel of the Students' Health Centre under study are therefore obliged to also adopt and use the foregoing intervention strategies.

INCIDENCE OF STDs

Literature indicates that the incidence of these diseases has risen rapidly despite the progress made in their diagnosis and treatment which renders patients non-infectious. Authors have described the target age group that is at risk as the age that ranges between 20-30 years. Robertson, McMillan and Young (1986) report that the target group is within 15-30 years of age. A survey conducted in a Durban STD clinic indicated that 15-19 years are the age group at most risk of acquiring STD (World Health Organisation 1995:9).

Robertson **et al** (1986) further state that syphilis, for example, is distributed worldwide; but in the case of gonorrhoea it is difficult to compare the incidence of the disease as methods of reporting vary. The reporting of victims according to literature reviewed is still a problem. In a study conducted by the American Social Health Association (1989) it was demonstrated that only one out of nine victims of STDs were reported; though reporting of STD victims is required by Public Health Law. Many private physicians and clinics fail to report their STD patients.

Regarding statistics; the incidence in KwaZulu clinic services showed 55 630 new STD patients and 30 502 repeat visits by STD patients in 1992 (Department of Health KwaZulu, 1992:10). In his report, Mfenyana (1993) stated that there were 363 patients in 1993 and 459 patients in 1994 in one of the institutions in Cape Town. Ahmed and Kajee (1994) undertook a descriptive investigation on STD caseload in general practice in Cape Town. The results showed 4142 repeat visits and 3 235 new cases of STD receiving treatment every month in general practice. The indication of these high statistics is that STDs are still a serious problem.

There was also a comprehensive survey that was done on women attending Family Planning at one of the hospitals in Johannesburg which showed that 90 percent of those women had STD. The results of the survey further indicated that about 17 percent gynaecological admission to hospital had STD infections (Schneider, 1995). The incidence at the institution under study was 420 STD patients in 1993; 610 STD patients in 1994 and 810 STD patients in 1995. This is quite alarming as this Health Centre caters only for day students registered on a full-time basis. Part-time and evening students are unable to use the service as explained in Chapter 1 (Students' Health Service Annual Reports, 1990-1995).

TYPES OF STDs

There are twenty diseases considered to be sexually transmitted with syphilis and gonorrheoa being the primary venereal diseases (Caliandro and Judkins, 1988). In

South Africa, regulations under the Health Act No. 63 of 1977 and WHO (1990) classify gonorrheoa, syphilis, non-gonococcal urethritis, trichomoniasis, chancroid, genital herpes, genital candidiasis and bacterial vaginosis as sexually transmitted diseases. These diseases are considered to be a major cause of morbidity and mortality (Kassner, 1988). According to WHO (1990) these diseases are quite difficult to identify, treat and control thus causing serious complications. The researcher will discuss the eight more common diseases briefly as well as the killer disease - that is AIDS.

Stanhope and Lancaster (1988) and the Department of National Health and Population Development (1991) indicate that STDs are highly contagious and communicable diseases and are therefore notifiable to the Centres of Disease Control (CDC) but the reporting system is still a problem. De Schryver and Mahens (1990) also confirm that STDs are the commonest group of notifiable infectious diseases world-wide particularly in the age group of 15 to 50 years and in infants. In the new South Africa, a single comprehensive national reporting system needs to be created by the new Government. There is hope that the Provincial AIDS Implementation Plan developed by the National AIDS Co-ordinating Committee of South Africa (NACOSA) will devise better means of reporting STDs and AIDS in order to control the spread of these diseases (NACOSA; 1994:1).

AETIOLOGY, CLINICAL FEATURES, COMPLICATIONS, DIAGNOSIS AND TREATMENT OF THE COMMONER STDs

There is a need to consider the guidelines on the management of STD as indicated by the Department of National Health and Population Development (1994:12) assisted by Professor Ballard; the founder of STD Society of South Africa and who is the Head of STD Laboratory of South Africa. These guidelines are - education of persons at risk; detection of infection in asymptomatic carriers of disease and in persons with symptoms

and provision of effective diagnosis and treatment for patients with symptoms. All workers in the field of health services should be guided by these guidelines; including personnel in the Health Centre under study. They should educate teenagers/young adults (students) regarding mode of transmission and means of reducing spread of disease. Here under follows the discussion of the most common types of STDs:

Gonorrhoea

Ballard in the 1996 Conference of the South African Association of Health Service for Students (SAAHSS) held in Durban; presented a paper on STDs. The speaker maintains that gonorrhoea remains the most common STD problem presenting at STD clinics in Southern Africa. De Schryner and Mahens (1990) point out that the highest incidence of gonorrhoea is among females in the age group of 18-19 years and for males, the age group being 20-40 years. According to the above authors; the available figures are unreliable, but estimates for large cities in Africa suggest an annual incidence rate for gonorrhoea of 3000 - 10 000 per 100, 000 inhabitants. The causal organism is Neisseria gonorrhoea - a gram - negative diplococcus that affects mostly the urethra in men and the uterine cervix and urethra in women. Rectal infection is common in homosexual men and women (Ballard, 1994).

The clinical feature of gonorrhoea is that at times the disease is asymptomatic. When symptoms occur, the onset may be sudden or start less than one week after sexual contact with an infected person. Profuse and purulent urethral discharge, dysuria and frequency in micturition are the main features in men. In women; the main complaint may be dysuria and vaginal discharge originating from the cervical os. The vaginal discharge may be profuse and purulent (Ballard, 1994 and Nzimande, 1994).

Complications of the disease in males include urethral stricture, epididymitis and acute prostatitis. In females, salpingitis and bartholinitis are common; associated with pelvic inflammation. Infertility in both sexes is common. There may be conjuctivitis in neonates and adults characterised by oedema of eyelids and profuse purulent discharge

later. Visual loss may occur if the condition is left untreated (Ballard, 1994; Nzimande, 1994).

Regarding laboratory diagnosis, Ballard (1994) states that endo-urethral, endocervical and rectal swabs are the most suitable specimens for culture in cases of gonorrhoea. Gonorrhoea should be treated with antibiotic regimens that are effective against Neisseria gonorrhoea and Chlamydia trachomatis as a result of the emergence of a significant number of infections that are antibiotic-resistant. Treatment includes:- Ciproflaxin 500mg orally as a single dose and Doxycline 200 mg daily orally for 10 days. If the partner is pregnant; Erythromycin 500 mg orally for 10 days is recommended (Ballard, 1994; Nzimande; 1994, Treadwell, 1995).

Non-gonococcal urethritis (N.G.U.)

N.G.U. is considered by the Department of Health as the most common STD in developed countries (Nzimande, 1994). N.G.U. is caused by a number of organisms and according to Ballard (1994) trichomonas vaginalis, candida albicans and various bacterial agents are possible causative organisms. Current evidence suggests a multiple aetiology for N.G.U. with chlamydia trachomatis being the causative organism in 50 - 60 percent of patients. Ballard (1994) further indicates that, in many cases the aetiology of the disease is unknown.

The clinical features in males are the same as those of gonorrhoea except that the discharge is often scanty and clear. In females the clinical manifestations tend to be mild. Chlamydial cervicitis and mucopurulent discharge from cervical os may be seen; whereas in the majority of patients the condition may be asymptomatic (Ballard, 1994; Nzimande, 1994).

Complications and laboratory diagnosis of N.G.U. are the same as those of gonorrhoea. Though the treatment of N.G.U. is the same as for gonorrhoea, Metronidazole 2 gram orally as a single dose is recommended in females and Gyno pevaryl depot x 1 pessary vaginally. Ballard (1994) also recommends that treatment should cover both infections that are gonococcal and chlamydial in origin.

Trichomoniasis

This condition is caused by the Flugillate protozoan trichomonus vaginalis (Ballard, 1994). The clinical features in males are urethritis and balanitis but the majority of infected males are asymptomatic. In females, vaginitis occurs, characterised by a slight discharge vaginally. In severe cases a copious, thin, offensive, white, yellow discharge; frothy in appearance may be noticed. On vaginal examination; acute inflammation and excoriation of the vulva, perineum and inner thighs are often seen (Ballard, 1994; Nzimande, 1994).

Complications of trichomoniasis in males include urethritis and balanitis being most common. In females complications are bartholinitis and rarely pyelitis (Ballard, 1994; Nzimande, 1994). Laboratory diagnosis of trichomoniasis includes microscopic examination of 'wet preparations' (Ballard, 1994; Treadwell, 1995). Treadwell (1995) and Ballard (1994) recommend Metronidazole 2 grams as a single dose orally or 400 mg twice daily for 7 days as treatment. Gyno pevaryl depot one vaginally in case of a female patient.

Chancroid

This is a specific sexually transmitted infection caused by Haemophilus ducreyi (Ballard, 1994). The disease is characterised by multiple, painful genital ulcerations with slough. These ulcers bleed easily. In males, ulcers are found on the prepuce or on the penile shaft. In females, the most common infection sites are the labia, vaginal walls, cervix and perineum. It is important to note that in recent years chancroid has been found to be a major co-factor in the heterosexual transmission of HIV in developing countries (Ballard, 1994; Nzimande, 1994).

Complications of chancroid include phimosis, genital ulceration, balanitis in males. In females, pelvic inflammatory disease as well as genital ulcerations are common complications (Ballard, 1994; Nzimande, 1994).

Diagnosis is made on clinical grounds and a definitive diagnosis can be made in a laboratory with basic bacteriological facilities (Ballard, 1994). The treatment of chancroid includes Monocycline 100 mg twice daily for 10 days by mouth or Erythromycin 300 mg three times daily by mouth for five days (Ballard, 1994; Nzimande, 1994).

Herpes

This is one of the sexually transmitted infection caused by herpes simplex virus (Ballard, 1994). The clinical features in males include the herpetic lesions commonly found on the glans, prepuce and penile shaft. In females, the lesions are on the vulva and cervix. Fever, malaise may also be marked on those infected (Ballard, 1994; Nzimande, 1994).

Literature reviewed show that genital herpes rarely causes complications. The diagnosis is on clinical manifestations. The definitive diagnosis is made in laboratory settings (Ballard, 1994). The treatment of herpes is systemic, consisting of Acyclovic 200 mg five times daily for 7-10 days by mouth or until clinical resolution occurs (Ballard, 1994; Treadwell, 1995).

Candidiasis

This is fungal infection of the genitalia caused by Candida albicans and other yeast agents. The disease is more common in women causing infection of the vulva (Ballard, 1994). The clinical features in women are vulva irritation and vaginal discharge that is scanty and watery. Sometimes the discharge may be thick and white resembling 'cottage - cheese' in consistency, causing inflammation of cervical tissues. In men, the disease may be asymptomatic and in some cases slight redness and irritation of the glans penis may be marked (Ballard, 1994; Nzimande, 1994). The infection in men can lead to balinitis but in women there are no known complications except that repeated relapse may occur (Ballard, 1994).

Diagnosis of candidiasis is done through microscopic examination of vaginal discharge (Ballard, 1994). The treatment of candidiasis consists of Nystatin pessaries inserted vaginally twice daily for two weeks or Cotrinazole 200 mg pessaries vaginally at night for three days. For both males and females treatment is Flagyl 400 mg twice daily for ten days orally (Ballard, 1994; Treadwell, 1995).

Bacterial vaginosis (BV)

This is considered by Ballard (1994) as a 'non - specific vaginitis' that causes vaginal discharge and is characterised by greyish adherent vaginal discharge. The causal organism is thought to be Gardenerella vaginalis which is associated with certain anaerobic bacteria (Ballard, 1994; Nzimande, 1994). According to Ballard (1994) the main complaint is the discharge itself which may be profuse and has a 'fishy' smell but no inflammation of the underlying tissues.

There are no known complications of bacterial vaginosis except repeated relapses (Ballard, 1994). Treatment of bacterial vaginosis is the same as that of genital candidiasis.

Syphilis

Syphilis is a chronic sexually transmitted infection that is systemic in nature; characterised by a primary lesion and a secondary eruption involving the skin, bones, central nervous and cardiovascular systems. The causal organism is Treponema pallidum (Nzimande, 1994; Ballard, 1994). According to these authors, the disease develops in four stages; namely primary, secondary, tertiary and congenital syphilis. These stages will be discussed briefly as follows:

Primary syphilis is manifested after about nine to ninety days, characterised by a papule that breaks down to form an ulcer that does not bleed easily. In males, this 'chancre' is commonly found on the glans of the penis. In females, the ulcer may be noticed on the vulva, vaginal walls or cervix. Other clinical features include bilateral enlarged inguinal

lymph nodes, that are non-tender. If the disease is not treated; the ulcer may resolve spontaneously after three to eight weeks without leaving a scar (Ballard, 1994; Nzimande, 1994).

Secondary syphilis occurs after the interval of six to eight weeks between the primary chancre and the onset of secondary manifestations if the condition is not treated. Clinical signs are fever, headache, malaise and generalised rash which may be papulo-squamous and non-irritant. These lesions are called condylomata lata found in warm moist areas such as peri-anal region. Hair-loss and patchy alopecia are marked on the scalp. This stage according to Nzimande (1994) lasts for about two years and if untreated thereafter the tertiary stage sets in.

Tertiary syphilis is the destructive stage of the disease. Any organ of the body during this stage may be involved. The disease is non-infectious at this stage. The main features of this stage are:-

- Cutaneous, mucosal and bony gummas affecting the skin, mucosal surfaces and bones;
- Ulcers have a sloughy base and a 'punched-out' appearance;
- Underlying bony structures may be destroyed and the skull may be affected;
- In cardiovascular syphilis, the aorta may be affected, leading to coronary stenosis, aneurysm and aortic incompentences;
- In neurosyphilis, the condition may be asymptomatic, having no clinical abnormality but examination of cerebrospinal fluid (CSF) may show abnormalities. In practice, it is rare to find a patient whose syphilis has reached the tertiary stage described above; possibly as a result of the widespread use of antibiotics for other infectious diseases (Ballard, 1994; Nzimande, 1994; KwaZulu-Natal Health Department, 1995:34).

Congenital syphilis

Congenital syphilis can be divided into early and late congenital syphilis. The early congenital syphilis is acquired by transplacental infection of the foetus and is

characterised by bullous eruption called 'syphilitic pemphigus'. Early signs and symptoms of the disease may be noticed 2-8 weeks after birth. Skin lesions occur which are similar to those of secondary syphilis in adults. The first signs to be noticed is failure to thrive and to gain weight. Other features include bone lesions, generalised lymphadenopathy and meningitis.

Late congenital syphilis occurs when the early congenital syphilis is left untreated and the infant survives. The features of late congenital syphilis are similar to those of adult acquired disease including gumma formation and neurosyphilis. Cardiovascular syphilis is rare.

Complications of both early and late congenital syphilis are Hutchinson's teeth, perforation of the hard palate; 'saddle nose', corneal opacities, optic atrophy, 8th nerve deafness (Nzimande, 1994; Ballard, 1994; Meyer, 1993).

Laboratory diagnosis of congenital syphilis include Dark-field microscopy of material obtained from primary ulcerations, skin rashes and condylomata ata. These may show Treponema pallidum organism as diagnostic of the disease. In secondary syphilis, serological tests are always positive. Diagnosis of tertiary syphilis is on clinical grounds combined with the results of chest X-ray and X-ray of long bones. Serological tests in relation to clinical signs may be used to confirm the diagnosis of syphilis (Ballard, 1994; Meyer, 1993).

Regarding treatment of congenital syphilis, Meyer (1993) suggests preventive measures. In a retrospective analysis of records at ante-natal clinic in Cape Town; undertaken to assess the efficiency of the prevention programme and to identify points of breakdown in the process; results were that 70 percent of 607 mothers who had serological evidence of syphilis had received no ante-natal care. Reasons being delayed laboratory results reaching the relevant unit and a delay in the referral of patients from ante-natal clinic to a separate STD clinic; thus making it difficult for routine management of patients to be initiated. Serological tests for syphilis at ante-natal clinics and initiation of appropriate therapy without delay, all play an important role in preventing congenital syphilis

(Meyer, 1993). Treatment consists of Benzathine penicillin G. 2,4 million units - that is 4 mls by 4 mls on each buttock at a single dose intramuscularly. If the patient is allergic to penicillin, Doxycline 200 mg should be given daily orally for 15 days (Treadwell, 1995; Ballard, 1994). For neonates and young children Aqueous crystalline penicillin G. 50,000 units per kilogram intramuscularly or intravenously daily in two divided doses for ten days should be given. It is important to note that if more than one day of therapy is missed, the entire course should be restarted (Ballard, 1994, Nzimande, 1994).

Acquired Immuno Deficiency Syndrome (AIDS)

AIDS is the leading cause of mortality worldwide. This is a disease that was first described in 1981 by the Centre for Disease Control in America. This is also a disease that impairs the body's ability to fight infection. AIDS is caused by the Human Immunodeficiency Virus (HIV). AIDS virus was isolated in 1983. Through research, it has been discovered that AIDS represents the terminal phase of the HIV infection (Nzimande, 1994; Department of National Health and Development, 1994:45; Health Systems Trust, 1996:2).

Though all sexually transmitted diseases are spread by sexual intercourse, including HIV/AIDS, it is important to note that HIV/AIDS also spreads or is transmitted through a transfusion of infected blood, from an infected mother during pregnancy or birth, through any body fluid from an infected person (Nzimande, 1994; Ballard, 1994).

Regarding clinical features, a large number of HIV/AIDS infections are asymptomatic. As illness progresses, fever, lethargy, sorethroat, vesicular rash begin to appear (Department of National Health and Population Development 1994:47). According to Nzimande (1994) clinical features manifest around the four stages of the disease. The first stage is asymptomatic infection but about one third of patients develop generalised lymphadenopathy. During the second stage, early symptoms of HIV infection become marked. This stage is characterised by mild weight loss, skin rashes, upper respiratory infections, oral ulceration. Herpes zoster may also occur during this stage. The third stage with intermediate symptoms of HIV infection is characterised by pneumococcal

pneumonia. Pulmonary Tuberculosis (PTB) is common in Southern Africa as well as skin rashes and herpes zoster infection just to mention a few. During the fourth stage, late symptoms of HIV infection appear. This is a manifestation of full blown AIDS. Peritonitis, Pulmonary Tuberculosis, pericarditis, severe weight loss are some of the clinical features common during this stage.

For diagnostic purposes; the Enzyme - Linked Immunosolvent Assay (ELISA) is the most commonly used diagnostic method to detect the virus (Department of National Health and Population Development, 1994:47).

Regarding treatment of AIDS, there is no cure for this infection - it is fatal. Therapy with Zidovudine has side effects such as anaemia (Department of National Health and Population Development, 1994:48). Preventive measures include prevention of other STDs, promotion of the use of the condoms, STD control, reduction in the number of partners is a long term rather than a short term goal and male circumcision. AIDS prevention necessitates the participation of community members. Vester-Cohen and Bamber (1993) suggest a need to change society's attitude as the patient's feelings of isolation and the unnecessary stigma attached to this disease have produced enormous suffering over and above the suffering imposed by the disease itself. HIV/AIDS infection should be regarded as just another disease. This is very important in the management of HIV/AIDS infection.

HEALTH POLICY IN THE MANAGEMENT OF STDs

Primary Health Care is one of the main keys towards health for all. Bac (1993) states that health for all has received endorsement as policy at the highest official level. The Primary Health Care adopted after the Alma Ata Declaration in 1978 was considered to be the approach in implementing this policy; thus closing the gap between theory and practice. The basic features for this policy which are also important in STD services are that of the service being available, accessible, affordable, acceptable efficient and effective. It is important to ensure that the service provided is as near to the community

as possible. The health service at the institution under study is, for example, situated inside the institution's campus for easy research by students.

Having the above slogan in mind, the Minister of Health in 1994 added to the Health Policy that STD and HIV/AIDS counselling and support services be established in all community health centres. Continuity of care is emphasised in all health services. Preventing the spread of infection, early detection and treatment of all STD victims are of prime importance in this Health Policy (Ballard, 1994).

MANAGEMENT OF STDs USING WORLD HEALTH ORGANISATIONS' (WHO) STRATEGIES

The area of prevention is the key to ensure a healthy community at all times (Stanhope and Lancaster, 1988). According to Dreyer, Hattingh and Lock (1993) there are three levels or strategies that have been developed by WHO for all STDs and other diseases to prevent the spread of diseases namely, Primary, Secondary and Tertiary levels. These will be discussed briefly.

Primary prevention

Primary prevention is the level where all necessary activities are undertaken to prevent a disease from occurring. According to Dreyer **et al** (1993) the aim of Primary prevention is to break the chain of events before the pathological changes begin. Dreyer **et al** (1993) state that the agent, that is, the factor whose presence causes a disease is prevented from affecting the host, who is the man or the environment. This means that the organism that causes STD is prevented from affecting the individual, in this case, the host is the student at the institution under study.

There are two components that are applicable in Primary prevention, and those are, health promotion and specific prevention. The aim of health promotion is to improve the functioning level of the individual rather than treating the disease. Specific prevention on the other hand aims at the prevention of a specific disease, for example,

STD. During primary prevention, the organism is prevented from causing the disease through:-

- Health education regarding types of STDs, signs and symptoms, complications and the need to seek medical advice;
- Adolescent counselling with regard to sexual life-style, so as to bring about changes in sexual behaviour;
- Encouraging one faithful sex partner and if this is not possible, encourage either abstaining from sex or the practice of safe sex by using condoms;
- Emphasising the importance of bringing one's sexual partner for examination and treatment if one is on STD treatment;
- Emphasising the importance of avoiding casual sexual relations (Nzimande, 1994; Dreyer **et al**, 1993).

Secondary prevention

During this level, the disease has already occurred. According to Dreyer **et al** (1993) this level comprises early diagnosis through screening and case finding of infected persons and then prompt treatment to prevent the spread and complications of the disease. The above authors further indicate that education is crucial to early detection of the disease. Regular check-ups of infected persons are of utmost importance. Having detected victims and diagnosis made, the above authors emphasise prompt treatment, re-education and follow-up to prevent the spread and complications of disease. Limitation of complications or disability should take place through adequate and up to date STD treatment, re-education and early referral for further investigation and management of the disease.

Tertiary prevention

This is during the late stage of a disease that takes place when Primary and Secondary preventive measures have either been ineffective or have failed. The focus of this stage is on restoration or rehabilitation of abilities, that is, helping the individual to maintain

optimum levels of functioning regardless of disability. The patient during this level can be helped to cope with disabilities through education focussing on abilities rather than disabilities, building self-esteem, referral when need arises and provision of facilities to limit disabilities (Nzimande, 1994; Dreyer **et al** 1993). All Health Centres and practitioners treating and managing STD patients should have their patients counselled and educated on methods to lower their risk of acquiring STD, using the above three strategies of management of disease.

THE FRAMEWORK OF CONCEPTS AND PRIMARY HEALTH CARE APPROACH (PHCA)

The framework consists of three concepts that are crucial to this study; namely Nursing intervention, Primary Health Care and Quality Care. Nursing intervention overlaps with Primary Health Care and Quality Care because intervention takes place within the context of Primary Health Care (Balecheck and McCloskey, 1985).

Nursing intervention is what the nurses do with and for patients in order to solve a problem. According to Balecheck and McCloskey (1985) nurses use the stages of the nursing process to solve patients problem in nursing intervention. These stages are - assessment, planning, implementation, recording and evaluation. These stages will be discussed briefly with special reference to STD patients.

STAGES OF THE NURSING PROCESS

Assessment being the first step of the nursing process involves reviewing of the whole situation of the patient from data collection in order to confirm the health status of the individual up to diagnosing the individuals' problem. This phase ends up with making the nursing diagnosis (Balecheck and Mc Closkey, 1985).

The planning phase involves designing the plan of action to assist the individual towards the goal of optimal wellness. Nurses should discuss the plan of action with the patient in respect of the role to be played by the patient; enquiry about sexual contacts of the

patient and the means of tracing sexual contacts for treatment (Balecheck and Mc Closkey, 1985).

Implementation is the actual management of the disease in order to attain the defined goals of optimal wellness. Nurses during this phase should explain to the patient all instructions with regard to treatment and the importance of finishing the course of treatment, the importance of abstaining from sexual intercourse or practising safe sex by using condoms whilst on treatment for STD and bringing sexual contacts for treatment (Balecheck and Mc Closkey, 1985).

The recording activity is important in nursing intervention as nurses, according to Dreyer **et al** (1993) are responsible for their own actions and omissions. In any nursing situation, full, legible, accurate and scientific documentation should be maintained as evidence of care of patients. The nurse can produce such records in self-defence if the occasion demands (Balecheck and Mc Closkey, 1985).

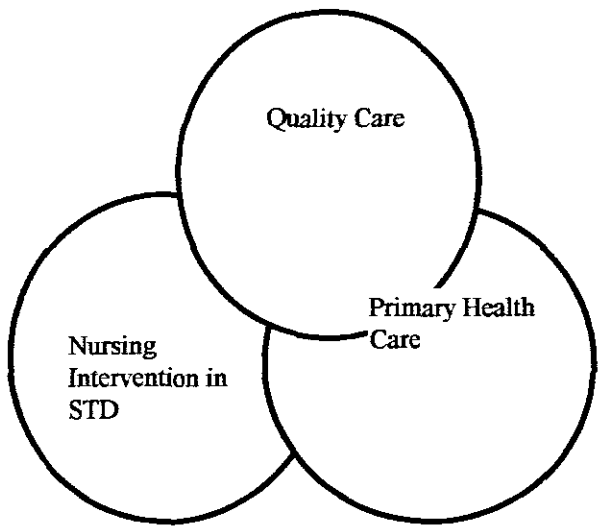
The evaluation phase constitutes appraisal of changes experienced by the patient in relation to goals to be achieved. Patients satisfaction with quality of care rendered should be evaluated and improvements made. The health service where nursing care takes place should also be evaluated for improvement where necessary (Balecheck and Mc Closkey, 1985).

Primary Health Care and nursing intervention in the case of STD overlap with quality care; in that these two concepts should reflect good quality care with regard to structure, process and outcome.

Recoveanu and Johansen (1995) state that the structure of a Health Service includes personnel, equipment, facilities as well as the organisational settings. The process in a health service consists of management and care of patients, preventive, diagnostic and curative services. The outcome constitutes the effects of the care given to patients, the degree of satisfaction and the efficiency of utilisation of resources. This means that periodical evaluation of a service to STD patients is necessary and will be effective if it

revolves around three phases - that is, structure, process and outcome. The interrelation of Primary Health Care and Nursing intervention in the case of STD against the background of Quality Care is diagramatically represented here in Figure 2:1.

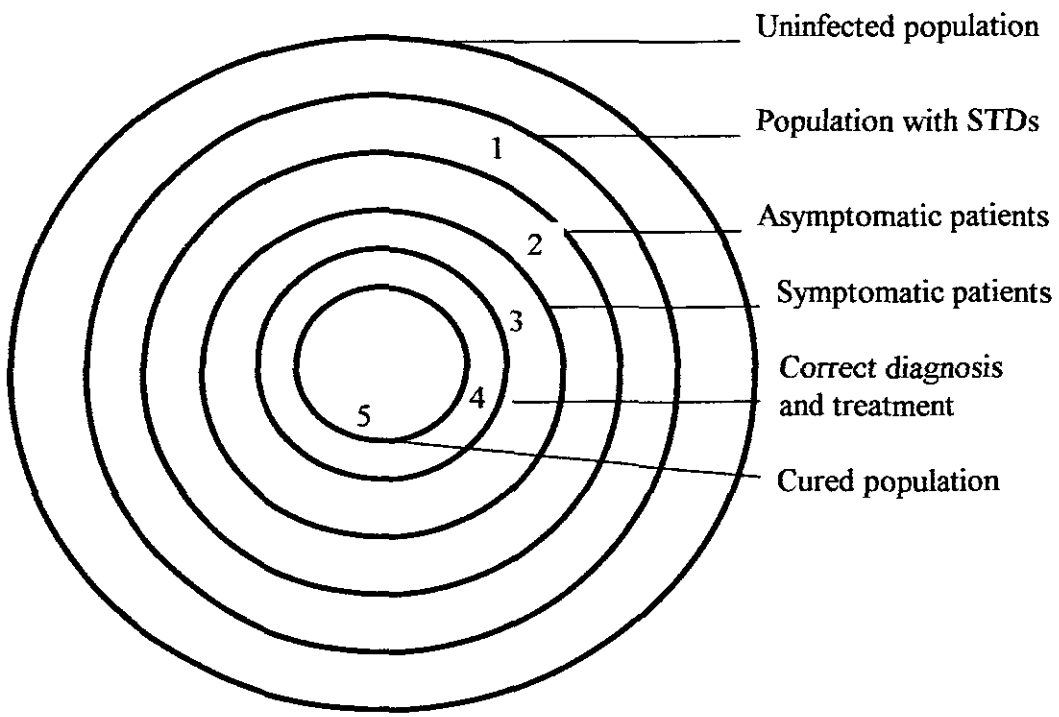
Figure 2.1: Diagram of the framework of concepts



Primary Health Care is discussed in a study by Schneider (1995) who states that it is not enough for STD services to continue concentrating on diagnosis and treatment of STD patients. A holistic approach is required which will embrace prevention, accessibility to health care centres, diagnosis, treatment, counselling, contact-tracing, health education, data collection and the empowerment of individuals to protect themselves from infection. All these need to be integrated into an appropriate sustainable Primary Health Care Approach; which will form the basis for the future provision for South Africa's health needs.

Schneider (1995) further states that the Primary Health Care Approach should take place at a number of levels - that is from levels one to five. A diagram of these levels of Primary Health Care Approach is as follows:

Figure 2:2: A diagram of levels of Primary Health Care Approach



In the above diagram, the outer circle represents the total population presumed to be uninfected. They are uninfected because they either abstain from sexual intercourse and/or practice safe sex.

Level 1 represents population with STDs. Of these patients; some will be symptomatic and others asymptomatic.

Level 2 represents patients that are asymptomatic; but they already harbour the disease. The infection will be detected and treated through screening programmes and good partner notification systems.

Level 3 represents patients who already show symptoms of the disease. They will be encouraged to seek early intervention and utilise opportunities within health services to detect and treat symptomatic infections. Health services should be made accessible and affordable, thus integrating STD services into Primary Health Care.

Level 4 constitutes patients who get correctly diagnosed and treated mainly by nurses that have the skills to diagnose and treat STD adequately and provide preventive counselling services and education to all patients with STDs. Apparently, patients seen at the Health Centre under study are mostly at level 3 and 4. If care in this place is effective, the population at level 5 should increase as well as the uninfected population.

Level 5 represents the cured population. To increase this population; people whose STDs are not yet cured must be encouraged to come back for follow-up treatment.

The foregoing conceptual framework forms the basis of this study. Nurses in the Health Centre of the institution under study are expected to be systematic in order to be effective in providing care and cure to STD patients. Such intervention by itself may or may not be successful. Therefore, such intervention is best practised within the mould of Primary Health Care Approach. This means that when dealing with a patient/client; the nurse needs to realise the level of Primary Health Care Approach at which he/she is intervening as well as the goals of intervention at that level. Further, nursing intervention within Primary Health Care should be tested and evaluated periodically to establish if it conforms to standards and criteria of good quality patient care. This study uses the criteria stated by Recoveanu and Johansen (1995) to evaluate the care of STD in the Health Centre for quality or good standards of nursing care.

THE NEED FOR A CLINICAL NURSE SPECIALIST IN COMMUNITY HEALTH NURSING IN GENERAL AND STD MANAGEMENT IN PARTICULAR

A clinical nurse specialist with expert knowledge and skills is crucial to the future development of quality patient care. Such a nurse is defined by Menard (1987) as a person who has special skills and advanced knowledge in a clinical area of expertise and has become an expert in a defined area of knowledge and practice through study at the post graduate level - that is Master's or Doctorate at degree level. The clinical nurse as an advanced nurse specialist serves as a model of expertness to render direct care to selected patients. In this study, selected patients are STD victims in a university

campus. As a nurse specialist in a clinical setting, he or she has independent and interdependent functions as well as major roles to play as identified by Menard (1987). Some of these functions and roles are at an advanced level thus distinguishing this nurse from an ordinary community health nurse.

In support of independent and interdependent functions of a clinical nurse specialist, Dladla (1991) evaluates the role individuals play towards promotion of their health and well-being. In that study, the researcher states that Health Act No. 63 of 1977 introduced valuable changes in South Africa - that is, changing from curative orientated services to a comprehensive health care; which gives equal attention to preventive, promotive, curative and rehabilitative health care. These changes according to the researcher lead to the extended role of a nurse which involves independent and interdependent functions of a nurse. These functions in regard to a clinical nurse specialist are at an advanced level.

Independent functions refer to the power the clinical nurse specialist has over his or her practice and thereafter remaining responsible and accountable for his or her actions and omissions. Interdependent functions on the other hand refer to the interrelationship the clinical nurse specialist has between her and other members of the health team in the interest of the patient. These functions are important in the implementation of nursing intervention (Balecheck and McCloskey, 1985; Searle, 1987 and Menard, 1987).

The major roles of a clinical nurse specialist are that of being a practitioner, consultant, teacher, change agent, researcher and manager at an advanced level. As a practitioner a clinical nurse specialist directs care of selected patients - that is STD patients in any clinical setting. This is the primary function of such a nurse. As an expert practitioner, a clinical nurse specialist uses all the stages of nursing process to assess, diagnose, plan implement and evaluate the wellness of patients in order to ensure quality nursing care (Menard, 1987).

The major function of a clinical nurse specialist is that of being a consultant. By being available to patients, health care personnel and the community, a clinical nurse specialist

uses a broad theoretical and experiential base to form a working diagnosis of the correct problem. This consultation role is at an advanced level (Menard, 1987).

The other important role of a clinical nurse specialist is that of being a teacher. As a skilled teacher; this nurse guides and leads in health teaching and health maintenance aspects, particularly in the management of STDs at health centres (Menard, 1987; Searle; 1987).

As a change agent, a clinical nurse specialist positively influences change. The change that is effected by a clinical nurse specialist is one that improves patient care ensuring quality management for STD patients as well as bringing change in people's awareness, attitudes and practices in relation to STDs and their prevention (Menard, 1987; Searle 1985).

The research role of a clinical nurse specialist is important in the sense that the development of nursing as a science is a professional responsibility of all health care providers. As a specialist, the clinical nurse takes a leadership role in the development of nursing science by initiating, facilitating, utilising and co-ordinating research and implementing changes according to research findings (Menard, 1987). This in turn will ensure quality patient care thus lowering the incidence of STD.

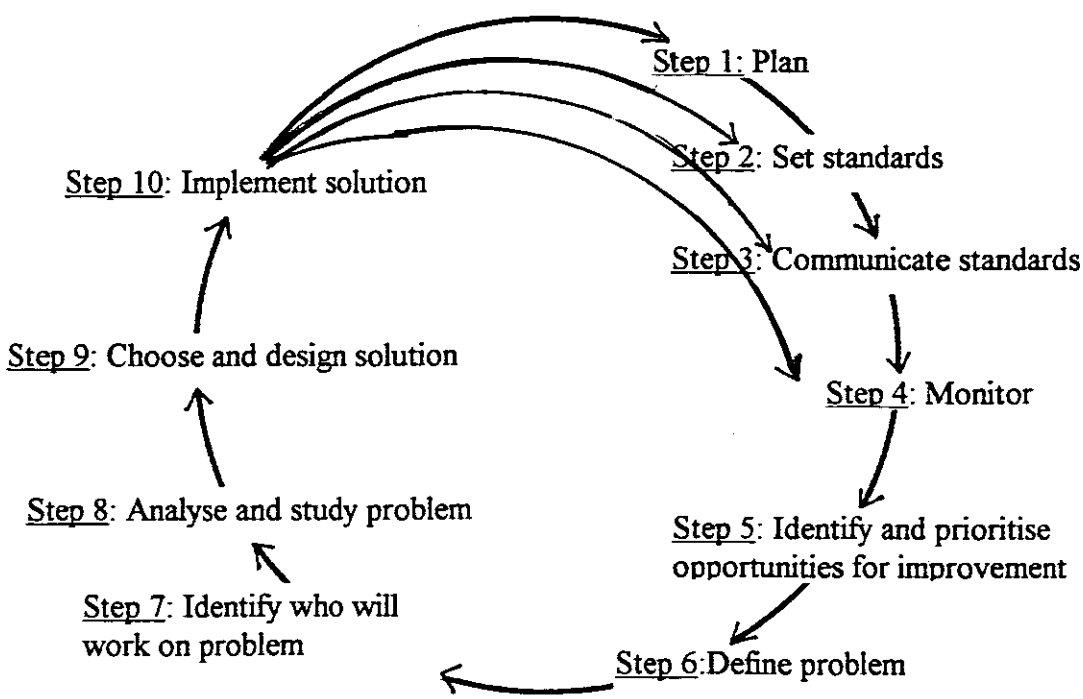
The management function of the clinical nurse specialist involves setting policies and procedures, budget management as well as hiring and firing health personnel (Menard, 1987). However, in the institution under study, hiring and firing of personnel falls outside the scope of practice of the nurse. The nurse can only make recommendations in this regard.

The above roles of a clinical nurse specialist differentiate him or her from the ordinary registered community health nurse and also make him or her the king pin in the development of quality patient care for communicable diseases, particularly STD and HIV/AIDS infections.

Quality Assurance has been a part of health care for the past 100 years. According to Brown, Franco, Rafeh and Hatzell (1990) Quality Assurance is described as a process of measuring quality, analysing the deficiencies discovered and taking action to improve performance, followed by measuring quality again to determine whether improvement has been achieved. This Quality Assurance was introduced by Florence Nightingale, a British nurse, who assessed the quality of care in military hospitals during the Crimean War. Standards in nursing care were introduced by Nightingale resulting in dramatic reductions of mortality rates in hospitals (Stanhope and Lancaster, 1988).

According to Brown **et al** (1990) Quality Assurance is a ten-step process developed by the Joint Commission on Accreditation of Health Care Organisation. These ten-steps consist of applying total quality management to health services namely - planning for quality assurance, communicating standards and specifications, monitoring quality, identifying problems and setting opportunities for improvement, defining the problem operationally, choosing a team, analysing and studying the problem, developing solutions and actions for improvement and implementing and evaluating quality improvement efforts. In practice, these ten-steps are in a cyclical process. The diagram below presents these steps and a brief description of each step will follow.

Figure 2.3: A diagram of Quality Assurance cycle



The process may begin with a comprehensive effort of planning, setting standards and communicating these standards in preparing an organisation to carry out Quality Assurance activities. As it is impossible to improve quality in all aspects at once; most organisations select high priority areas or problem-prone services, for example STD service at the institution under study will receive high priority attention for a Quality Assurance programme. Assessment of opportunities and constraints within the Health Service will be taken into consideration and a quality improvement approach will be selected (Brown **et al**, 1990).

In step 4 - monitoring of quality is central to a quality programme. Routine collection and review of data will help to assess whether outcomes of the service rendered are of good quality. Special attention is going to be paid to detailed assessment of processes taking place within the health service (Brown **et al**, 1990).

Step 5 to 10 consist of identifying and prioritising opportunities for improvement, defining the problem, choosing a team, analysing and studying the problem to identify the root cause, developing solutions and actions for quality improvement thus building a Quality Assurance programme. If all this is undertaken in the Health Centre being studied, there should be more effective control and management of STD and AIDS in this institution. A comprehensive approach is carefully planned and implemented gradually for improving the quality of health care. The success of a comprehensive approach will depend on the commitment of all health providers and authorities financing the health centre (Brown **et al**, 1990).

The theoretical framework on which this study is based uses the nursing process, as a scientific approach to care. This is used here as the starting point for maintenance of quality care, standards and the criteria to measure such standards. The nursing process according to Yura and Walsh (1988) is an orderly systematic manner of determining the patient's health status and specifying problems. The nursing process consists of making plans and evaluating the extent to which the plan is effective in promoting optimum wellness and resolving the problem defined. This study will reflect the application of the

steps of the nursing process in the maintenance of standards using structure, process and outcome of the Donabedian's model for Quality Assurance (Brown **et al**, 1990).

Structure

The structure involves evaluating the setting and instruments used to provide care such as equipment, facilities, characteristics of administrative organisation, types of patients nursed and qualifications of nursing personnel (Stanhope and Lancaster, 1988; Brown **et al** 1990). There should be efficiency in all components of the structure mentioned for nursing care to be of quality. A systematic application of the nursing process phases - that is, assessing, planning, implementing, recording and evaluating should be employed throughout to ensure quality of care.

As the components of structure include consultation hours, doctor's availability, cleanliness of the health service, adequate ventilation, comfortable and convenient waiting area, confidentiality of all health matters, availability of posters and magazines on STDs; qualitative and quantitative assessment will be done. Planning will determine what equipment will be required and for what purpose. The how to acquire, maintain and use equipment will also be considered during the assessment phase. Assessing nursing personnel who will use the equipment and considering their qualifications to provide quality care will be taken into consideration. Implementation will include initiating the action referring back to the planning phase to accomplish defined goals and objectives. Nursing personnel should have adequate skills to render the service. In service teaching, in order to develop necessary skills will be made available and accessible to all personnel rendering the health care service. Records of intervention will be properly kept in order to upgrade the standard of care.

Process

This phase includes the actual action taken as related to standards and expectations of health care personnel in the management of patient care. In the study; the process involves focusing on nursing personnel regarding their friendliness, interpersonal

relationship, listening attentively to patients complaints, showing interest, being aware of patient's expectations, maintaining a professional attitude and behaviour, being non-judgemental, explaining in simple terms all health problems identified during physical examination and making time for questions before giving instructions regarding treatment.

Planning during the process phase will involve nursing personnel discussing the plan of treatment with the patient, the role the patient needs to play, the importance of taking treatment, compliance and adhering to times and finishing the course. Inquiring about sexual contacts so that they can be traced and treated is essential during the planning process.

During the implementation phase, nurses need to emphasise the importance of either abstaining from sexual intercourse or using condoms whilst the individual is on treatment for STD. Emphasis should be on bringing of sexual partner or partners for treatment. Request to report any drug reaction should also be emphasised.

Outcome

This phase is regarded by Stanhope and Lancaster (1988) as the net results of the health care. In other words, this is the evaluation of nursing intervention done by health care providers which should show changes in the patients health status. During this phase data is obtained from patients who had received STD treatment to check whether treatment given at the Health Service has been of such quality as to bring about complete recovery. Patients' records will also be evaluated to check the ongoing nursing care of STD patients as documented by nurses delivering health care system.

In summary, evaluating of care to STD patients in this Health Centre is undertaken within a theoretical framework using the nursing process as a core theory in the context

of Brown **et al** (1990) Quality Assurance Process using the format of the Donabedian's model.

CONCLUSION

The foregoing literature constitutes evidence of the nature and extent of STD as a widespread health problem and its control and management as an ongoing challenge to health care providers in general and nurses in particular. Investigation of the nature of care in the Health Centre under study is undertaken against this background.

CHAPTER 3

RESEARCH METHODOLOGY

INTRODUCTION

Research methodology is concerned with the researcher's ultimate goals and the general plan for achieving these goals. According to van der Walt, Cronje and Smit (1982) research methodology is the study of methods and logic of science; rules of organised research and the norm by which procedures and techniques are chosen and emphasised. In this chapter; attention is paid to research methodology used in the study. This includes research methods, techniques and procedures followed in conducting the research study.

DELIMITATION OF THE SCOPE OF THE STUDY

The study was carried out at a tertiary institution in the province of KwaZulu Natal, which is one of the provinces of South Africa. The institution has a main campus and a satellite campus that is geographically distant from the main campus. There is a Health Centre called the Students' Health Service that is situated on the main campus. The Health Centre operates from 07h30 to 15h45. Students pay a sum of R4.50 per visit to the Health Centre; even if they are suffering from a sexually transmitted disease.

The study focussed on those students who were registered as full time students and living at student residences during the 1995 academic year. Part time and evening students as well as those at the extra-mural satellite campus were excluded; because these groups tend not to use the Health Centre for their health problems; due to restrictive hours of business and the distance of the Health Centre from where they live.

THE TARGET POPULATION

The target population consisted of the 1995 full time, resident student population of the main campus of this institution. A computer printout was obtained from the student registration office of the institution under study. This printout reflected the entire student body of 1,939 males and 3,225 females, thus making a total of 5,164 students registered on full time basis. The target population for this study was formed by those residing in students residence at the main campus and that was 2,790 students (54) percent. Forty six percent of student population resided outside the campus.

Although this institution is open to all races; the student population is predominantly Black and Zulu speaking. Historically, this institution was designed for a particular ethnic group according to the previous Government policy. Another important characteristic of the student population is that; students are mostly Christians. Although this factor is not used as a variable; it is important in determining their attitude towards sexual involvement.

THE SAMPLE AND SAMPLING

It was not possible to reach all the target population of 2 790 students due to limiting factors such as time and finance. Polit and Hungler (1987) state that it is more economical and efficient to work with small groups of elements than with an entire population. As the study was on human inquiry; it was impractical and costly to study the entire population. Brink (1993) supports this statement by stating that; in human inquiry as well as scientific inquiry; knowledge is generally based on samples. A sample is therefore a selection of a subset of the population that contains all the general characteristics of the entire population (Treece and Treece, 1982; Polit and Hungler, 1987). In other words; a sample is a portion of the population that represents the entire population.

Researchers work with samples; therefore it must be noted that there are two types of samples namely probability and non-probability samples. Probability sample rests on the

assumption that human populations are heterogenous with variations such as gender, age, level of study and so on. Any study should therefore be limited to the relevant characteristics of the population (Babbie, 1990). Non-probability sampling techniques are employed for situations in which the selection of a representative sample is impossible. In other words; there is no assurance that each element will have a chance for inclusion (Bailey, 1987 and Seaman, 1987).

In view of the fact that clinical records of students diagnosed as having STD were available at the Student Health Centre; use could have been made of these to guide the giving of questionnaires only to STD patients. The disadvantage linked to this was that; most of the potential respondents would fall away for fear of becoming known to other people as suffering or having suffered from STD; by virtue of having participated in the study. This would adversely affect confidentiality and anonymity especially because there is still a stigma attached to this type of disease.

Therefore, the present study used what is termed 'incidental' or 'availability' sampling technique. This is a non-probability sampling; as the probability of an element is not known. In other words, subjects selected did not have an equal chance of being chosen (Seaman, 1987 and Huysamen, 1994). This type of sampling allowed the researcher to draw participants by incident or availability and ignore representatives which becomes difficult to attain in such situations. The risk of involving also students who do not/have not suffered from STD was unavoidable.

The student residences in this institution are divided into two sections; namely, the East and the West residences. Questionnaires were handed over to floor heads of both residences to be distributed to any student that was available and willing to participate in the study. Further; students who visited the Health Centre were given questionnaires, on condition they had not filled in those questionnaires distributed by floor heads at their residences.

These questionnaires were distributed between October and November 1995. A record of all distributed questionnaires was kept. As the target population was 2,790; ten

percent (279) was considered enough to form the sample size as cited by Treece and Treece (1982). Further; Notter (1979) states that most current clinical research samples in nursing are small but representative of the entire population. In view of the fact that some of the subjects may refuse to participate in the research and to make an allowance for failure to return completed questionnaires; it was decided to distribute a total of 300 questionnaires (Huysamen, 1994). There was a very good return rate of questionnaires that is 80 percent. Those which had gaps or incomplete responses were discarded. Babbie (1990) states that a response rate of 50 percent is adequate; a rate of 60 percent is good and a rate of 75 percent or more is very good. The return rate of questionnaires is presented in Table 3.1 below.

TABLE 3.1: RETURN RATE OF QUESTIONNAIRES FROM RESPONDENTS

STATUS OF QUESTIONNAIRES	NUMBER	PERCENTAGE
Distributed	300	100
Returned	240	80
Discarded	10	4
Analysed	230	77

THE RESEARCH DESIGN

The information was obtained by means of the non-experimental case study research design. This research design was regarded as the most appropriate for the study, in that, the researcher would be able to focus on the situation of the particular institution and what its students think, believe and experience in respect of management for STD; and to examine the data carefully to gain insight in order to offer a solution to the problem that was identified.

THE RESEARCH INSTRUMENT

In order to examine and evaluate the Health Service structure, process and outcome regarding the management and nursing care of STD patients; two instruments were used; namely, a questionnaire and a checklist. A questionnaire was chosen to collect data from students residing at the main campus. Treece and Treece (1982) describes a questionnaire as a document that contains a series of questions that are answered by the participants in a sample. A questionnaire is considered by Polit and Hungler (1987) and Treece and Treece (1982) as the most commonly used research instrument.

The choice of a questionnaire for this study was based on the following advantages:-
Apart from a questionnaire being the most popular research instrument for collecting research information as mentioned by Treece and Treece (1982); bias would be avoided. According to Polit and Hungler (1987) this is possible because the researcher is absent during the answering of questions in the tool. The two authors further state that using a questionnaire as a research tool ensures the possibility of complete anonymity which is not possible in the face to face process. In addition; this type of tool has a high degree of ability to handle sensitive information such as STD (Kunene, 1995). Further, subjects would complete questionnaires at their convenient time (Treece and Treece, 1982).

The questionnaire was found to be the most easily distributed research instrument at a lower cost for collecting data from subjects (Notter, 1979). These questionnaires were distributed to students currently registered on full time basis and resident at this institution's main campus during the 1995 academic year.

The structuring of the questionnaire was such that the first part consisted of personal particulars of respondents; that is gender, age and the level of study. The second part of the questionnaire consisted of Likert scale type of questions as well as open-ended questions focusing on the structure of the Health Centre; the process of nursing intervention; that is assessment, planning, implementation, and the outcome/evaluation of the care rendered.

The checklist was the second research tool that was used to validate information provided by the respondents. Leedy (1980) defines checklist as a prepared list of items with marked columns used by a researcher to collect relevant data. Treece and Treece (1982) indicates that checklists come in many types and may use the scales such as often, seldom or never. In the study; the checklist provides for yes, no and not certain responses. The checklist helped to guide collection of data from clinical health records of STD patients managed at the health centre. The checklist further helped in examining previous and current practices at the Health Centre in relation to handling students' health problems. The format of the checklist corresponded to that of the questionnaire; except for the part with personal particulars.

TESTING OF TOOLS FOR VALIDITY

To ensure validity of the questionnaire; a mini study having the same general characteristics as the major study was undertaken. The purpose of the mini study was to improve the research process; detect problem areas and ensure understanding of the language used (Polit and Hungler, 1987).

Validity is explained by Treece and Treece (1982) and Leedy (1980) as the ability of the instrument to measure what it is actually meant to measure. Leedy (1980) further indicates that there are various types of validity; namely face validity, content validity, construct validity, criterion validity and so on; to ensure effectiveness of their measurement procedures. For the present study face validity was tested. Face validity being consensus or agreement that a measure represents a particular concept based on validation by a variety of researchers (Treece and Treece, 1982).

The researcher undertook pretesting of the tools for face validity in the following manner:-

The instruments were presented to research and nursing experts for checking and recommendations for improvements. These experts found tools to possess face validity.

Further, the questionnaire was pilot tested on ten subjects who were not going to participate in the major study to avoid bias. These subjects were incidentally chosen as they visited the Health Centre for consultation and treatment. Results of the pilot study, showed that the instrument was reasonably valid. There was no need for amendment or improvement. A trial run of the checklist to ascertain attainment of intended objectives showed no faults or weaknesses.

ETHICAL CONSIDERATIONS

The following ethical aspects were given due consideration as this study is concerned with private and personal data.

Permission for the study

Permission to conduct the case study was obtained from the Assistant Registrar to conduct the study at the student residences of this institution.

Informed consent

An ethical principle is truth-telling. According to Polit and Hungler (1987) informed consent is truth telling that includes diagnosis, prognosis, risks and benefits in the words that the patient can understand. Individuals have the right to information and the right to agree or refuse to participate. Informed consent acts to safeguard participants by preventing harm being done on them. People can give informed consent once information is sufficient on which to base a decision (Davis and Aroskar; 1988). In view of the sensitivity of the problem under study; the issue of voluntary participation was emphasised to subjects constituting the sample. There was a covering letter for each respondent explaining the purpose of the study.

Anonymity and confidentiality

The covering letter emphasised the assurance of anonymity and confidentiality by indicating to participants not to write their names anywhere on the questionnaire. Participants were further assured that the research results will not be published.

METHODS OF DATA ANALYSIS

Data are the pieces of information collected during the course of the study. In order for the pieces of information collected to have meaning; data must be organised in a way that will give answers (Polit and Hungler, 1987).

The above authors identify two basic types of data analysis; namely - quantitative analysis and qualitative analysis. Qualitative analysis involves non-numerical data such as analysis of historical material. Quantitative analysis involves use of statistical procedures. Since the researcher was dealing with statistics; quantitative analysis was found to be ideal for the study.

Quantitative analysis of data from structured questions using the Likert scale type of measure was computerised; as the researcher would be unable to analyse a broad variety of statistics manually. Polit and Hungler (1987) explain that computers have made it possible to operate what could not be attempted manually. Open-ended questionnaires were analysed manually. Frequency tables, graphs, and means were constructed in order to facilitate the analysis and presentation of data. A computer software which is Statistical Analysis System (SAS) was used in this study. The SAS according to Polit and Hungler (1987) is able to handle a broad variety of statistical analyses. The other advantage of this type is that it is available in the institution under study.

OPERATIONALISATION OF THE VARIABLES

The variables under investigation were operationalised or reduced to indicators. Literature reviewed show that in operationalisation; the concept of "care" can be reduced into constituent variables which in this study are structure, process and outcome. These variables have been reduced to indicators as follows:-

Indicators

Quality care indicators were recorded in a five point Likert scale measurement of Never (1), Rarely (2), Sometimes (3), Regularly (4) and Always (5).

Indicators for the variable "structure" are:-

- Consultation hours
- Availability of a doctor
- Policy for management of STD patients
- Cleanliness of the Health Centre
- Adequate privacy
- Confidentiality of personal health matters
- Display of posters and pictures on STDs
- Magazines and leaflets on STDs

Indicators for the variable "process" are:-

- Assessment
- Planning
- Implementing

The above indicators of the process were reduced to sub-indicators as follows:-

Sub-indicators for "assessment" are:-

- Nurses displaying sound interpersonal relationship

- Taking personal and family history
- Undertaking full physical examination
- Ensuring confidentiality'
- Allowing time for questions

Sub-indicators for "planning" are:-

- The plan of action; considering priorities
- Indication of the role to be played by the patient
- Indication of times when the patient has to return to Health Centre and why
- Indication of relevant health education to be undertaken.

Sub-indicators for "implementing" are:-

- Giving appropriate care and treatment
- Taking pap smears and penile swabs
- Giving Health Education on sexual practices
- Requesting patient for names and addresses of sexual contact and tracing the contacts
- Reporting of patient back to the Health Centre to check whether he/she has been cured or not and for follow up treatment
- Referring to other health services, STD clinics and others if necessary
- Keeping of accurate records of all patients/clients

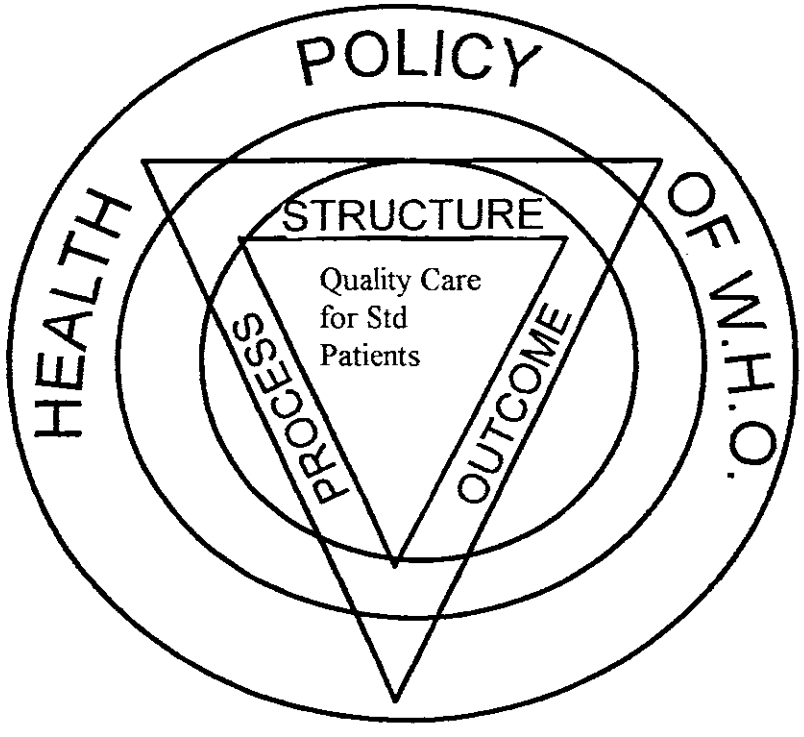
Indicators for the variable "outcome"/"evaluation"

- Effectiveness of Health Education to prevent relapse of patient and further spread of disease
- Success in observing ethical aspects
- Success in doing check up of STD patients to watch recovering of the patient

- Success in tracing of sexual contacts and treating them
- Competence and effectiveness in imparting knowledge
- Incidence of STD (that is new cases reporting at the Health Centre)

The diagram below represents the conceptual framework of the study.

FIGURE 3.1: DIAGRAMMATIC REPRESENTATION OF THE CONCEPTUAL FRAMEWORK OF THE STUDY



The diagram reflects the interrelationship of the major concepts of the study. The researcher was attempting to assess the quality care of STD patients at the Health Centre in respect of structure, process and outcome. The care being investigated was the nursing perspective and therefore was anchored on the nurse's scope of practice while based on the existing Health Care Policy.

CONCLUSION

The foregoing is an account of how the researcher adhered to scientific rigor based on available research literature. In the next chapter presentation of analysis and interpretation of data is going to be made.

CHAPTER 4

PRESENTATION, ANALYSIS AND INTERPRETATION OF DATA

INTRODUCTION

This chapter contains presentation, analysis and interpretation of data. Objectives formulated in Chapter 1 are tested in this chapter. Quantitative descriptive statistical analysis; for example frequency distribution, class intervals, ordinal scales, measures of central tendency such as the mean were used. Findings were presented in the form of tables, bar graphs and pie diagrams. The scoring of close-ended questions was done by the Statistical Analysis System (SAS) computer software. Questions were reduced into variables and were given numbers from 1-55 (Q1-55). Variables were thereafter programmed into the computer, thus creating a data file. The computer was thereafter programmed to sort the raw data starting from the first variable, processing frequencies, percentile scores, mean scores, minimum scores and standard scores in order to facilitate the analysis of the data (Mthembu, 1994). Analysis and interpretation of data was done simultaneously. Open-ended questions were analysed manually and responses presented under recommendations in Chapter 5.

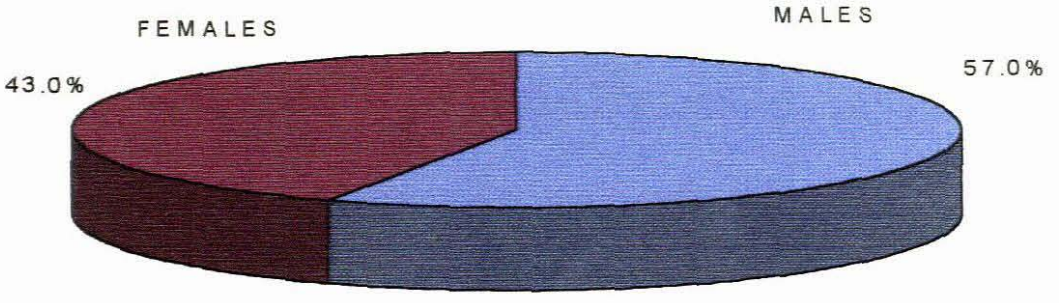
ANALYSIS AND INTERPRETATION OF DATA

PERSONAL PARTICULARS

ITEM OF GENDER

This involved determination of clinic attendance according to the gender of subjects visiting the Health Service. Figure 4:1 reflects the gender of the sample.

FIGURE 4.1: PIE DIAGRAM OF GENDER DISTRIBUTION OF RESPONDENTS N=230

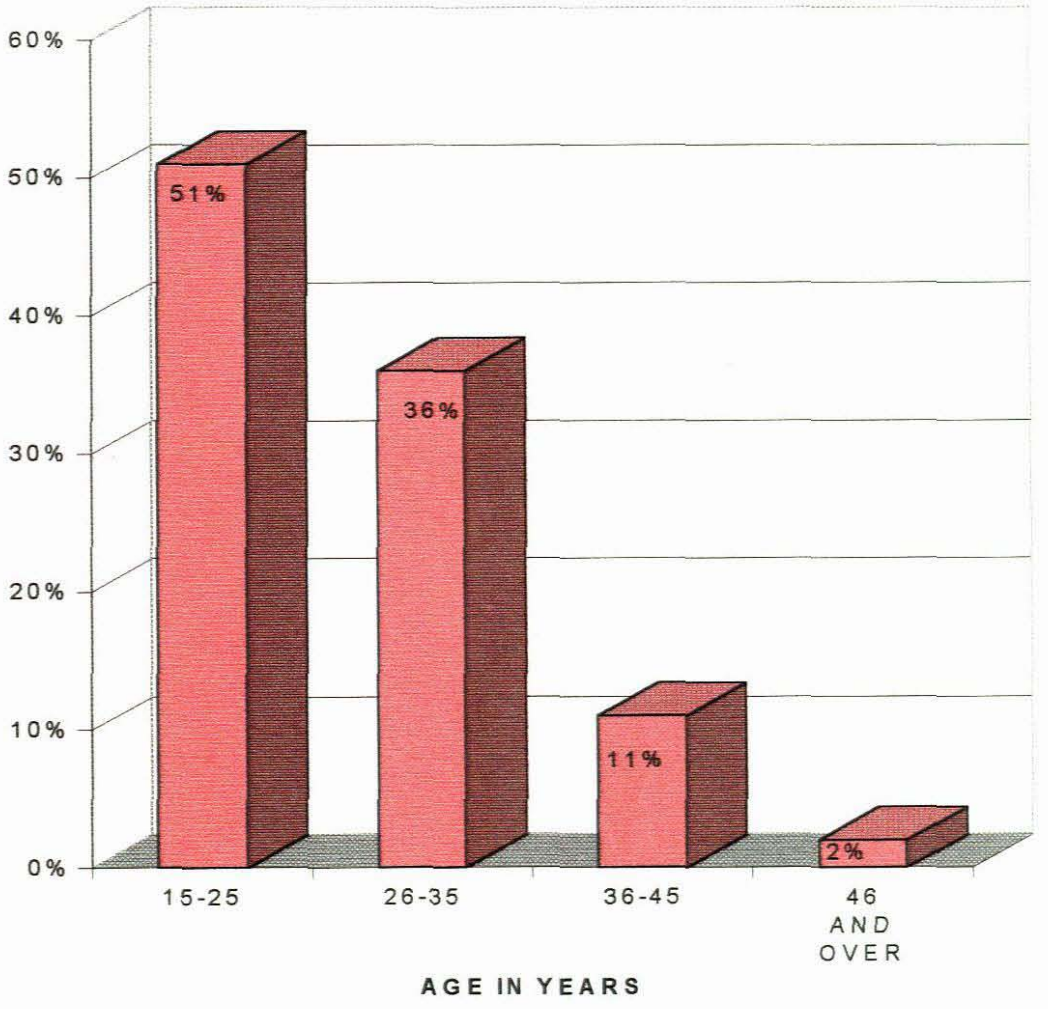


There were more males (57 percent) than females (43 percent). Though there were more female students registered in 1995 academic year than males; the situation reflected in Figure 4.1 can be attributed to a number of factors. One such factor is the manifestation of STD in different sexes. According to Ballard (1994) and Nzimande (1994) gonorrhoea for instance may be asymptomatic in females and only diagnosed on vaginal examination. In males, there is sudden onset of symptoms characterised by smelling and purulent urethral discharge. The male patient will therefore seek medical advise and prompt treatment to relieve symptoms. This probably accounts for more male patients attending the Health Service. Another factor could be failure to use condoms when a male student is engaged in casual sexual intercourse as a result of social activities like late night parties, alcohol and drug abuse. After such an engagement, the male student may contact the disease easily and a few days later seek medical treatment.

ITEM OF AGE

Determining the incidence of the disease according to age groups of people in the sample yielded the following:

FIGURE 4.2: BAR GRAPH OF AGE DISTRIBUTION N=230



The highest clinic attendance is in the 15-25 year age group (51 percent). The next highest group is between 26-35 years (36 percent). These two groups are at the adolescent stages and early adulthood stages and therefore at high risk for STD and HIV/AIDS infections. Kassner (1988) confirms this statement and is supported by Ballard (1994). During this age; it is believed that young adults are strong, active and healthy, which increases their participation in sexual activities. As one becomes older; that is from 36 years and above (11 percent) he or she is matured, sexually stable and

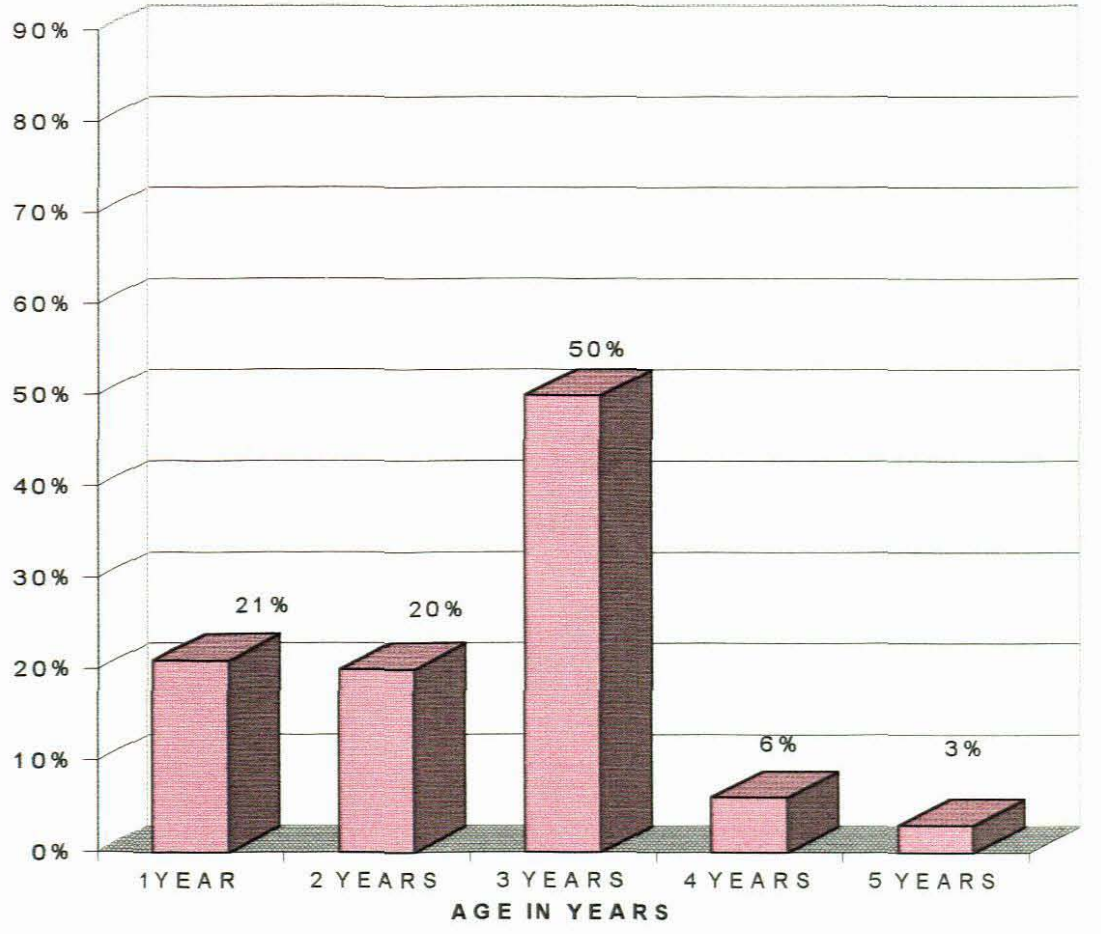
sometimes one's marital status is good and this lowers the risk of STD problems (Bradley, 1987).

ITEM OF PERIOD BEING A UNIVERSITY STUDENT

Seeking to establish the respondents' duration of stay at this institution was based on the assumption that more years of study mean more exposure to STD. The results can be seen in Figure 4.3.

FIGURE 4.3: BAR GRAPH OF NUMBER OF YEARS AT THIS INSTITUTION

N=230



The majority of respondents (50 percent) are third year students. This is probably due to the fact that the more senior one becomes at the university; the more sociable and the more sexually active and exposed to STD. This compels one to visit the Health Centre.

On the other hand; the junior students (21 percent) are shy and have not yet adjusted to the surroundings. Possibly, they are less sexually active during the first year of study. This in turn reduces their visits to the Health Centre with STD related complaints.

STRUCTURE OF THE HEALTH SERVICE

The structure which is the first component of Donabedian's model for Quality Assurance will be the starting point to ensure that quality care for STD patients is taking place at the institution under study. The students as the community who utilises the service were requested to give their views regarding the operation of the structure which is in other words the Students' Health Service. Responses regarding this subtopic will be presented as follows:

ITEM OF CONSULTATION HOURS BEING CONVENIENT

In seeking to establish if consultation hours at the Health Service are convenient to all students; the responses were as shown in Table 4.1.

TABLE 4.1: RESPONSES TO THE STATEMENT OF CONSULTATION HOURS BEING CONVENIENT TO STUDENTS N=230

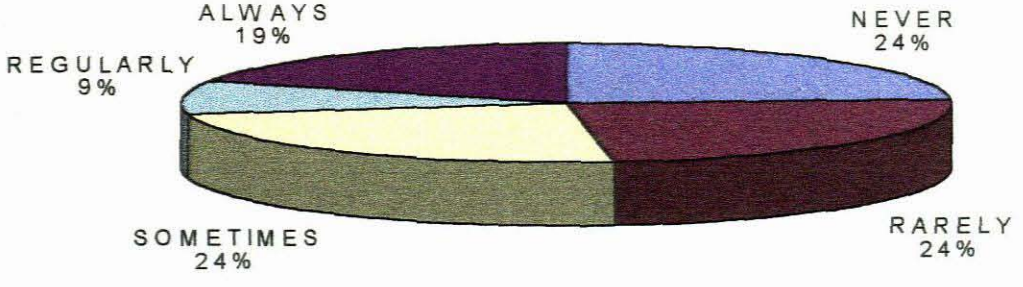
RESPONSES	FREQUENCY	PERCENT
Never	46	20.0
Rarely	34	14.8
Sometimes	90	39.1
Regularly	21	9.1
Always	39	17.0
TOTAL	230	100.0

The majority of respondents (39.1 percent) are not happy with the hours of consultation at the Health Service. A checklist used by the researcher also indicates that though hours of consultation are well stipulated, they are not convenient to all students. This is an indication that this service is not very accessible to those who need it. Accessibility of the service according to Brown **et al** (1990) means that hours of attendance are conveniently organised for prospective patients. In support of the above named authors; Yura and Walsh (1988) state that the issue of accessibility of the service should be addressed during Step 1 of the Quality Assurance Cycle in order to ensure that health care is not restricted by organisational hours of business.

ITEM OF DOCTOR'S AVAILABILITY BEING CONVENIENT

In this item, the researcher was trying to establish if the availability of the doctor at the Health Service is convenient to all students. The responses are reflected in Figure 4.4.

FIGURE 4.4: PIE DIAGRAM OF RESPONSES TO THE STATEMENT THAT DOCTOR'S AVAILABILITY IS CONVENIENT N=230

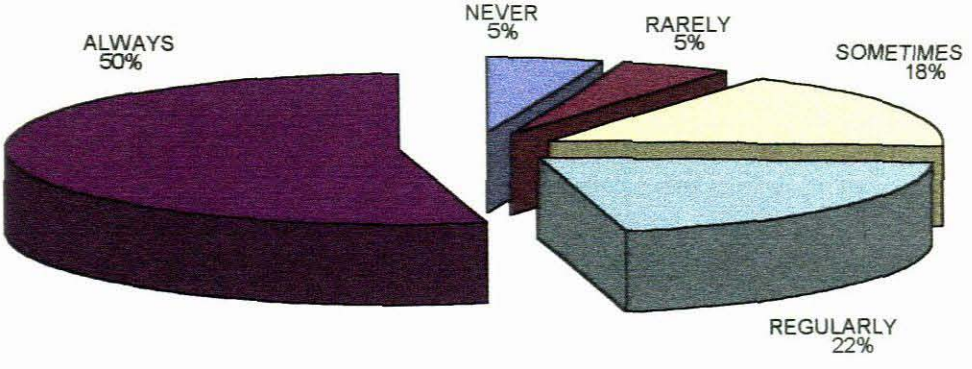


The majority of respondents (72 percent which includes never, rarely and sometimes) state that the availability of the doctor is rarely or sometimes convenient to students. Findings through a checklist also confirm this issue. This may be an indication of lack of acceptance or of knowledge of the role and function of a community health nurse; especially a clinical nurse specialist in a clinic setting. The fact that a clinical nurse is a nurse practitioner and a consultant should be communicated to students so that students at this institution can accept him/her as a medical doctor's substitute at times and in turn visit the Health Centre more frequently for promotion of health and prevention of diseases as well as for early initial treatment of diseases. Students should be aware that nurses in a clinic setting have skills and are knowledgeable to deal with health problems in general and STD problems in particular. It is one of the duties of a clinic nurse in clinic setting to guide and teach students as he or she has a teaching role to play (Searle, 1987; Menard, 1987; Brown **et al**, 1990).

ITEM OF WAITING AREA BEING COMFORTABLE

In trying to address the issue of the waiting area at the Health Service as to whether it is convenient and comfortable, the following was found. See Figure 4.5.

FIGURE 4.5: PIE DIAGRAM OF RESPONSES TO THE STATEMENT OF WAITING AREA BEING CONVENIENT AND COMFORTABLE N=230



Though the majority of respondents (72 percent which includes always and regularly) were comfortable with the waiting area and the findings from a checklist support these responses, 28 percent of respondents were not happy. This suggests that the structure of the Health Service needs some improvement so that more if not all students feel comfortable to visit the Health Service. This issue should be handled during Step 1 of Quality Assurance Cycle - that is the planning phase. Improvement in this issue could probably in turn positively affect students' attendance at the Health Service and maintain a healthy and homely atmosphere for students (Brown **et al** 1990; Yura and Walsh, 1988).

ITEM OF CLEANLINESS OF THE HEALTH SERVICE

The attempt to verify if the Health Service is clean and furniture free of dust and dirt in the opinion of consumers of the service, the responses yielded the picture in Table 4.2.

TABLE 4.2: RESPONSES ON CLEANLINESS OF THE HEALTH CENTRE N=230

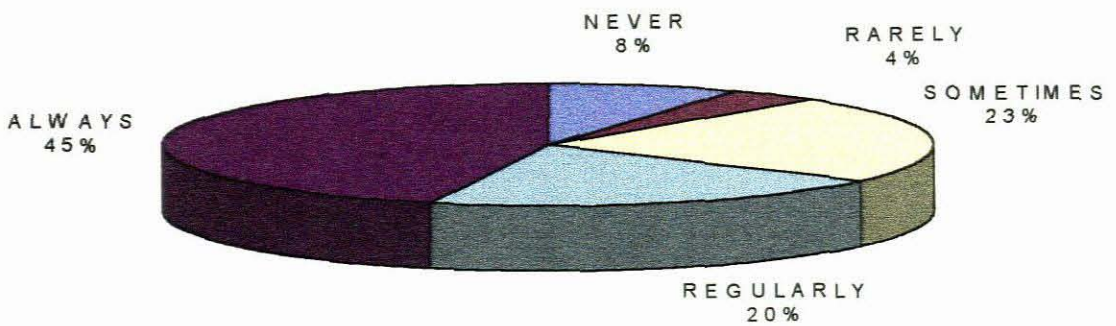
RESPONSES	FREQUENCY	PERCENT
Never	6	2.6
Rarely	12	5.2
Sometimes	49	21.3
Regularly	42	18.3
Always	121	52.6
TOTAL	230	100.0

The majority of respondents (70.9 percent which includes regularly and always) are happy with regards to the cleanliness of the Health Service. What was found through the checklist also confirms this statement. This indicates that the hygienic condition of the Health Centre is good and therefore contributes to the prevention of diseases. Dreyer **et al** (1993) indicate that an unhygienic environment surrounding the patient may

ITEM OF MAINTENANCE OF PRIVACY DURING CONSULTATION AND EXAMINATION OF THE PATIENT

On determining if privacy is maintained during the consultation and examination of the patient at the Health Service, the responses can be seen in Figure 4.6.

FIGURE 4.6: PIE DIAGRAM OF RESPONSES WITH REGARD TO MAINTENANCE OF PRIVACY



According to the above pie diagram 45 percent of respondents who responded: always were positive and so were 20 percent of respondents who responded: regularly with regard to privacy during consultation and examination processes. According to the checklist findings, by the researcher, privacy at the Health Centre is not of an ideal standard. The indication is that the review of the whole Health Service is necessary. Assessment as a phase of the nursing process should be applied; followed by

identification and prioritization of opportunities for improvement in order to ensure quality care of STD patients (Balecheck and Mc Closkey, 1985; Brown **et al**, 1990).

ITEM OF DISTRIBUTING STD LEAFLETS

In trying to determine if STD leaflets and literature are distributed routinely at the Health Centre, the respondents' opinion is presented in Table 4.4.

TABLE 4.4: RESPONSES REGARDING DISTRIBUTION OF STD LEAFLETS AND LITERATURE

RESPONSES	FREQUENCY	PERCENT
Never	19	8.3
Rarely	20	8.7
Sometimes	58	25.2
Regularly	49	21.3
Always	84	36.5
TOTAL	230	100.00

From the above table 57.8 percent (which includes always and regularly) of respondents are aware of STD leaflets and literature being distributed routinely at the Health Centre. Checklist findings indicate that STD leaflets and literature are distributed when available. This could suggest that there is an under supply of these leaflets and literature. Alternatively, it could be that health providers are failing to distribute these due to a number of factors such as shortage of health personnel, a heavy workload and lack of time to distribute STD leaflets and literature. In order to provide preventive measures, STD leaflets should be distributed as much as possible at the Health Centre. Leaflets distribution to students will be a way of influencing change in their behaviour thus preventing the disease. Being a change agent is one of the important functions of a

health care provider in a clinic situation (Menard, 1987; Searle, 1985; Dreyer **et al**, 1993).

ITEM OF DISPLAYING STD POSTERS AND PICTURES AT THE HEALTH CENTRE

In seeking to establish if STD posters and pictures are being displayed at the Health Centre, Table 4.5 provides the evidence collected.

TABLE 4.5: RESPONSES TO THE STATEMENT ABOUT DISPLAYING STD POSTERS AND PICTURES

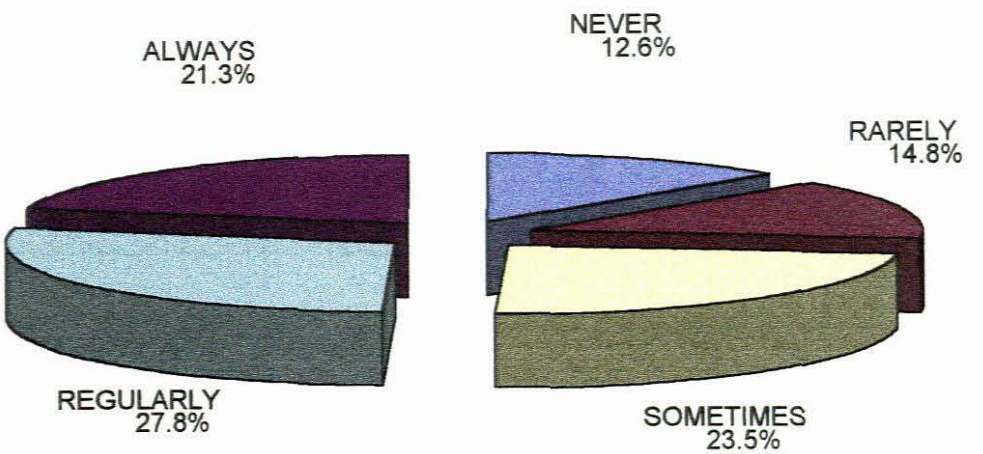
RESPONSES	FREQUENCY	PERCENT
Never	14	6.1
Rarely	21	9.0
Sometimes	50	21.7
Regularly	51	22.2
Always	94	41.0
TOTAL	230	100.00

From the foregoing table, it can be noted that less than 50 percent (41 percent) of respondents are aware of the presence of STD posters and pictures. The checklist confirms this. This could be attributed to factors such as - the poor presentation of posters and pictures on STD thus not delivering the message to students; students themselves spending little time at the Health Service and health providers during consultation not displaying these STD posters and pictures. Identifying of individuals to display STD posters and pictures at the Health Centre could be done to ensure availability of health education to students. This is Step 7 of Quality Assurance Cycle (Brown **et al**, 1990).

ITEM OF STD STANDARD PRACTICE BEING KNOWN TO PATIENTS

On determining if the standard practice for STDs is made known to patients; findings are reflected in figure 4.7.

FIGURE 4.7: PIE DIAGRAM OF RESPONSES WITH REGARD TO STD STANDARD PRACTICE BEING KNOWN TO PATIENTS N=230



There was a positive response to this statement - that is 49.1 percent (which includes regularly and always). The checklist also indicates some effort being exerted on this issue. This is an indication for improvement by applying Step 3 of Quality Assurance Cycle which involves communication of standards to patients with regard to STD. This also constitutes the evaluation of the Health Care setting to monitor the standards and ensure improvement where necessary (Brown **et al**, 1990; Yura and Walsh, 1988).

ITEM OF ADEQUATE EQUIPMENT FOR MANAGEMENT OF STD PATIENTS

Here the researcher sought to find out if the Health Service under study is properly equipped for handling STD patients. Findings are reflected in Table 4.6.

TABLE 4.6: RESPONSES TO THE STATEMENT THAT THE HEALTH CENTRE IS PROPERLY EQUIPPED FOR STD CARE N=230

RESPONSES	FREQUENCY	PERCENT
Never	35	15.2
Rarely	33	14.3
Sometimes	83	36.1
Regularly	46	20.0
Always	33	14.3
TOTAL	230	100.0

In the above table, almost half of responses (65.6 percent which includes never, rarely and sometimes) are negative about the Health Service being properly equipped for STD care. The checklist on the other hand yielded a positive response. The negative responses from students may mean that some of the students are not aware or knowledgeable of aspects of the service to be provided at the Health Centre. According to Menard (1987) a clinical nurse specialist may be the ideal person to teach students about STD facilities available at the Health Centre.

The summary and weighing of responses with regard to quality of structure is important. This is displayed below:

TABLE 4.7: SUMMARY AND WEIGHING OF RESPONSES - SHOWING THE OVERALL QUALITY OF STRUCTURE - IN PERCENTAGES

	RESPONSES				
ITEMS OF STRUCTURE	NEVER	RARELY	SOME-TIMES	REGU-LARLY	ALWAYS
	FREQ. %	FREQ.%	FREQ. %	FREQ. %	FREQ. %
Consultation hours	20.0	14.8	39.1	9.1	17.0
Doctor's availability	24.0	24.0	24.0	9.0	19.0
Waiting area	5.0	5.0	18.0	22.0	30.0
Cleanliness	2.6	5.2	21.3	18.3	52.6
Confidentiality	7.0	5.2	16.1	23.0	49.0
Privacy	8.0	4.0	20.0	23.0	45.0
Leaflets distribution	8.3	8.7	25.2	21.3	36.5
Display of posters	6.1	9.0	21.7	22.2	41.0
Standard of practice	12.6	14.3	23.5	27.8	21.3
Health centre - equipped	15.2	14.3	36.1	20.0	14.3
Mean scores	21.76	10.45	24.5	39.14	34.57
	Never and Rarely Constitute Negative = Poor Quality		Sometimes Constitute Neutral= Satisfactory Quality	Regularly and Always Constitute Positive = Satisfactory Quality	

The above table shows that in the opinion of respondents, the structure of Health Service is more of good quality. A comprehensive effort for a Quality Assurance programme is needed to improve the service for the better and thus eradicate STD infections. It is encouraging to note that mean scores for 'regularly' (39.14%) and

'always' (34.57%) are somewhat higher than those of the other columns. The two collectively form positive responses which is an indicator for good quality. Positive responses of the Health Centre outweigh the others even though it is by a narrow margin. The mean of 24.5% for neutral responses is next in weight, which is disturbing in that it could point to the fact that respondents have reservations about quality of the structure of this Health Service. Responses to the effect that the structure is poor have the least weight although almost equal to neutral responses. As pointed out in Chapter 1, possibly care in this Health Centre is questionable.

PROCESS AT THE HEALTH SERVICE

Data on the process, which in other words refers to the actual management of STD patients at the Health Centre is going to be analysed and presented under the following sub-topics:-

ASSESSMENT - this is the stage of the nursing process whereby the nurse gathers information about the patient's health status.

PLANNING - which is the phase of embarking on the plan for treatment/care and how to give it.

IMPLEMENTATION - is putting the plan into action, which amounts to the actual management of STD patients.

The following references refer to all three of the above sub-topics (Yura and Walsh, 1988; Balecheck and McCloskey, 1985).

ITEM OF ASSESSMENT PHASE DURING MANAGEMENT OF STD PATIENTS

This involved determining if nurses are friendly, approachable, display good interpersonal relationship, listen attentively, show interest, show awareness of patient's expectations, keep health information confidential, maintain professional attitude and are non-judgemental. The findings can be seen in Table 4.8.

TABLE 4.8: RESPONSES ABOUT ASSESSMENT DURING THE PROCESS OF MANAGEMENT OF STD PATIENTS N=230

	RESPONSES									
PRACTICE	**NEVER**		**RARELY**		**SOME-TIMES**		**REGU-LARLY**		**ALWAYS**	
	FREQ.	**%**	**FREQ.**	**%**	**FREQ.**	**%**	**FREQ.**	**%**	**FREQ.**	**%**
(a) Friendly and approachable	35	15.2	48	20.9	81	35.2	26	11.3	40	17.4
(b) Display good interpersonal relationship	17	7.4	52	22.6	89	38.7	32	13.9	40	17.4
(c) Listen attentively	16	7.0	36	15.7	101	43.9	34	14.8	43	18.7
(d) Show interest	30	13.0	44	19.1	90	39.1	42	18.3	24	10.4
(e) Awareness of patients' expectations	41	17.8	43	18.7	72	31.3	43	18.7	31	13.5
(f) Keeping health informa-tion secret	28	12.2	57	24.8	52	22.6	34	14.8	59	25.7
(g) Maintain professional attitude	14	6.1	50	21.7	88	38.3	33	13.3	45	19.6
(h) Being non-judgemental	31	13.5	56	24.3	70	30.4	31	13.5	42	18.3

N.B.: In this and in subsequent tables Freq. stands for frequency.

The high frequency of 'sometimes' responses to items (a) 35.2%, (b) 38.7%, (c) 43.9%, (d) 39.1%, (e) 31.3%, (g) 38.3% and (h) 30.4% indicate that respondents have reservations about the behaviour of nurses during the process of assessment. This means that the problem of attitude should be addressed and a solution should be designed for the problem. This will be Steps 6 and 9 of Quality Assurance Cycle (Brown **et al**, 1990). Research on the problem should also be undertaken (Yura and Walsh, 1988).

The skill of history-taking and health assessment to establish the patient's health status is enhanced by good relations, trust and a professional image of the nurse; especially because STDs carry a social stigma. Effective nursing intervention begins with good assessment in a conducive psycho-social environment. Nursing as a science needs to be developed by those rendering care to ensure quality (Menard, 1987; Searle, 1985; Dreyer **et al**, 1993).

The high frequency of 'always' responses to item (f) 25.7% demonstrates that nurses do ensure professional secrecy with regard to health matters of the patient. This suggests monitoring the service to maintain this good standard. Monitoring according to Brown **et al** (1990) is Step 4 of the Quality Assurance Cycle.

ITEM OF KNOWLEDGE ABOUT THE PATIENT'S HEALTH STATUS

In this item, the researcher was trying to establish if nurses get full information about patient's personal and family history, previous admission to hospital, past and immediate

health problems and their treatment, sexual partners and practices. The responses can be seen in Table 4.9.

TABLE 4.9: RESPONSES TO THE STATEMENT ABOUT INFORMATION WITH REGARD TO PATIENT'S HEALTH STATUS N=230

INFORMATION ABOUT THE PATIENT	RESPONSES									
	NEVER		RARELY		SOME-TIMES		REGU-LARLY		ALWAYS	
	FREQ.	%	FREQ.	%	FREQ.	%	FREQ.	%	FREQ.	%
(a) Personal and family history	37	16.1	47	20.4	64	27.8	37	16.1	45	19.6
(b) Previous admission to hospital	45	19.6	21	9.1	58	25.2	53	23.0	53	23.0
(c) Past and immediate health history	35	15.2	26	11.3	78	33.9	48	20.9	43	18.7
(d) Sexual partners and practices	42	18.3	28	12.2	72	31.3	54	23.5	34	14.8

The majority of respondents under 'sometimes' responses show that the issue of obtaining information about the patient is neither good nor bad. This can be seen in responses 27.8% for item (a) 25.2%, in (b) 33.9%, in (c) and 31.3% in (d). According to the findings of the checklist, nurses do take full history about the patient and his/her family. The approach required for this issue of patient's health history is to review the whole situation regarding data collection when assessing the patient. According to Balecheck and Mc Closkey (1985); supported by Yura and Walsh (1988) proper assessment leads to an accurate diagnosis which can then guide the nursing care plan. This phase, if handled well, will also reveal the level of Primary Health Care Approach at which the patient is correctly diagnosed and treated by the nurses. This is level 4 of the Primary Health Care Approach Model (Schneider, 1995).

ITEM OF PHYSICAL EXAMINATION

The attempt to verify if nurses do explain what the physical examination entails, which health problems are identified during examination and make time for patients to ask questions before giving medication, yielded the data in Table 4.10.

TABLE 4.10: RESPONSES WITH REGARD TO HANDLING OF PHYSICAL EXAMINATION N=230

HANDLING PHYSICAL EXAMINATION	RESPONSES									
	NEVER		RARELY		SOME-TIMES		REGU-LARLY		ALWAYS	
	FREQ.	%	FREQ.	%	FREQ.	%	FREQ.	%	FREQ.	%
(a) Explanation of what physical examination entails	40	17.4	33	14.3	60	26.1	52	22.6	45	19.6
(b) Explain all health problems identified during examination	27	11.7	23	10.0	75	32.6	45	19.6	59	25.7
(c) Making time for questions	37	16.1	30	13.0	66	28.7	33	14.3	64	27.8

With regard to the issue of explaining to the patient about physical examination and health problems identified during examination; respondents' 'sometimes' responses are the highest, amounting to 87.4% for items (a), (b) and (c) put together, which results in a mean of 29.1%. Although the checklist yielded positive findings on this issue the application of Step 4 of Quality Assurance Cycle, that is monitoring of standards is of importance to ensure improvement in the quality of care and therefore ensuring patients' satisfaction (Brown **et al**, 1990). It is also essential to note that in order for the plan of action to be a success and for the patient to be co-operative during examination, the

procedure to be carried out should be explained to the patient and findings made known to the patient (Balecheck and Mc Closkey, 1985).

ITEM OF PLANNING PHASE DURING THE MANAGEMENT OF STD PATIENTS

The researcher in this instance was trying to establish if nurses do discuss with the patients the plan of treatment, the role to play, possible problems or sensitive areas, the importance of taking and finishing the course of treatment. The findings about the above statement are represented in Table 4.11.

TABLE 4.11: RESPONSES ABOUT THE PLAN OF INTERVENTION N=230

	RESPONSES									
PLAN OF INTERVENTION	NEVER		RARELY		SOME-TIMES		REGU-LARLY		ALWAYS	
	FREQ.	%	FREQ.	%	FREQ.	%	FREQ.	%	FREQ.	%
(a) Plan of treatment	38	16.5	41	17.8	69	30.0	51	22.2	31	13.5
(b) Patient's role	37	16.1	35	15.2	67	29.1	56	24.3	35	15.2
(c) Possible problems	26	11.3	50	21.7	53	23.0	54	23.5	47	20.4
(d) Importance of taking and finishing the course of treatment	17	7.4	55	23.9	57	24.8	44	19.1	57	24.8

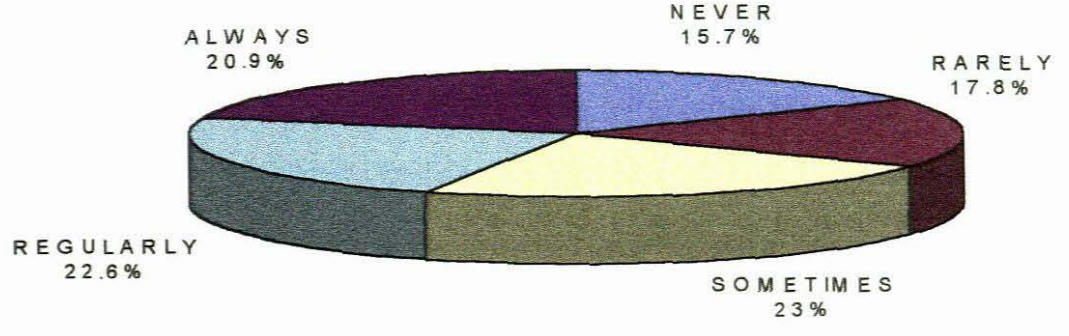
The high frequency of 'sometimes' responses to items (a) 30.0% and (b) 29.1% show that respondents are neither negative nor positive about the issue of nurses discussing and involving the patient in the plan of treatment. In item (c) 'regularly' responses (23.5%) agree that nurses do discuss the plan of treatment. The last item that is (d) has

equally low 'sometimes' (24.8%) and 'always' (24.8%) responses regarding the issue of planning which constitute a rather negative assessment. The checklist on the other hand gave positive findings. The indication of the above responses is the application of Step 4 and 5 of Quality Assurance Cycle that involve monitoring; identification as well as prioritising opportunities for improvement (Balecheck and Mc Closkey, 1985; Brown **et al**, 1990; Schneider, 1993). If the planning is well done; it will give rise to an effective intervention and patients would probably be cured. Cured patients constitute Level 5 of the Primary Health Care Approach model (Schneider, 1995).

ITEM OF ENQUIRING ABOUT SEXUAL PARTNERS AND PRACTICES

In seeking to ascertain if nurses do enquire about patient's sexual partners and sexual practices; the findings are as depicted in Figure 4.8.

FIGURE 4.8: PIE DIAGRAM SHOWING RESPONSES REGARDING SEXUAL PARTNERS AND PRACTICES



There was a high 'sometimes' response to this item (23%). The checklist findings indicate that nurses do enquire about sexual partners and practices but a method of tracing sexual contacts is still a problem. Attention needs to be given to this aspect by setting standards and designing a plan of enquiring and tracking down sexual partners of STD patients (Balecheck and Mc Closkey, 1985; Brown **et al**, 1990). A realistic plan may result in more effective implementation of treatment. In terms of the Primary Health Care Approach the STD population should be moved from Level 4 to Level 5 which is for cured people (Schneider, 1995). Proper planning of intervention where the patient actively participates can be the strong basis for moving patients across levels of the Primary Health Care Model.

ITEM OF IMPLEMENTATION PHASE DURING MANAGEMENT OF STD PATIENTS

Implementation phase is the actual management or what nurses do for STD patients to ensure optimal wellness. According to Schneider (1995) this is Level 4 of Primary Health Care Approach whereby patients are correctly diagnosed and adequately treated by health providers. Preventive measures and counselling services are also applicable during this phase of implementation. The phase involves nurses taking smears, vaginal or penile swabs, blood tests, emphasising the importance of abstaining or using condoms whilst still on STD treatment,emphasising the importance of bringing sexual partners for treatment, explaining how to take treatment, adhering to times as instructed, requesting the patient to report any drug reaction and explaining the need to see a doctor or for referral. The opinions of consumers of this Health Service in the form of responses can be seen in Table 4.12.

TABLE 4.12: RESPONSES ABOUT THE IMPLEMENTATION PHASE WHICH IS ACTUAL TREATMENT OF STD PATIENTS N=230

PRACTICE	RESPONSES									
	NEVER		RARELY		SOME-TIMES		REGU-LARLY		ALWAYS	
	FREQ.	%	FREQ.	%	FREQ.	%	FREQ.	%	FREQ.	%
(a) Explain the importance of taking smears and vaginal or penile swabs	37	16.1	26	11.3	74	32.2	46	20.0	47	20.4
(b) Explain the reason of taking blood tests	26	11.3	46	20.0	53	23.0	34	14.8	71	30.9
(c) Emphasise the importance of abstaining or using condoms whilst on STD treatment	17	7.4	29	12.6	72	31.3	34	14.8	78	33.9
(d) Emphasise the importance of bringing sexual partners for treatment	16	7.0	21	9.1	65	28.3	43	18.7	85	37.0
(e) Explain about treatment and to adhere to times as instructed	19	8.3	37	16.1	70	30.4	32	13.9	72	31.3
(f) Request patient to report in case of any drug reaction	23	10.0	37	16.1	7	24.8	47	20.4	66	28.7
(g) Explain the need to see a doctor or for referral to hospital	19	8.3	40	17.4	62	27.0	38	16.5	71	30.9
Mean scores		9.7		14.6		28.1		17.0		30.4
	Negative = Poor quality				Neutral = Satisfactory Quality		Positive = Good Quality			

The above Table shows that the high frequency of 'sometimes' responses to items (a) 32.2%, (b) 23.0%, and (c) 31.3% indicates that respondents are neutral about the practice of nurses during the implementation phase. On the other hand 'always' responses to items (d) 37.0%, (e) 31.3%, (f) 28.7% and (g) 30.9% show that respondents are aware of bringing their sexual partners for treatment, adhering to times of taking treatment as instructed, reporting any drug reaction and lastly being aware of the need to see a doctor or to be referred to hospital. The checklist findings were positive about the practice of nurses. The fact that consumers of the Health Service are neutral suggests need for improvement of the actual management of STD patients. To ensure effective management of STD patients; health providers should treat, teach and guide students of the institution under study thus preventing STDs and maintaining good health (Menard, 1987; Searle, 1985). Analysis and evaluation of implementation phase should be a continuous process in order to maintain quality care of STD patients at all times (Brown **et al**, 1990).

SUMMARY AND WEIGHING OF RESPONSES - SHOWING THE OVERALL QUALITY OF PROCESS

Findings under this variable appear to be less favourable than those under structure, in the light of the following:-

In assessment phase (Table 4.8) scores for 'sometimes' range from 22.6% to 43.9%, 'regularly' range from 11.3% to 18.7%, 'always' range from 10.4% to 25.7%. In Table 4.9 scores range as follows:

'Sometimes' 25.2% to 33.9%

'Regularly' 16.1% to 23.5%

'Always' 14.8% to 23.0%

In planning phase (Table 4.11) the range of scores shows:

Sometimes 24.8% to 30.0%

Regularly 19.1% to 24.3%

Always 13.5% to 24.8%

In Implementation phase (Table 4.12) scores range thus:-

Sometimes 24.8% to 32.2%

Regularly 13.9% to 20.4%

Always 20.4% to 37.0%

Assessment and planning scores for 'sometimes' are relatively high, and evidently outweigh those in other columns. This constitutes an assessment of satisfactory quality. By comparison, implementation scores for 'sometimes' and for 'always' are almost equally high; denoting somewhat good quality. It can be concluded that process is of quality that varies from satisfactory to good.

OUTCOME OF INTERVENTION IN THE HEALTH SERVICE

Outcome is the last phase of Donabedian's Model in the maintenance of standards. During this phase the nursing intervention is evaluated. Evaluation is the last step of the nursing process (Stanhope and Lancaster, 1988; Yura and Walsh, 1988). The outcome involves checking patients' satisfaction with the service rendered, patients recovering completely after a course of treatment and reporting back for regular check up and re-assessment. Respondents were requested to give their views with regard to outcome of the service rendered. Table 4.13 shows their responses.

TABLE 4.13: RESPONSES ABOUT THE OUTCOME OF CARE AT THE HEALTH CENTRE N=230

ITEMS OF OUTCOME	RESPONSES									
	NEVER		RARELY		SOME-TIMES		REGU-LARLY		ALWAYS	
	FREQ.	%	FREQ.	%	FREQ.	%	FREQ.	%	FREQ.	%
(a) Patient's satisfaction with the service rendered	54	23.5	38	16.5	61	26.5	35	15.2	42	18.3
(b) Patient's complete recovery after treatment	27	11.7	42	18.3	93	40.4	38	16.5	30	13.0
(c) Reporting for regular check-up	42	18.3	50	21.7	67	29.1	42	18.2	29	12.6
Mean scores		17.0		18.8		32.0		16.6		14.6
	Negative = Poor Quality				Neutral = Satisfactory Quality		Positive = Good Quality			

The high frequency of 'sometimes' responses to items (a) 26.5%, (b) 40.4%, and (c) 29.1% is evidence that the outcome of treatment is neither poor nor good. The checklist findings contradict the 'neutral' responses of the sample. The outcome, according to the checklist was found to be good. The foregoing contradiction makes it difficult to judge the situation. Possibly the criteria used by respondents to make neutral comments is not quite the same as that used by the researcher in examining

neutral comments is not quite the same as that used by the researcher in examining outcome and arriving at a positive assessment. Therefore, on-going monitoring of the situation, identifying and analysing the problems that are basic to differences in assessments, as well as finding a solution according to steps of the Quality Assurance Cycle should be a constant challenge facing the clinical nurse specialists of the Health Centre (Brown **et al**, 1990).

To summarise, it is disturbing to note that the highest scores are those of 'sometimes'. The scores on the lower end of the scale, denoting poor quality and those on the upper end of the scale denoting good quality care are equally low, falling below those of 'sometimes'. Obviously, the quality of outcome is not good, although this observation has to be validated through further research.

HEALTH EDUCATION AT THE HEALTH CENTRE

Health Education is one of the WHO's strategies that is used to ensure a healthy community. Health care providers consider Health Education coupled with preventive measures as the only weapon against prevention of communicable diseases in general and STD and HIV/AIDS infection in particular (Stanhope and Lancaster, 1988; Dreyer **et al** 1993; Ballard, 1994). Health Education regarding types of STDs, signs and symptoms, complications, mode of spread needs to be a strategy that is used at all Health Centres to update students and the community as a whole. Respondents in this study were requested to give their opinion with regards to STD information gained at the Health Centre under study. Table 4.14 shows responses of the sample about the variable of Health Education.

TABLE 4.14: RESPONSES ABOUT STD INFORMATION GAINED AT THE HEALTH CENTRE N=230

INFORMATION	RESPONSES									
	NEVER		RARELY		SOME-TIMES		REGU-LARLY		ALWAYS	
	FREQ.	%	FREQ.	%	FREQ.	%	FREQ.	%	FREQ.	%
(a) Causal organism	59	25.7	44	9.1	60	26.1	37	16.1	30	13.0
(b) Signs and symptoms	47	20.4	51	22.2	52	22.6	46	20.0	34	14.8
(c) Incubation period	31	13.5	56	24.3	57	24.8	45	19.6	41	17.8
(d) Transmission of disease	38	16.5	43	18.7	57	24.8	48	20.9	44	19.1
(e) Diagnosis	42	18.3	44	19.1	61	26.5	40	17.4	43	18.7
(f) Complications of disease	31	13.5	57	24.8	60	26.1	31	13.5	51	22.2
(g) Latest STD treatment	37	16.1	43	18.7	59	25.7	36	15.7	55	23.9
(h) Need for one faithful partner	26	11.3	32	13.9	62	27.0	44	19.1	66	28.7
(i)Tracing and treating sexual partners of the patient	26	11.3	33	14.3	42	18.3	69	30.0	60	26.1
(j) Ways to avoid complica-tions	7	3.0	36	15.7	53	23.0	72	31.3	62	27.0
(k) Patient's role in reducing the impact of STD	18	7.8	24	10.4	48	20.9	67	24.1	73	31.7
Mean scores		14.2		18.2		24.1		21.1		22.0
	Negative = Poor Quality				Neutral = Satisfactory Quality		Positive = Good Quality			

The above Table shows that the high frequency of 'sometimes' responses to items (a) 26.1%, (b) 22.6%, (c) 24.8%, (d) 24.8%, (e) 26.5%, (f) 26.1% (g) 25.7% (h) 27%, (j) 23% and (k) 20% indicates that respondents are uncertain about STD information gained at the Health Service. The frequency of 'never' responses to items (a) 25.7%,

(b) 20.4% and (e) 18.3% indicates that respondents dispute gaining STD information at the Health Centre. The checklist findings indicate that this aspect of teaching students is not effectively done as a result of the high workload. The frequency of 'regularly' responses to items (i) 30.0% and (j) 31.3%, and 'always' responses to items (h) 28.7% and (k) 31.7% indicate that respondents are updated about the relevant STD information. Health education being the key preventive measure for STD seems not to be effective or not done properly or regularly at the Health Service under study. This suggests that the teaching role of nurses at the clinic situation should be improved especially their skills and strategies of teaching so that these nurses can be able to guide and lead students about STD and HIV/AIDS infections in particular (Menard, 1987; Searle, 1987). Brown **et al** (1990) suggest a comprehensive effort of defining the problem about the apparent lack of Health Education and choosing as well as designing solutions to problem areas. The above aspects are Steps 6 and 9 of Quality Assurance Cycle.

SUMMARY AND WEIGHING OF RESPONSES - SHOWING THE OVERALL QUALITY OF HEALTH EDUCATION

It is evident from Table 4.14 that scores of 'sometimes' and those of 'regularly' and 'always' responses are almost equally high, exceeding those in the lower end of the scale. This constitutes assessment of quality of Health Education as satisfactory according to an average of 24.1% of respondents and as good in the opinion of an average of 21.1% to 22.0% of respondents. It can be deduced that in comparison to previous variables of structure, process and outcome the overall quality of Health Education is satisfactory to good.

CONCLUSION

The analysis and interpretation of data yielded the findings that:-

- Structure of the Health Centre is of good quality

- Process of management of STDs ranges from satisfactory to good quality
- Outcome of intervention is regarded as not so good
- Health Education in this Health Centre is seen as varying from satisfactory to good.

Therefore, this implies that the application of the nursing process by nurses in the Health Centre is satisfactorily done. But the evaluation phase leaves a great deal to be desired (see 'Outcome' above, Table 4.14).

These findings appear to support the concern expressed under statement of the problem that nursing intervention in this Health Centre is questionable. This possibly contributes to the unabating evidence of STDs as depicted by clinic attendance or visits over the current and past years. However, Ballard (1994) sounds a warning that there may be other factors that contribute to the apparent rise in the incidence of STDs. This author maintains that, for an example, the students frequency of visiting the Health Centre could also be a sign that these students are utilising this centre more and more because the service at this centre is becoming known to be credible and effective. In support of this Waltz, Strickland and Lenz (1986:324) maintain that patients' attitude and behaviour may be influenced by services received from other providers. Therefore, outcomes cannot be solely attributed to any one factor such as nursing care or a particular health care programme.

CHAPTER 5

SUMMARY, CONCLUSION AND RECOMMENDATIONS

INTRODUCTION

This chapter contains the summary of the four preceeding Chapters, conclusion, limitations, implications and recommendations arising from findings of the study.

SUMMARY OF THE STUDY

This study focussed on investigating the quality of care for STD patients at this university Health Service. A high incidence of STDs among students has been noticed during the past six years (see table 1.1.) This needs attention because STDs are considered to be a co-factor for HIV/AIDS infection - the killer disease.

The problem investigated was the apparent increase in STD patients which was assumed to be due to low quality management at the Health Service. The overall aim was to assess and evaluate the quality of management and care of STD patients. The study was anchored on the nursing process using structure, process and outcome of the Donabedian's model for Quality Assurance.

The target population was students residing at this institution's main campus in the 1995 academic year. The sample consisted of 279 subjects drawn incidentally from this target population, which was ten percent of the entire population. There were two research

instruments used for collecting data namely - questionnaire and checklist. Pretesting was done before conducting the major study.

The literature reviewed show that STDs are a major public health problem affecting young adults within 15-30 years of age. Further, literature indicates that young adults within the above age are the most vulnerable group at risk of acquiring STD as well as the silent killer disease AIDS. It also came to light that, it is within the nurses' scope of practice to effectively fight STDs using WHO's strategies and constantly evaluating their intervention for quality. The clinic nurse specialist should demonstrate her leadership and change agent role.

On analysis of data, the findings were as follows:

Personal particulars

The sample was predominantly males who are mainly in the age of 15-35 years. The majority of subjects were in the Third year, followed by First and Second years of study. These findings are supported by Flemming (1993) who states that STDs are the diseases of the adolescents and young adults who are the more educated members of the community.

Structure of the Health Service

It was found that according to the majority of respondents, the structure of the Health Service is of good quality.

Process at the Health Service

The majority of respondents indicates that the process which includes assessment, planning and implementation of intervention varies from satisfactory to good.

Outcome of intervention at the Health Service

With regard to the outcome or evaluation of nursing intervention, respondents regard the outcome as being neither poor nor of good quality. This is an indication that although nursing intervention is on the good side; respondents have reservations about the outcome of the service.

Health Education at the Health Service

The Health Education that takes place at the Health Service varies from satisfactory to good in the opinion of the sample.

Conclusion

The objectives of the study were:-

- To establish Health Education content and methods used at this institution's Health Service.

- To establish the extent of counselling and training of sexual contacts.

- To establish the extent to which the nursing process is applied in nursing care of STD patients

- To establish if early diagnosis is made and appropriate treatment commenced.

- To investigate the preventive and screening measures to detect and eradicate STDs.

In the light of the foregoing findings, the objectives of this study have been attained in that:-

Objectives 1,2 and 5: Health Education content and methods, extent of counselling and preventive and screening measures

Findings indicate that Health Education content and methods, extent of counselling and preventive and screening measures are adequate.

Objective 3: Extent of application of the nursing process

Findings grade this application as satisfactory to good.

Objective 4: Early diagnosis and appropriate treatment

The majority of respondents made a rating of good quality.

In conclusion, although nursing intervention at this institution's Health centre is not of the best quality; possibly there are other factors that contribute to the problem identified through this study.

LIMITATION OF THE STUDY

The time and financial constraints limited undertaking of the study to one university instead of more tertiary institutions in South Africa; as STD is considered as a major public health problem worldwide.

The stigma attached to STDs was another limiting factor; which made it impossible for the researcher to select only those students who had suffered from STDs. This would adversely affect the confidential nature of diagnosis of one's disease. Therefore, some of the students in the sample may have not suffered from the disease.

Hours of business were another limiting factor that caused the researcher to exclude part-time and evening students of the institution under study. Exclusion of the above groups of students possibly does not create a realistic picture, as STD can also be picked up by these students.

The foregoing limitations mean that the findings of this investigation can only be generalised to the target population of the institution under study. Even here, results should be generalised with caution becuase it is not known how many respondents belonged to the uninfected population.

IMPLICATIONS OF THE STUDY

The findings of this study have several implications for the authorities of this institution, nurses providing care, consumers of health and the Government.

Institutional authorities

Personnel in authority as stakeholders need to be aware that health issues facing adolescents and young people have changed during the past quarter of the century. According to Kibel, Philathiou and Springler (1992:241) young people of today are endangered mostly by injury, alcohol and drug abuse, pregnancy and STD as well as HIV/AIDS. If these health issues are played down by educational authorities; they could assume epidemic proportions in the institution with disastrous outcomes on the calibre of students.

Nurses providing care

To this group, findings of this study imply low standards in their rendering of service. Nurses need to improve their skills and strategies of teaching and intervention in order to be able to help students as a community to lower or eradicate STDs. As professional people, they should realise that they are accountable and they will be held responsible

whether the situation improves or deteriorates. Effectiveness and quality of any health care system depends, according to King (1922:214), on co-ordination and team work.

Consumers of the health care

Consumers of the health service are students of this institution. Findings imply questionability of their involvement in the comprehensive health education programmes which will bring about the desired behaviour and attitudinal change. 'Optimal health for all' is the aim of the Human Science Research Council (Kibel, **et al** 1992). Students themselves should take full responsibility of their health.

The Government

With regard to the Government, this study implies a great demand on the health care and social services. According to the report of a study by Whiteside, Wilkins, Mason and Woods (1996:13) increased load especially that of HIV/AIDS leads to overcrowding in hospitals. The budget for the managment of STDs and HIV/AIDS is quite high. Regarding social and welfare; the above authors state that as income earners fall ill; severe financial difficulty results thus more burden is on the Government. Therefore, if STD and HIV/AIDS are not lowered or eradicated; this will mean more burden on the Government and the tax payers.

RECOMMENDATIONS

In the light of the foregoing findings and conclusions the following recommendations are suggested including those suggested by respondents in the form of data from open-ended questions.

Budget by institutional authorities should be revised and a plan to be designed that will ensure that students diagnosed as suffering from STD receive a free service. This will in turn encourage students to be able to visit the Health Centre more frequently and thus early detection of the disease and management will be possible. Preventive campaigns need to be considered seriously and financially catered for by institutional authorities in

order to be able to diminish risk taking behaviour of all students. This should be a team effort not merely by trained nurses rendering the service. More funds need to be budgeted for by the authorities of the institution for restructuring of the Health Centre, with emphasis on preventive care and Health Education.

There should be a comprehensive Health Education programme, which can bring about the desired behaviour and attitudinal change. Nurses in a clinic setting are in a position to influence change as they are change agents. Health Education and preventive measures are still the only weapons we health providers have against STDs. Health Education at the Health Service under study can be achieved by directly involving students in these programmes. Students involvement can take place through planning Health Education programmes with Students' Representative Council (SRC) and residence committees making use of senior students and training of peer counsellors on health and sexually related issues. Health Education workshops should be on ongoing basis at students' residences.

Restructuring of the Health Service in the form of extending hours of service should be looked into. Accessibility of the Health Service could be improved by requiring the institutional authorities to re-address this issue. This may mean that those rendering health care could take shifts in order to ensure that the service is available and convenient to all students registered at this institution. In respect of the availability of the doctor; a clinical nurse specialist should be available as he or she will use a broad theoretical and experiential base to solve problems of STD patients.

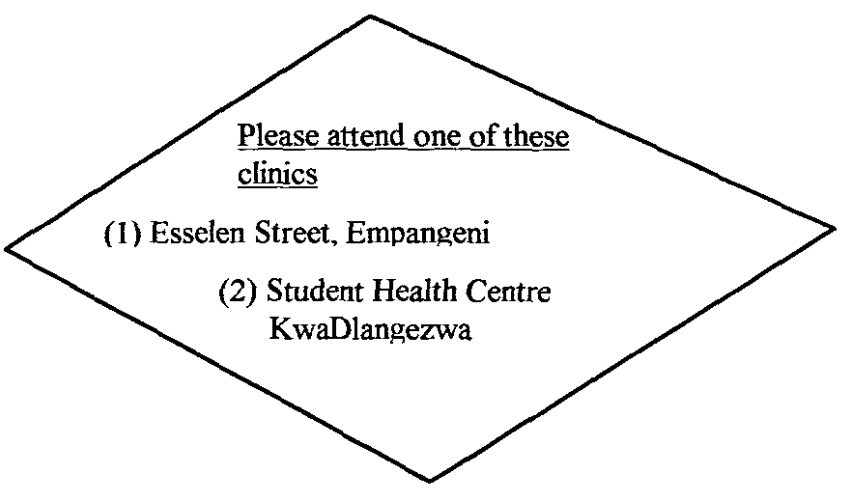
The issue of health care providers' attitude need to be addressed. As Barker (1993) has pointed out, society's attitudes need to change in order to provide our patients with whatever protection we can. STD has a social stigma and this stigma is worse in cases of HIV/AIDS infections. Health care providers must learn not to attach shame to a person who is infected with STD as well as with HIV/AIDS. Non-judgemental, respectful attitude, listening attentively, being thorough and competent and explaining

the diagnosis and managment to the patient in clear and simple terms should be practiced by all health care givers in order to ensure an effective approachable staff at the clinic (Department of Community Health, 1995:23). In-service education and workshop progammes should be given to nursing personnel to effect change in their attitude and behaviour to patients.

Routine screening of all patients complaining of penile or vaginal discharges should be done to ensure early detection and treatment of STDs. Respondents suggested open STD lectures, videos, pamphlets, seminars to take place at the Health Service. Counselling of sexual partners and contacts is also emphasised by respondents. As one of the preventive measures, all STD patients should be issued with condoms as well as instructions on how to use them.

A standardised contact card should be issued to all STD patients in order to be able to trace their sexual partners (Department of Community Health, 1995:27). Figure 5.1 will be an example of a contact slip that can be used.

FIGURE 5.1: CONTACT SLIP FOR SEXUAL PARTNERS OF STD PATIENT



Trained counsellors for STD clinic attenders should be available in order to identify ways of avoiding re-infection thus keeping the students population free of STDs.

Syndromatic management of STD which is the approach that identifies the syndrome or disease and treat the most important symptoms of that syndrome, should be available at the Health Service on regular basis (Ballard, 1994). The advantage of syndromatic management according to Ballard (1994) is effective comprehensive and good quality care of STD. According to Schneider (1995) the information on syndromatic management includes history taking, examining the patient, treating the patient, counselling, tracing of sexual contacts and follow up, encouraging use of condoms and referral if necessary should be concise and up-to-date.

Auditing of quality care by the Department of Community Health (1995:57) should be on regular basis. Schneider (1995) suggests this auditing to take place through observations and consultations of patients' records.

The findings of this study should be known to the university stakeholders, clinic staff and recommendations should be implemented.

Finally, it is recommended that this study be repeated again in two years' time to assess the quality of service for STD patients. It is also recommended that the study be extended to other tertiary institutions in KwaZulu-Natal in order to determine the extent of STD and HIV/AIDS infections.

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ANNEXURE 1

University of Zululand

Universiteit van Zoeloeland

Private Bag X1001
Privaatsak
KWADLANGEZWA 3886
South Africa
(0351) 93911
'Unizul'
SA 631311
FAX (0351) 93735

Ref./Verw.

31 October 1995

Miss B. Vilakazi
Professional Nurse
UNIVERSITY OF ZULULAND MEDICAL CLINIC

Dear Miss Vilakazi

APPLICATION FOR PERMISSION TO CONDUCT RESEARCH ON SEXUALLY TRANSMITTED DISEASES AT OUR RESIDENCES: YOUR LETTER OF 30 OCTOBER 1995 REFERS

This office welcomes the nature of your research and congratulates you for deciding to face squarely so important an issue in our residences and, indeed, in our country as a whole.

Please feel free to consult with this office should you encounter problems in the process of conducting your research. We are more than prepared to assist in whatever manner possible.

Thank you.

ASSISTANT REGISTRAR: RESIDENCES

ANNEXURE 2

UNIZUL
Private Bag X1001
KWADLANGEZWA
3886

Student Health Service

Dear Respondent

The researcher (Miss B. Vilakazi) working at the University of Zululand Health service is requesting a few minutes of your time to answer this questionnaire.

The researcher is deeply concerned by the escalation of sexually transmitted diseases (STDS) at the University campus. Being aware that it is a sensitive topic to tackle and respecting you as an individual, privacy and responses received will be kept strictly confidential.

A questionnaire has been included which, with your permission will take not more than fifteen minutes of your time to answer.

The University Health Service need to grow and with your help it can grow in a professional manner. The researcher is sure that you will be willing to co-operate and help the clinic staff to reach desired goals.

Thank you for your assistance.

Sincerely Yours,

BEQUIET VILAKAZI (PROFESSIONAL NURSE)

UNIVERSITY OF ZULULAND STUDENT HEALTH SERVICE

QUESTIONNAIRE ABOUT THE QUALITY OF CARE

FOR STUDENTS WITH SEXUALLY TRANSMITTED DISEASES

This questionnaire will help to improve the quality of nursing care of students with sexually transmitted disease at the University of Zululand Health Service.

You are therefore kindly requested to provide us with sincere information on this subject.

Your name should not appear anywhere on this form. Please answer all questions and mark with an (x) against the appropriate answer or response.

1. Please indicate the following about yourself

1.1 Gender

Male	
Female	

1.2 Age (in years)

15 - 25	
25 - 35	
36 - 45	
46 +	

1.3 Year of study

First year Diploma or Bachelor's degree	
Second year Diploma or Bachelor's degree	
Third year Diploma or Bachelor's degree	
Honours's degree	
Master's degree	
D.PHD degree	

2. The Student Health Service/Structure

	Never	Rarely	Sometimes	Regularly	Always
	1	2	3	4	5
2.1 The consultation hours at the Health Service are convenient to all students					
2.2 Regularity of the doctor's availability is convenient to all students.					
2.3 Comfortable, convenient waiting area is available at the Health Service					
2.4 Nursing staff do ensure that the Health Service is clean and furniture free of dust and dirt					
2.5 Privacy for clients during interviews and examination is provided					
2.6 Information regarding your health and personal matters are kept strictly confidential					
2.7 Nursing staff do display posters, and pictures on sexually transmitted diseases					
2.8 Reading leaflets and magazines on sexually transmitted diseases are distributed routinely and freely to clients at the health service					

1.3 Year of study

First year Diploma or Bachelor's degree	
Second year Diploma or Bachelor's degree	
Third year Diploma or Bachelor's degree	
Honours's degree	
Master's degree	
D.PHD degree	

2. The Student Health Service/Structure

	Never	Rarely	Sometimes	Regularly	Always
	1	2	3	4	5
2.1 The consultation hours at the Health Service are convenient to all students					
2.2 Regularity of the doctor's availability is convenient to all students.					
2.3 Comfortable, convenient waiting area is available at the Health Service					
2.4 Nursing staff do ensure that the Health Service is clean and furniture free of dust and dirt					
2.5 Privacy for clients during interviews and examination is provided					
2.6 Information regarding your health and personal matters are kept strictly confidential					
2.7 Nursing staff do display posters, and pictures on sexually transmitted diseases					
2.8 Reading leaflets and magazines on sexually transmitted diseases are distributed routinely and freely to clients at the health service					

	Never	Rarely	Sometimes	Regularly	Always
	1	2	3	4	5
2.9 Protocols (standard of practice) for sexually transmitted diseases are made known to clients					
2.10 Student Health Service is properly equipped for handling sexually transmitted disease clients.					

2.11 In your opinion what are your suggestions for improving the health service structure for clients with sexually transmitted diseases

.....

.....

.....

3. PROCESS

3.1 Assessment

	Never	Rarely	Sometimes	Regularly	Always
	1	2	3	4	5
3.1.1 - The nurses are friendly and approachable.					
3.1.2 - Nurses do display sound interpersonal relations that contribute to effective health counselling and a positive rapport with patients by					
a) - Listening attentively to client's complaints					
b) - Showing interest to the patient					
c) - Being aware of patient's expectation, fears and feeling					

	Never	Rarely	Sometimes	Regularly	Always
	1	2	3	4	5
d) - explaining to the patient that all the information given will be kept secret					
e) - maintaining a professional attitude and behaviour					
f) - Being non-judgemental					
3.1.3 Nurses do get full information from a patient about:					
a) - personal and family history					
b) - Immediate and past health problems and their treatment					
c) - Sexual practices and partners					
d) - Previous admission to a hospital					
3.1.4 Nurses do explain fully what the physical (body) examination will entail					
3.1.5 Nurses do explain in simple terms all health problems identified during physical examination					
3.1.6 Nurses do make time for questions before treating the patient					

	Never	Rarely	Sometimes	Regularly	Always
	1	2	3	4	5
d) - explaining to the patient that all the information given will be kept secret					
e) - maintaining a professional attitude and behaviour					
f) - Being non-judgemental					
3.1.3 Nurses do get full information from a patient about:					
a) - personal and family history					
b) - Immediate and past health problems and their treatment					
c) - Sexual practices and partners					
d) - Previous admission to a hospital					
3.1.4 Nurses do explain fully what the physical (body) examination will entail					
3.1.5 Nurses do explain in simple terms all health problems identified during physical examination					
3.1.6 Nurses do make time for questions before treating the patient					

3.1.7 - Are you satisfied about the way the nurses carry out assessment phase at the health centre? If no, please give suggestions .....

.....

.....

3.2 Planning

3.2.1 Nurses do discuss with the client:

	Never	Rarely	Sometimes	Regularly	Always
	1	2	3	4	5
a) - The plan of treatment and the short and long term goals					
b) - the role to be played by the patient and how					
c) - the possible problems or sensitive areas and what is to be done					
d) - the importance of taking treatment, adhering to times and finishing the course					
3.2.2 Nurses do enquire about sexual contacts so that they can be traced and treated					

3.2.3 What is your role in the planning process of your treatment? .....

.....

3.3 Implementing

3.3.1 Nurses do

	Never	Rarely	Sometimes	Regularly	Always
	1	2	3	4	5
a) - explain the importance of taking smears and vaginal or penile swabs					
b) - explain the reason for taking blood tests					
c) - emphasize the importance of abstaining from sex or using condoms whilst on treatment for sexually transmitted disease					
d) - emphasize the importance of bringing sexual partner or partners for treatment					
e) - explain about the tablets and injection given					
f) - Request one to report back in case of any reaction to a drug or injection					
g) - Explain if one need to be seen by a doctor or referred to hospital for further investigation					

3.3.2 In your opinion what is expected of you regarding treatment of sexually transmitted disease?

.....

.....

3.3 Implementing

3.3.1 Nurses do

	Never	Rarely	Sometimes	Regularly	Always
	1	2	3	4	5
a) - explain the importance of taking smears and vaginal or penile swabs					
b) - explain the reason for taking blood tests					
c) - emphasize the importance of abstaining from sex or using condoms whilst on treatment for sexually transmitted disease					
d) - emphasize the importance of bringing sexual partner or partners for treatment					
e) - explain about the tablets and injection given					
f) - Request one to report back in case of any reaction to a drug or injection					
g) - Explain if one need to be seen by a doctor or referred to hospital for further investigation					

3.3.2 In your opinion what is expected of you regarding treatment of sexually transmitted disease?

.....

.....

4. EVALUATION /OUTCOME

4.1 According to your knowledge and observation:

	Never	Rarely	Sometimes	Regularly	Always
	1	2	3	4	5
a) - Are clients satisfied with the quality of service at the Student Health Service?					
b) - Do clients recover completely after a course of treatment given by nurses at the Health Service?					
c) - Do nurses request client's with sexually transmitted disease clients to report back at the Health Service for regular check up and feedback?					

4.2 Do you have any comment regarding evaluation of the health service? If yes please feel free to comment

.....

.....

5. HEALTH EDUCATION

5.1 According to the information gained at the health service we (clients) are updated on

	Never	rarely	some times	Regularly	Always
	1	2	3	4	5
a) - causal organism of sexually transmitted disease					
b) - signs and symptoms					
c) - Incubation period					
d) - How the disease is spread					
e) - How the disease is diagnosed					

	Never	Rarely	Sometimes	Regularly	Always
	1	2	3	4	5
f) - Complication, dangers of the disease					
g) - Latest treatment of sexually transmitted disease					
h) - Need for having one faithful sexual partner					
i) - Importance of tracing and treating sexual partners when suffering from sexually transmitted diseases.					
j) - the best way to avoid complications of sexually transmitted disease, especially AIDS					
k) - The role one has in reducing the impact of sexually transmitted diseases					

.....

.....

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	Never	Rarely	Sometimes	Regularly	Always
	1	2	3	4	5
f) - Complication, dangers of the disease					
g) - Latest treatment of sexually transmitted disease					
h) - Need for having one faithful sexual partner					
i) - Importance of tracing and treating sexual partners when suffering from sexually transmitted diseases.					
j) - the best way to avoid complications of sexually transmitted disease, especially AIDS					
k) - The role one has in reducing the impact of sexually transmitted diseases					

.....

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ANNEXURE 3

CHECKLIST

To assess the quality of care for STD patients at the University of Zululand Students' Health service.

Students' Health Service/Structure

	Yes	No	Not certain
-Are hours of service convenient to all students?			
-Are doctor's availability being convenient to students?			
-Is the waiting area convenient and comfortable?			
-Is the health service clean and furniture free of dust and dirt?			
-Is confidentiality of health and personal matters maintained?			
-Is privacy during consultation and physical examination of the patient maintained?			
Are STD leaflets distributed routinely at the Health service?			
Are STD posters and pictures displayed at the Health service?			

Is the standard of practice for STDs management known to patients?			
Process **Assessment Phase** Are the nurses: - Friendly and approachable? - Display good interpersonal relationship - Listen or have listening ear - Show interest - Aware of patients' expectations - Keep health information secret - Maintain professional attitude - Non-judgemental			
Obtaining information with regard to patient's health status. Do nurses obtain information from patient about his or her - Personal and family history - Previous hospital admission - Past and immediate health history - Sexual partners and practices			

During physical examination of the patient do nurses: - Explain what physical examination entails - Explain health problems identified during physical examination - make time for patient to ask questions			

<u>Planning phase</u> During the planning of nurses' intervention do nurses - Involve the patient in the planning of the treatment - Explain what the patient's role is - Explain what are possible problems - Explain the importance of taking and finishing the course of treatment - Enquire about sexual partners and practices			

<u>Implementation phase</u> Do nurses explain - The importance of taking smears and vaginal or penile swabs? - The reason of taking blood tests? - The importance of abstaining or using condoms whilst on STD treatment? - The importance of bringing sexual partners for treatment? - About treatment and the importance of observing times as instructed? - Request patient to report in case of any drug allergy? - The need to see a doctor or for referral to hospital?			
<u>Outcome of intervention</u> Do nurses evaluate - Patient's satisfaction with the service rendered? - Patient's complete recovery after STD treatment? - Regular check-up of STD patients?			

<u>Health education</u> Do nurses give education regarding - STD casual organism? - Signs and symptoms of the disease? - Incubation period? - Mode of spread of the disease? - Diagnosis? - Complications of STDs? - Latest STD treatment? - The need of one faithful partner? - Tracing and treating sexual partners of the STD patient? - Ways to avoid complications? - Patient@s role in reducing the impact of STD?			

ANNEXURE 4

PROPOSAL FOR RESEARCH

TITLE:

AN INVESTIGATION INTO THE QUALITY OF NURSING INTERVENTION FOR SEXUALILY TRANSMITTED DISEASE PATIENTS AT THE UNIVERSITY OF ZULULAND STUDENTS' HEALTH SERVICE

NAME OF RESEARCHER: BEQUIET N. VILAKAZI

REGISTERED NUMBER : 870991

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INTRODUCTION

This study is conducted at University of Zululand and after this University will be used for this institution. STDS will also be used for sexually transmitted diseases. STD constitute a major public health problem in South Africa as well as in other countries.

Studies that have been undertaken estimate that over one million clients seek treatment for STD each year at all health services, private practice, hospital out-patient department and primary health care clinics.

It has been noted that in South Africa, STD remain a social health problem to families, employers, countries' economy as well as to lovers. Millions of public funds that could be used for other social services are spent on treatments of patients suffering from STDs.

An effective health delivery service would probably reduce public funds spent on health services for STD. In this investigation, the researcher's intention is to probe into the feasibility of reducing repeat visits by victims of STDs in the University's students' health service.

STATEMENT OF THE PROBLEM

There appears to be low quality nursing intervention in the management of patients with STDs at the University Students' Health Service. Evidence for this low quality nursing intervention is an increased incidence of patients with STDs. The figures below indicate the increased incidence of patients with STDs as revealed by Students' Health Service annual reports:

YEAR	TOTAL NUMBER OF REGISTERED STUDENTS	TOTAL NUMBER OF VISITS TO THE HEALTH SERVICE
1991	5,255	610
1992	3,805	420
1993	5,194	180

The researcher intends investigating the causes of the apparently poor quality nursing intervention in the management of patients with STDs. The situation in other universities is that STD is not unique for university of Zululand campus nor for universities only, but it is a public health problem in many underserved areas.

It was not possible to get the figure showing the incidence of STDs in other universities as students at one university in Natal are being advised and referred to a doctor at the STD special clinic in town. Also a students' Health Service at a technicon in Natal applies the same procedure for clients with STDs.

The prevalence of STD at a university health service in the Cape was determined in 1992 and again in 1993. In 1992, four hundred and fifty nine (459) patients out of a total of 1928 were picked up. In 1993, three hundred and sixty three (363) patients out of a total of 1820 had STDs - both sexes (verbal report: Prof Mfenyana).

The above figures indicated that for both years, the prevalence of STD was higher than that found at the Department of Family Practice at one of the Cape General hospital in 1992.

Professor Mfenyana also indicated that the diagnosis of STD is made on clinical grounds but laboratory investigations are necessary because of the problem of mixed infection. Nursing care and management need to be evaluated for quality in order to lower the rate of STDs.

SIGNIFICANCE OF THE STUDY

A related study have been done but this one emphasize nursing intervention. The significance of this study is to highlight to nurses the need to ensure good quality nursing intervention. Other tertiary institutions are probably going to benefit from this study because of similar age groups that get enrolled in these institutions. The students who have been affected by STDs may end up being hospitalized and thus have their

academic progress hampered. The significance of this study will be to obviate the percusions that may result from the disturbance brought about by these diseases.

MOTIVATION FOR THE STUDY

The researcher who has been involved in the management and care of students with health problems since 1985, has observed that the quality of nursing intervention is inappropriate. This results in escalation of STDs at this university.

The researcher feels that the problem needs to be researched in respect of the quality of nursing intervention rendered. Although, help, quidance and assistance could be given to these students, it remained the researcher's belief that measures like full medical examination and more intensive health education could be undertaken in order to ensure quality nursing intervention. Therefore the researcher in conducting this study, hopes to identify better means to plan and implement quality nursing intervention in the management of STDs' patients. This in turn should lower the rate of STDs on the campus and ensure a healthy university community.

OBJECTIVES OF THE STUDY

The overall aim is to examine and evaluate the quality management and nursing intervention of patients with STDs. The study should attain the objectives of:

1. Identifying health education content and methods used at the health service.
2. Identifying method of counselling sexual partners and tracing of sexual contacts.
3. Establishing the extent to which the nursing process is used for nursing intervention.
4. Identifying methods used in marking early nursing diagnosis and treatment of patient with STDs.
5. Assessing the referral system for further management at specialized clinics or hospital.
6. Assessing the rehabilitation process that is undertaken at the health service.

THEORETICAL FRAMEWORK

The theoretical framework on which this study is based is the nursing process. Yura and Walsh (1988) consider the nursing process as an orderly systematic manner of determining the client's health status, specifying problems defined as alterations in human need fulfilment. Nursing process further makes plans and evaluates the extent to which the plan is effective in promoting optimu wellness and resolving the problem defined. As the

researcher will be using nursing process as the base of the study, the stages need to be taken into consideration.

According to Yura and Walsh (1988) the stages are:

1. Assessment
2. Planning
3. Implementing
4. Evaluating
5. Recording.

The above stages will be discussed briefly.

Assessment

This is the first step of the nursing process. This step involves reviewing a human situtation from a data base in order to affirm the wellness state and diagnose potential clients' problem. This phase is concluded by making a nursing diagnosis.

Planning

This is the determination of a plan of action to assist the client toward the goal of optimal wellness.

This phase begins with the utelization of judgements made about human need fulfilment.

Implementing

This is the initiation and completion of actions necessary to accomplish the defined goals of optimal wellness.

Evaluating

Evaluating is considered in terms of how the client responded to the planned action. This stage is the appraisal of the changes experienced by the client in relation to goal achievement.

Recording

This is the fifth step of the nursing process according to South African literature. Dreyer et al (1993) regard recording as essential as nurses are responsible for their own actions and omissions. Full, accurate and scientific documentation is of utmost importance in any nursing service.

These stages of the nursing process provide a systematic means by which nurses can describe, explain, prescribe and replicate those activities necessary to impact on human need fulfilment. In this study, the researcher intends to investigate the extent to which nursing intervention at the Students' Health Service adheres to the steps of the nursing process. If it does not, this could be one of the factors underlying the high incidence of STDs.

CHAPTER TWO

LITERATURE REVIEW

INTRODUCTION

On perusing available literature and research studies on this issue, it was established that STDS are the most common communicable diseases in the world. The number of people has continued to increase each year for almost the past two decades.

The World Health Organisation has estimated that over 250 million persons are infected annually with gonorrhoea and over 50 million with syphilis. The above statement indicates that STDS are a world wide health problem which need to be attended to by health authorities in the nursing profession. The quality of nursing intervention need to be looked at in order to lower the rate of STDS among students.

Balecheck and McCloskay (1985) regard nursing intervention as an autonomous action based on scientific rationale that is executed to benefit the client in a predicted way related to nursing diagnosis and the stated goals. Nursing interventions are thus what the nurses do with and for patients in order to solve a problem or prevent a possible problem. After a nursing diagnosis,

the nurse tries to alter the client's state of affairs with the aim of assisting the client to move towards desired goals. Goals specify how a patient can move toward promotion, maintenance or restoration of health.

As professiona nurses at the University Health Service assist students to move towards desired goals -that of promoting health, nursing intervention need to be of high quality in order to meet the desired goals.

In order to be in line with quality care for STDS the Department of National Health and Population Development has guidelines on STDS. All Workers in the field of health care should be guided by these guidelines. These guidelines are:-

Education of persons at risk, on modes of transmission of disease and means of reducing transmission.

Provision of effective diagnosis and treatment for patients with symptoms.

Detection of infection in asymptomic carries of disease and in persons with symptoms who would otherwise not present for consultation.

Taking into consideration the incidence of STD clients at University Health Service, the above principles hardly exist. It appears as if the Health Service is either incompetent to effectively deal with students suffering from STDS.

In view of the policy guidelines from the Department of National Health and Population Development for STDS it is strange that the University would not have an organized plan in terms of which students could be subjected to clinical examination at least on arrival to ensure that no STD is transmitted into the campus. If this was to happen, one would have had to deal only with the problem of students contracting STDS during their years of study.

The World Health Organization (Searle et al, 1989) is hoping that by the "year 2000" individuals will realise that they themselves have the power, to shape their lives and that they will use better ways of growing up, growing old and dying gracefully.

Dladla (1991) conducted a study on evaluation of the role individuals play towards promotion of their Health and well-being. She indicated that the Health Act 63 of 1977 has introduced valuable changes into the system of health care provision in South Africa - that is, change from curative orientated services to a comprehensive health care which gives "equal attention to promotive, preventive, curative and rehabilitative health". The researcher further indicated that the influence of the Alma-ata conference in 1978 led to the extention of the role of nurse which involves idenpendent and interdependent functions of a professional nurse.

Balecheck and McClskey (1985) consider independent and interdependent functions of a nurse as most important in the implementation of nursing intervention.

Searle (1987) regards independent function of a nurse as the power and control the nurse has over his or her practice and she remains responsible and accountable for her actions and omissions. Such power and control on the other hand allow for interdependence in the delivery of health service, meaning that the nurse has that interrelationship between her and the other members of the patient. In addition to promoting health of students, Primary health care is a competent strategy for combating and controlling STDS thus ensuring a health nation.

In a research study conducted by Ngubane (1986) on Primary health care needs of urban and rural African community, it was found that primary health care is a universally accepted health care service. It is at a price the community can afford and with resources they can provide, rendered by the health care workers coming from the people and living with people. In the above study, the authorities are urged to utelise the existing willingness to accept primary health care services.

The World Health Organization in the declaration of Alma-ata regards Primary health care as an essential health

care made accesible to individuals and families in the community by means acceptable to them through their full participation and at cost that the community can afford to maintain the spirit of self-reliance. Students at a University level should be encouraged to be aware that primary health care is the first contact care and constitutes an individual's point of entry into the comprehensive health care system (Vlok, 1980).

Primary health care is the key to achieve acceptable level of health throughout the world as part of social development and in the spirit of social development and social justice.

Nurses on the other hand need to be knowledgeable and be up to date in the prevention and promotion of health. Nursing intervention using the nursing process will be the key.

DEFINITION OF TERMS

Sexually transmitted diseases

Sexually transmitted disease are communicable disease that are transmitted or spread by sexual intercourse - for example - Gonorrhoea, syphilis, candida (Berhow, 1987)

In the study, sexual transmitted disease will mean all those infectious diseases that are spread by way of sexual contact between two people of opposite sex.

Nursing intervention

Pinnell and Meneses (1986) regard nursing intervention as any action that prevents harm from occuring to a client or that maintains or improves the mental, physical or psychological function of a client.

Balecheck and McCloskay (1985) define nursing intervention as "an autonomous action based on scientific rationale that is executed to benefit the client in a predicted way related to the nursing diagnosis and the stated goals." In this study, nursing intervention will mean nursing action in the management of students with STDs aimed at lowering the high incidence of the disease.

Quality

According to Longman Dictionary of English usage, the concept quality refers to the degree to which something is excellent or the standard of goodness. Quality of nursing in this study will mean the effectiveness, efficiency and economy with which health delivery services are rendered. The benefit of such services in the final analysis gives rise to clients' satisfaction as well as to the providers of human and material resources.

CHAPTER THREE

METHODOLOGY AND COLLECTION

RESEARCH DESIGN

The type of research design for this study will be the descriptive research design. According to Seaman (1989) a descriptive design observes, describes, explores and solves a problem. This design has been chosen as the most appropriate for this study in that it will involve collecting data from subjects visiting the Students' health service of the university for consultation and treatment of health problems.

RESEARCH INSTRUMENT

Data will be collected by means of questionnaire as well as examining clinical records of clients visiting the Students' health servive.

This tool will be distributed easily whilst clients are waiting for consultation. Questionnaires will be given to students who volunteer to participate in the study.

THE TARGET POPULATION

The researcher will focus on adolescents and young adults from ages 16 - 35 years, both males and females. A total number of 100 subjects will constitute the target population since the health service staff sees 800 - 1000 clients per month.

THE SAMPLE AND SAMPLING

The sample will consist of full time registered students who visit the health service.

The researcher will start collecting data as from February to November 1995. Considering the size of the sample Treece and Treece (1982) state that a large sample is too costly and time consuming thus they suggest 10 percent of the target population to be used when choosing the sample size. As the target population is 1000 subjects, 10 percent will be 100 subjects with STDS who visit the health service between February 1995 to November 1995. These subjects will be taken as representatives of the entire population.

The sample will be incidentally selected in the sense that not every student will have an equal chance of being chosen. Subjects will be taken as they come for

consultation and treatment at the health service.

RESEARCH INSTRUMENT

Data will be collected by means of questionnaire as well as examining clinical records of clients visiting the Students' health servive.

This tool will be distributed easily whilst clients are waiting for consultation. Questionnaires will be given to students who volunteer to participate in the study.

PILOT STUDY

Polit and Hangler (1983) regard the pilot study as a small scale version or trial run done in preparation for a major study. The pilot study is done to improve the research tool, detect faults and pretest the instrument for validity and realibility before the major study is undetaken. The pilot study for this research will include all the steps of data collection as well as analysis except that the number of subjects will be on a smaller scale. Subjects participation in the pilot study will not be included in the main study.

ETHICAL PRECAUTIONS

Ethical precautions will be observed with respect to adherence to professional, legal and social obligations to research subjects (Treece and Treece, 1982).

Ethical precautions will be taken into consideration seeing that one is dealing with human beings. Subjects will be assured of anonymity and confidentiality. Informed consent will be obtained from subjects in order to protect human rights.

Results will be handled with confidentiality. Permission for doing the study will be obtained from the Senior professional nurse in charge of the health service. The results will be made available to the Health service of the university.

DELIMITATION OF THE STUDY

As this study will be done at the university, annual reports produced by the students' health service as well as students' clinical records will to a very large extent determine the extent to be covered by this investigation.

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