Improving the quality of STI care by private general practitioners: a South African case study

H Schneider, N Chabikuli, D Blaauw, I Funani, R Brugha

Methods: We implemented a multifaceted intervention, the core of which were four interactive continuing medical education seminars. Changes in STI treatment practices were evaluated through record reviews before and after the continuing medical education intervention in 17 randomly selected practices in the intervention districts and in nine randomly selected practices from a reference GP group (n = 34).

Results: There were statistically significant improvements in the quality of drug treatment for urethral discharge but not pelvic inflammatory disease among both intervention and reference GPs.

Conclusions: Improvements in STI quality were possibly the result of a background secular trend rather than the intervention itself. Further research is needed on financial and other incentives to improved quality of STI care in the private sector environment.

The growth of a private for profit sector has been a key feature of health systems in many developing countries.1 In South Africa, estimates are that half or more sexually transmitted infection (STI) care episodes in the formal health sector are treated by private general practitioners (GPs).2 The majority (76%) of GPs dispense drugs and most have a mixed clientele of insured and “cash” clients, offering all inclusive packages of care for a fixed fee.3

Poor quality STI care has been well documented in this setting and stems from a lack of access to up to date knowledge and a low profit environment creating powerful economic incentives to minimise expenditure on care.2–4

We report on a study that aimed to identify and test local strategies to improve the quality of STI care by private GPs in South Africa.

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clients with health insurance varied from 34.2%, to 43.3% and 71.2% in D1, D2, and D3, respectively.

Of the 1194 records reviewed, PID was the most common (65.9%) STI syndrome. Although the overall adherence to national STI treatment guidelines was low, in the before-after analyses we observed a significant improvement in treatment practices for urethral discharge in D2 (p = 0.005) and D3 (p = 0.036) (table 1). Quality of treatment for PID did not change significantly in the intervention groups, while in the reference group there was an increase in both ineffective and effective regimens (p = 0.007).

### DISCUSSION

Our conclusion is that the intervention probably did not influence the quality of STI care, as positive trends were present in both intervention and reference districts. However, the three groups of GPs studied were not randomly selected and the socioeconomic status of their patients varied. This may have reduced the ability to detect changes resulting from the intervention.

Behaviour change is evidently taking place among private GPs in poor urban areas in South Africa, although the exact mechanisms for this are not clear. Further research is needed into STI quality improvement strategies relevant to private GPs, possibly addressing financial incentives more explicitly.

### ACKNOWLEDGEMENTS

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### CONTRIBUTORS

HS and RB were co-PIs of the study; HS drafted the article; NC, TF, and HS jointly managed the intervention; DB had a significant role in the design and analysis of the study.

### REFERENCES


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**Table 1** Effectiveness of drug combinations for urethral discharge and pelvic inflammatory disease in records of STI clients by syndrome among intervention (D1, D2) and reference (D3) GPs (n = 1105)

<table>
<thead>
<tr>
<th>District</th>
<th>STI syndrome</th>
<th>Time period</th>
<th>Syndrome effectiveness</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1</td>
<td>Urethral discharge</td>
<td>Before (64)</td>
<td>Effective: 18 (28.1%)</td>
<td>0.595</td>
</tr>
<tr>
<td></td>
<td></td>
<td>After (56)</td>
<td>Partially effective: 31 (48.4%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PID</td>
<td>Ineffective: 15 (23.4%)</td>
<td></td>
</tr>
<tr>
<td>D2</td>
<td>Urethral discharge</td>
<td>Before (78)</td>
<td>Effective: 23 (29.5%)</td>
<td>0.005</td>
</tr>
<tr>
<td></td>
<td></td>
<td>After (56)</td>
<td>Partially effective: 42 (53.8%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PID</td>
<td>Ineffective: 13 (16.7%)</td>
<td></td>
</tr>
<tr>
<td>D3</td>
<td>Urethral discharge</td>
<td>Before (33)</td>
<td>Effective: 6 (18.2%)</td>
<td>0.036</td>
</tr>
<tr>
<td></td>
<td></td>
<td>After (31)</td>
<td>Partially effective: 18 (54.5%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PID</td>
<td>Ineffective: 9 (27.3%)</td>
<td></td>
</tr>
</tbody>
</table>

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**Key messages**

- Private practitioners are key providers of STI care in South Africa and other developing countries.
- Adherence to nationally accepted STI treatment guidelines in the private sector environment is poor.
- More research is needed on interventions to improve quality of privately provided STI care, possibly combining knowledge based strategies with financial incentives.
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