

# District STD Quality of Care Assessment DISCA

## INSTRUCTIONS:

Please fill out this evaluation by:

1. Interviewing a senior clinician
2. Inspecting the facilities, equipment and supplies, and
3. Examining the laboratory specimen register and patient medical records

Province: ..... District: .....

Health facility name: .....

Date of visit: ..... / ..... / ..... / ..... Time of visit: ..... h .....  
day month year

Full name and title of district clinic supervisor: .....

## ACCESSIBILITY

1. Does this facility offer STD treatment **at all times** between 8 am and 4 pm on all weekdays?  YES  NO
2. Does this facility offer STD treatment as part of **after clinic hours** services?  YES  NO
3. How many **adult consultation rooms** are there in this facility? \_\_\_\_\_
4. a. Does this facility use **all adult consultation** rooms to treat patients with STDs?  YES  NO  
 b. If no, how many consultation rooms are used for STD care? \_\_\_\_\_
5. Please **observe** whether this facility offers **consultation** in private for all STD patients i.e. consultations cannot be observed by other patients and providers?  YES  NO
6. Please request a caseload book or register.  
 a. What is the total number of adult patient attendances last month? \_\_\_\_\_  
 b. What is the total number of STD attendances last month? \_\_\_\_\_

## SAFE EXAMINATION

7. Are the following pieces of equipment available in all adult consultation rooms ?  

	Total number in this facility	
a. Examination couch	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
b. Examination light	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
c. Sterile speculums	<input type="checkbox"/> YES <input type="checkbox"/> NO	

## PROVISION OF SAFE TREATMENT:

8. a. Are there STD syndromic management guidelines at this facility?  YES  NO
- b. Are there STD syndromic management guidelines in all adult consultation rooms?  YES  NO
- c. Are there individual patient education materials about: STD/ HIV prevention and treatment available in this facility?  YES  NO
- d. Are these educational materials written in a local language?  YES  NO
9. Is syphilis RPR testing available in this health facility?  YES  NO
10. What is the **turn-around time** \* for the RPR test results?  
 (\* The time elapsed between taking blood (for RPR) from the patient and getting the results back from the laboratory.) \_\_\_\_\_ days
11. Have there been any occasions over the last month that the male **condoms** ran out?  YES  NO
12. Are STD patients **shown** how to use condoms in this facility?  YES  NO
13. Is there a **dildo** available for condom demonstrations in this facility?  YES  NO
14. If no, how do you make sure that a patient knows how to use condoms in this facility?  
 .....  
 .....
15. Does this facility have a **referral policy** specifically for STDs in case where patients do not respond to treatment or have complications?  YES  NO
16. Partner Notification - **Observe**
- a. Are Partner Notification cards /letters available in all adult examination rooms?  YES  NO
- b. Are the cards written in a local language?  YES  NO
17. Ask for the Laboratory Specimen Book or Register.  
 How many STD clients had **blood taken** for RPR (syphilis) test last month?  
 \_\_\_\_\_

## ANTENATAL SCREENING AND STD TREATMENT

18. a. Does this facility provide **antenatal care**?  YES  NO
- b. If yes, is **syphilis screening** done on all pregnant clients who attend antenatal care for the first time?  YES  NO
19. Do you **examine and treat pregnant** clients for STDs other than syphilis?  YES  NO

## STAFF TRAINING

Number

20. a. How many clinicians (doctors or nurses who examine and treat patients) are working today? \_\_\_\_\_
- b. How many clinicians who are working today have been on a formal training course in STD syndromic management? \_\_\_\_\_
- c. How many clinicians working today have been on a formal HIV/ AIDS counselling course ? \_\_\_\_\_

21. Is there a nurse or doctor with responsibility to supervise STD care in this facility?

YES	NO
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## STD DRUGS AND TREATMENT

22. Visit the pharmacy or drug store room. Ask the pharmacist or nurse in charge of drugs the following:

DRUGS	Is it currently in stock? Yes/No	Over the last month has the drug run out? Yes/No	State the reasons for drugs running out.
1. Ciprofloxacin 250mg tabs			
2. Flagyl 2g tabs			
3. Erythromycin 250 mg tabs			
4. Doxycycline 100mg tabs			
5. Benzathine Penicillin 2.4 mu			

23. If patients folders are kept in this facility, please ask to see these at the pharmacy or treatment room. Take the most recent ten STD client cards, and fill in the information required using the table below.

STD patient folders	Was the patient diagnosed according to the syndromes below? Yes/No	Specify the syndrome. See codes below	What type of drugs did the patient receive? State the type, dose and duration	Is the drug prescription correct? Yes/No	Was the RPR or VDRL test requested? Yes/No
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

**Syndromic Codes:** (to be used in the 2nd column above);

1 - Penile discharge  
4 - Genital Ulcers

2 - Vaginal discharge  
5 - Genital warts

3 - Pelvic inflammatory disease (PID)  
6 - Other STD (specify)

24. Ask a clinician the following questions:

What drugs (type and dosage) would you use to treat:

- a. a man with penile urethral discharge? .....
- .....
- b. a woman complaining of a vaginal discharge? .....
- .....
- c. a man or a woman with genital ulcer? .....
- .....

**COMMENTS:**

25. What are the problems that affect the daily delivering of quality STD care in this facility?

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26. What recommendations will you make to improve the situation:

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27. What is the plan of action resulting from this supervisory visit?  
*( The supervisor should discuss this with senior clinicians)*

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28. Additional comments:

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**This assessment tool has been approved by the Department of Health  
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**This questionnaire may be photocopied for further distribution.**