

STAKEHOLDERS' PERCEPTIONS OF THE DELIVERY AND QUALITY OF SEXUALLY TRANSMITTED INFECTION TREATMENT BY PRIVATE PRACTITIONERS IN WINDHOEK, NAMIBIA

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ABSTRACT

The primary objective of this study was to explore the perceptions of the community and other stakeholders regarding the delivery and quality of sexually transmitted infection (STI) treatment and care provided by private general practitioners (PGPs) in Windhoek, Namibia.

The study provided a situational and contextual analysis employing qualitative methodologies using different methods of data collection. The methodology used included (1) a review of available country policy documents on STI management and surveillance, as well as the policy with regard to private primary care providers, (2) eight in-depth interviews conducted with key informants and (3) three focus-group discussions held with community members attending PGP practices in Windhoek.

The perceptions of the care received from PGPs differed from one person to the next. It emerged that some participants had good experiences and some had negative experiences of the care given. The participants believed that going to a PGP for treatment is a matter of affordability that goes hand in hand with the expectations of receiving care, whilst maintaining confidentiality. The study established that there is no real difference between the care provided to patients with medical aid or those without medical aid.

It is recommended that interactions between the public and private sector at various levels be initiated to ensure that curable STIs are appropriately managed and that national guidelines for STI management are adhered to. Health workers should also be sensitised about their approach towards patients. It is further recommended that awareness creation amongst PGPs with regard to the public health importance of STIs needs to be raised to encourage them to participate in the STI-control programme.

OPSOMMING

Die hoofdoel van die studie was om ondersoek in te stel na die persepsies van die gemeenskap en ander belanghebbendes oor die lewering en kwaliteit van die behandeling en sorg ten opsigte van seksueel oordraagbare infeksies (SOIs) deur privaat algemene praktisyne in Windhoek.

Die studie het 'n situasionele en kontekstuele analise behels, waarin gebruik gemaak is van kwalitatiewe metodologieë en verskillende metodes van data-insameling. Die metodologie het ingesluit (1) die bestudering van beskikbare nasionale beleidsdokumente oor die behandeling en monitering van SOIs sowel as die beleid op privaat primêresorgvoorsieners, (2) agt diepte-onderhoude met sleutelinformante en (3) drie fokusgroepgesprekke met lede van die gemeenskap wat die praktyke van privaat algemene praktisyne in Windhoek besoek.

Die persepsies van die sorg wat van algemene praktisyne ontvang is, verskil van deelnemer tot deelnemer. Dit het aan die lig gekom dat sommige deelnemers die gelewerde sorg positief ervaar het terwyl ander dit negatief ervaar het. Die deelnemers het geglo dat om 'n algemene praktisyn vir behandeling te besoek 'n kwessie van bekostigbaarheid is wat gepaard gaan met 'n verwagting van sorglewering terwyl vertroulikheid behou word. Die studie het bevind dat daar geen verskil is in die sorg wat gelewer word aan pasiënte met 'n mediese fonds teenoor dié daarsonder nie.

Daar word aanbeveel dat interaksie op verskillende vlakke tussen die openbare en privaat sektor aangemoedig moet word om te verseker dat behandelbare SOIs voldoende bestuur word en dat die nasionale riglyne ten opsigte daarvan nagekom word. Gesondheidswerkers behoort gesensitiseer te word ten opsigte van hul benadering tot hul kliënte. Daar word verder aanbeveel dat die bewusmaking van die openbaregesondheidsbelang van SOIs onder privaat praktisyne opgeskerp moet word sodat hulle aan die SOI-beheerprogram sal deelneem.

INTRODUCTION**Background**

Common sexually transmitted conditions can have severe consequences for individuals and communities all over the world and need to be addressed in an appropriate way within a specific framework of treatment (United Nations Fund for Population Activities 2004). In many parts of Africa, private general practitioners (PGPs) provide a significant proportion of primary-level health care services. One of the important conditions for which patients seek care in the private sector is sexually transmitted infections (STIs), being a disease acquired through sexual contact with an infected person. STIs are epidemic in most parts of the world and provide a unique set of challenges for the nurse and physician. Even countries with relatively accessible public sector health facilities that provide STI

treatment free at the point of delivery have more than 50% of all their STI patients preferring to be seen by PGPs because of greater levels of privacy and a perception that the quality of care is better in the private sector than in the public sector (Chabikuli, Schneider & Brugha 2004; Smeltzer & Bare 2000).

However, previous reports indicate that a large number of STI cases in the private sector are treated ineffectively and it is therefore considered essential to create an awareness amongst the community regarding the management of STIs (United Nations Fund for Population Activities 2004). The current situation of unregulated 'therapeutic chaos' in the private sector also has an equity dimension, as the poor tend to use informal and unqualified providers and are thus victim to unscrupulous practices. The lack of an effective and appropriate accountability framework for the private sector, coupled with the information asymmetry that does not enable patients to put pressure on providers, makes it difficult to ensure evidence-based practice and ethical behaviour in the private sector (Mayaud & Mabey 2004; South African Health Review 1999; United Nations Fund for Population Activities 2004).

STIs, including the human immunodeficiency virus (HIV), are the most common cause of illness in Namibia, posing social and economic consequences. In 1998, STIs were ranked eighth amongst causes of outpatient consultation, with 80 000 reported consultations (Government of the Republic of Namibia (1999, 2008)). The presence of HIV has changed and increased the importance of STI control, due to the strong correlation between the spread of conventional STIs and HIV transmission. Ulcerative STIs continue to facilitate high transmission of HIV because of the broken skin continuity making an easy port of entry for the HI virus and other infections. The presence of HIV has further affected the aetiology of STIs, causing the emergence of viral STIs such as herpes simplex to increase due to immune suppression. Antimicrobial resistance of several STI pathogens continues to increase over time, making treatment failure a common phenomenon in most STI-control programmes. Infection with one STI suggests the possibility of infection with other organisms as well (Smeltzer & Bare 2000; United Nations Fund for Population Activities 2004).

Although community members are not aware of the correct treatment, or do not have the capacity to judge whether the treatment provided is appropriate or not, they still prefer PGPs for STI treatment. They would rather return to the same doctor for the same problem than go to a public health facility. There is a general perception in the Namibian community that if one wishes to receive good quality care, one should consult a PGP. In general, public health facilities are associated with poor quality of care and unfriendly health workers. However, no data have been available to prove this perception, hence the decision to conduct this research.

Definition of concepts

Sexually transmitted infections (STIs): An infection that can be transferred from one person to another through sexual contact. In this context, sexual contact is more than just sexual intercourse (vaginal and anal) and also includes kissing, oral-genital contact, and the use of sexual 'toys' such as vibrators (*Webster's New World Medical Dictionary* 2008). It is generally defined as any disease that can spread through sexual intercourse (Hornby 2005).

General practitioner (GP): A physician whose practice consists of providing ongoing care, covering a variety of medical problems in patients of all ages, often including referral to appropriate specialists. Also called the *family doctor* (*The American Heritage Stedman's Medical Dictionary* 1995), the GP is furthermore defined as a doctor who is trained in general medicine and who treats patients in a local community rather than in a hospital (Hornby 2005). A private general practitioner (PGP) links to the above definition referring to a general practitioner who owns a private practice.

State health services: In Namibia, where the study was conducted, this refers to health service rendered by any state health facility.

OBJECTIVES

The main objective for this study was to explore the perceptions of the community and other stakeholders regarding the delivery and quality of STI treatment and care by PGPs in Windhoek. Specific objectives were:

- to assess the perceptions of the community regarding the delivery of STI treatment by the private sector with reference to the national recommended guidelines for the syndromic management of STIs in Windhoek
- to describe the perceptions of community members and other stakeholders regarding the STI treatment provided by PGPs
- to describe the reasons why individuals prefer the PGPs above the public sector for STI treatment in Windhoek
- to explore the perception of the relevant private practitioners stakeholders, for example, independent practitioners associations (IPAs), medical councils and other relevant medical regulatory bodies or councils, regarding STI management by PGPs
- to describe recommendations for the improvement of STI treatment provided by PGPs.

RESEARCH METHOD AND DESIGN

The study provided a situational and contextual analysis employing qualitative methodologies, using different methods of data collection. A qualitative design was deemed suitable for the study because it is a systematic subjective approach used to describe life experiences and give meaning about a specific situation. In this study, the researchers attempted to gain insight into the perceptions of the community regarding the care and treatment provided by PGPs (Burns & Grove 2005).

Study population, sampling and sample size

The study population included all the PGPs in Windhoek, the general community members, the members of the Medical Council and Nursing Council, the Namibian Medical Association and the Permanent Secretary of Health and Social Services in Namibia. Furthermore, STI policy and treatment guidelines were also included. All mentioned stakeholders constitute the context in which the care and treatment of STIs in Windhoek are provided. They all participate in formulating guidelines of care regarding STIs and could therefore not be excluded from the study.

Purposive sampling was applied to ensure that those who have a stake in private practice or the regulation of the practice, as well as patients who normally use PGPs, were included. The STI policy document as well as the STI treatment guidelines was reviewed, eight in-depth interviews were conducted with individuals from the Ministry of Health and Social Services, the Medical Council and Nursing Council, the Registrar of the Health Council and the Chairperson and the Secretary of the Medical Association. These bodies exist to ensure that the care provided by all health care workers in Namibia complies with the national guidelines regarding STI treatment and care.

Three focus-group discussions were conducted with the general public (this included willing community members that use both state and private health services as patients) and one with workers at Namibian Breweries who use mainly PGPs, although the workers have the option to use the state health services.

Data-collection methods

Various methods of data collection were used in this study and included the following:



Firstly, a review of available country policy documents on STI management and surveillance, as well as the policy with regard to private primary care providers, using a checklist, was conducted. The review of policy documents was necessary to assess what the guidelines stipulate in terms of STI treatment and to determine whether PGPs follow these national guidelines in their treatment of STIs.

Secondly, an unstructured questionnaire was used to interview stakeholders. This approach gave stakeholders the opportunity to give their view rather than to be restricted to answer certain questions about STI management (Burns & Grove 2005; Polit & Beck 2006). Interviews were conducted in English by the researchers in Windhoek.

Thirdly, a focus-group discussion guide was used during focus-group discussions with identified participants (Burns & Grove 2005; Polit & Beck 2006) and these were conducted in English and Afrikaans by the researcher who is conversant in both languages.

Data analysis

Data were analysed using open coding, as described by Guba and Lincoln (as cited in Krefting 1991). Themes, categories and subcategories were developed and described.

ETHICAL CONSIDERATIONS

The following ethical aspects were observed and considered:

- Written permission was obtained from the Ministry of Health and Social Services to conduct this study and a letter of ethical clearance was issued in this regard.
- Informed consent (verbal) was obtained from all the individual participants in the study.
- Participation was voluntary and participants had the freedom to withdraw from the interview or focus-group discussions at any stage.
- Confidentiality and anonymity was observed during all phases of data collection and reporting (Burns & Grove 2005).

TRUSTWORTHINESS

Trustworthiness, which refers to the truth value of qualitative data (Polit & Beck 2006), was ensured for the qualitative data in this study and employed Guba's model (cited in Krefting 1991). This model has been used extensively by qualitative researchers, particularly nurses and educators, for a number of years (Krefting 1991; Lincoln & Guba 1985).

The following four criteria to ensure trustworthiness were applied (1) credibility, (2) applicability, (3) consistency and (4) confirmability. The application of strategies of credibility ensures truth values, whilst the application of strategies of

transferability ensures applicability. To ensure consistency, strategies of dependability were applied and for neutrality, strategies of confirmability were applied.

A short, schematic presentation is provided in Table 1 to indicate how trustworthiness was ensured in the study.

DISCUSSION AND RESULTS

The results presented in this study are those obtained from focus-group discussions, in-depth interviews and the documents reviewed during this study.

Policy documents

Guidelines for the syndromic management of STIs in Namibia are available in Namibia, as is the South African Development Community (SADC) protocol for STI treatment. The study found that most PGPs are barely familiar with the Namibian guidelines for the syndromic management of STIs, and those that are familiar with them do not adhere to the guidelines all the time. Those PGPs who follow the guidelines do so inconsistently.

Preferences for health services in the Windhoek area

Most of the participants indicated during the focus-group discussions that the majority of the Namibians use public health facilities due to their affordability, although those who are employed and on medical aid sometimes use PGPs for their health services. One participant supported this observation, saying:

'most people go to state health clinics or the public health facilities because it does not cost a lot and you cannot be denied services if you cannot pay; however, those with medical aid go to private doctors.'

Employees of private companies and those who are employed, in general, use private health facilities for their health care needs, including those of STIs, as stated by two participants:

'We go to private general practitioners and private clinics, but it all depends on the contribution one makes to the medical aid.'

'For STIs it is more private to consult a GP than going to public health facilities because you do not know, people talk.'

It appeared that some private companies have arrangements with private health institutions in Windhoek to take care of their employees in order to avoid absenteeism by employees. Furthermore, people assume that if treatment is given by a PGP, their personal information is more secure than it would be in public health facilities. Preferences to consult a PGP were underpinned by the desire to minimise embarrassment and enhance confidentiality, through discussing sexual concerns with someone they felt was likely to be trustworthy (Gott & Hinchliff 2003).

TABLE 1

A schematic presentation of the strategies of establishing trustworthiness with their criteria and implementation in the study

Strategy	Criteria	Implementation
Truth value (credibility)	Reflexivity	• The researchers actively partook in data collection and did not just fulfil the role of observers.
-	Time sampling	• The meetings with the private practitioners and community members were preceded by a short period where the nature and purpose of the study were explained • Proper appointments had to be made with the practitioners to avoid disruption of their daily appointment routine • A pilot study was done
-	Member checking	• The participants were involved in preliminary results presentations to confirm the research findings are true to their experiences
Applicability	Dense description	• Rich descriptions of findings are done
Consistency	Dense description	• A full description of the data collection and data analysis methods is provided in order for other researchers to trace the methods utilized
Confirmability	Audit trail and audit process	• An audit trail was maintained by keeping personal notes and field notes, plus existing literature
-	Reflexivity	• As discussed under truth value

Perception of state health facilities

Most participants indicated that they use PGPs and private health facilities predominantly. A participant expressed perceptions of the state health facilities as follows:

'I am in [the] public health sector as an employee. I use to take my mother to the state clinic and Katutura state hospital. I must say though that if nurses know you they try to treat you well. This is not correct. Every person should be treated equally. They are rude sometimes, many times arrogant – whether you are young, middle-aged or old. They shout at patients. They do not explain to patients what they are doing. There is nothing! Most of the time, they [i.e. health workers in public health facilities] are not friendly.'

The perception is that those working in public health facilities are rude, unfriendly and not time-conscious and these perceptions force the community members to turn to the private sector for basic health care needs, even if they are unable to afford it (Gott & Hinchliff 2003).

Perception of private institutions

The study revealed that it is not always advantageous to be treated in the private sector: Some participants have also had negative experiences in the private institutions, as they sometimes had to wait for attention, despite having made appointments for consultation. One respondent commented:

'The waiting in consulting rooms! I do not like it, you must get up and ask why the waiting. They do not explain to why you wait.'

Another subject said:

'If you are late, they charge you for the consultation.'

However, some participants differ about the waiting aspect, as stated by one participant:

'I have not encountered sitting for hours at my doctor ever! Ten minutes [at] the most'.

The researcher assumed that all these sentiments were expressed from the individual point of view. The majority of the participants felt that in private practice, the business mentality exceeds the value attached to care provision, as supported by one participant's view:

'The business part is exceeding the health care; doctors are concerned about the money. Before they attend to you they will ask "Can you pay?" or "How are you going to pay?"'

This is a serious problem that can affect the quality of care rendered in general, because the patients' ability to pay could be used to determine the quality of care they would be given.

Experiences of care provided by private general practitioners

Experiences with regard to STI care provided by PGPs were mixed. It emerged that some participants had good experiences and some had negative experiences with the care given, as demonstrated in the following statement:

'They do not bother to get up from their chairs. They just give you a prescription with no explanations.'

Another respondent claimed that:

'I was for years at one doctor and every time they just give me the same prescription. I decided to change, and my new GP found a break in my stomach for the same complaint. I had to get an operation.'

Participants who had positive experiences stated the following:

'I have [had] one doctor for many years and he checks me every time.'

'You will not stay with a doctor if he does not treat you well.'

'I have never been to other institutions than the Roman Catholic Hospital. They are dedicated, they have compassion. People there really take care of the patients and love it!'

The sentiments of both positive and negative experiences are generally relative, individualistic and time-bound. In this study,

participants reported more positive experiences than negative experiences. The positive experiences are equated to quality of care and the negative experiences are branded as poor quality of care.

Preferences of sexually transmitted infection patients for treatment

Affordability appears to be a major determining factor when patients have to decide where to seek STI treatment, as one participant said:

'If people could afford it, they will go to a private doctor for confidentiality purposes. They will go where they can afford. Individuals in employment are using both sectors; not all of them have medical aid.'

Gott and Hinchliff (2003) observed in a study conducted in Sheffield that GPs are perceived as the main source of professional help regarding sexual problems.

A patient's place of residence is another factor, as expressed by another respondent:

'If where you live there are no general practitioners then obviously one will be forced to go to state institutions for treatment even if you would like not to do so. Availability of service will determine where you go. You may want to go to private but where you live is only a state health facility available.'

From these observations, it can be concluded that the economic status and the place of residence of an individual are the main determinants of health-seeking behaviours. PGPs are predominantly found in urban areas in Namibia and it is rare for them to conduct visits to rural areas. Language and culture are mentioned as some of the determinants of where to go for STI treatment in Windhoek. It is reported that in general, patients would prefer PGPs for STI treatment, chiefly for confidentiality purposes.

Reasons for preferences of private practitioners above the public health sector

During the focus-group discussions, participants were asked where they would seek STI treatment and the reason for their choice. This was significant information, because it would help establish the perceptions of preferences for STI treatment.

The discussion elicited various reasons for the preference of patients to use PGPs for STI treatment. Some of these are (1) that people can choose where to be treated, (2) the waiting period for services from PGPs is short or they do not have to wait at all, (3) people are friendly in private practices, unlike in public health facilities and (4) the consulting rooms are clean, unlike at state institutions (Vuylsteke *et al.* 2001).

Klausner and O'Toole (2006) conducted a study in which they found that the environment and the attitude of practitioners dealing with patients with STIs are of utmost importance. Confidentiality of client matters is very important and should be made clear in the way they handle their clients. The participants expressed the following sentiments in this regard:

'Because I have a choice. Why would I not go to the private sector? I do not trust all the non-Namibian doctors. I am scared they will treat you [incorrectly].'

'In public you have to wait in a queue. One does not have that kind of time.'

Another respondent who uses public health facilities said, to the contrary:

'My mother-in-law does not complain about service, but about waiting [...] It (the clinic) is not clean. The venue is not clean. Things are not as they used to be.'

The views of another participant were expressed as follows:

'It is issues of affordability, those who can afford go to private. Also an issue of communication and culture, one needs to know and understand the language, e.g. English or Afrikaans, to explain to the GP your problem.'



Another subject maintained that the attitude and approach of health care workers in the public sector is very poor:

'I took my children to clinic, there was a sister who screamed at children. I never went back. I take my kids to a private doctor.'

Another participant commented:

'When young ladies go there [public sector] for pregnancy, they shout at them'.

Sexually transmitted infection information given by private general practitioners

This variable was examined to determine the type of health education provided to patients and whether the PGPs have time to supply such information. The outcomes presented should be seen as contextual and individually based.

One of the respondents indicated that health information is provided only on request and not as part of the treatment:

'I like to talk to my doctor. I usually ask him and then he responds to that. I do not have a problem, but I have to ask for information, why?'

Another participant said:

'I do not believe that in private practice the doctor takes much time to explain the condition to the patient, never mind what. Each round equals a consultation, it is business as usual.'

Health education or patient counselling should be part of STI treatment and this is a clear requirement in the policy reviewed. However, this appears not to be the case with the PGPs in general (Government of the Republic of Namibia 1999, 2008; World Health Organisation 2006). To prevent reoccurrence of a preventable condition, it is best to teach patients, whilst they are unwell, about the causes and preventive activities that should be taken to prevent reoccurrence. For PGPs in Windhoek, this is not always the case, because the more the patients return, the more income the practitioner is able to collect from them (Government of the Republic of Namibia 2004).

As one respondent said:

'I really sometimes feel I am not given all the information but the doctor will make you feel uncomfortable that you are wasting his time, so one does not always get what you want during the consultation.'

This implies that the quality of care provided is questionable if patients feel that their needs are not provided for. Furthermore, it appears that patients are not encouraged to ask questions, which calls for some measure of monitoring on how some of the PGPs conduct their business.

It is clear that the longer patients remain in the consulting room of the PGP, the more income is accrued by the practitioner. According to the participants, each consultation takes 15 min in general. To keep to this time schedule, it is obvious that the time needed to provide health education is limited and this might compromise the quality of care, especially when it comes to STIs (Government of the Republic of Namibia 1999).

Uncertainty was also expressed as to whether there is an existing policy governing the quality of private practice in Namibia. The Medical and Dental Council, although in existence, seems not to be effective in observing private practices. One member of the Council said that 'the Medical and Dental Council has no capacity to do the monitoring'. The reason given is that the human resources at the Council are not adequate enough to conduct all the visits required to health institutions, to ensure that all facilities are up to standard and are using the national guidelines for STI case management (which are available for the control of STIs).

Suggestions to improve service delivery

Suggestions to improve service delivery, especially in the public

sector, include the premise that negative issues such as the following be addressed by the authorities (1) the elderly should be served first, (2) there should be shorter waiting periods, (3) proper trained nursing staff and proper in-service training should be available and (4) not only theoretical, but also practical training should be provided. This finding confirms what Vuylsteke *et al.* (2001) found in a study conducted in Abidjan whilst investigating the preferences of sex workers concerning places of treatment.

Training institutions should work hard at teaching health professionals to embrace certain values and make them appreciate the quality that is expected of them during care provision; as noted by one participant:

'There are certain values and stuff that are not there, caring responsibility of a patient you have to look after.'

Other suggestions made by participants were the following:

'Pro-active marketing is important. Government can present a nurse to a private company to outsource staff, then the company can pay the Government for their services.'

'In- and outsourcing will give nursing staff a challenge instead of old routine.'

'Invest in a mobile clinic. Companies are prepared to pay because then staff will not be away for the whole day. Companies cannot afford to have people away for long hours. Having a clinic on site will reduce absent man hours.'

It became clear from the interviews that there is currently no cooperation between the private and the public health sectors at all and this state of affairs can influence the quality of the care provided to patients. It was clear from the participants that the relationship between the two sectors is hostile to such an extent that patients are sent between the two health sectors, as explained by one participant:

'The GPs can refer their patients to the state but within the existing "legal framework" [...] "patients cannot just decide to be a private today and tomorrow they are state patients.'

According to another respondent:

'[...]the state doctors are so stressed and frustrated that they do not want to receive a patient who was once a private patient or [who has been] referred by a GP.'

With regard to training, it was also clear that the private health sector does not participate regularly in the training events run by the public health sector. In most cases they have excuses for their non-attendance and this could explain some of the inefficiency observed in their practices. As one key informant said:

'Even if you invite the private sector for training, they claim that they cannot leave their patients and such training should not last for a week as this means a loss of income.'

This statement implies that the private sector is more money-orientated and has little concern with the improvement of the care that they provide to their clients, although it was claimed that their continuing medical education (CME) is up to date. However, from the private sector's side, the following was reported:

'We are not always notified of available training opportunities in the Ministry in most cases. There is no culture of advertising the training sessions and that is why the GPs cannot just leave without making arrangement for their patients, especially those working alone.'

All the stakeholders expressed the need for greater cooperation between the private and public health sectors in Namibia for the sake of patients and also for the state of national health. It was put forward that the Ministry of Health and Social Services as a custodian of the health of the nation should reach out to other sectors so that the two sectors can pool their resources to improve the quality of care, especially with regard to the management of STIs. It was even suggested that a quality-assurance committee be established, in which all the health sectors are represented, to ensure continuous feedback to and from both sides regarding

what is happening in reality.

Affordability and the place of residence of a patient appear to be major determining factors in deciding whether to use a PGP for STI treatment or not. The attitude and approach of health care workers in the public sector and long waiting periods in the public sector are some of the reasons why people opt to use PGPs in Windhoek as service providers.

In general, patients presenting with STIs to PGPs are not given quality of care, because not all PGPs have time to do investigations, give counselling and condoms and provide other educational information. It is an accepted fact that patient education or counselling, notification of the partners of patients and the distribution of condoms to patients form a major part of the treatment regime of STIs as per the guidelines for the syndromic management of STIs in Namibia (Government of the Republic of Namibia 1999).

LIMITATIONS OF THE STUDY

To make appointments with PGPs for interviews proved difficult, and as a result the researchers had to make appointments under the premise that they were going for treatment and had to pay consulting fees. Another challenge was to complete the study on time, as the study was restricted to a specific finishing date.

RECOMMENDATIONS

It is recommended that the Ministry of Health and Social Services consider the suggestions given by the PGPs and try to implement them for the sake of preserving the quality of care provided to the public. These suggestions include (1) acceptance of referrals from PGPs, (2) the proposition of training PGPs on any new strategies introduced in treatment, (3) the distribution of condoms and notification slips at all private practices in the country and (4) regular visits to such practices.

There is a great need for interaction between the public and private health sector at various levels to ensure that curable STIs are appropriately managed and that national guidelines for STI management are adhered to. Health workers should also be sensitised about their approach towards their patients. It has been noted that due to the stigma and possible emotional threat to relationships, clients with STIs may be reluctant to seek health care in a timely fashion (Smeltzer & Bare 2000; United Nations Fund for Population Activities 2004).

A creation of awareness needs to be raised amongst PGPs of the public health importance of STIs, in order to encourage them to participate in the STI-control programme and to encourage the representation of a PGP on such a forum. Furthermore, the policy on granting permission to doctors to practice privately needs to be revised so that those entering private practice have enough experience and skill to work independently.

The Medical and Dental Council should make its presence in the country visible, especially amongst the PGPs, to help ensure a good standard of care at all times by being a 'living, watchful eye'.

There is a need for the Ministry of Health and Social Services to improve the care provided at their health facilities and to ensure that the processes at health facilities encourage patients to return rather than turn away because of the long queues experienced currently.

CONCLUSION

Although there are policy documents that serve as guidelines for PGPs with regard to treating STIs, it was established that only a few practitioners are aware of them and that they are hardly adhered to by the PGPs in Windhoek. The perceptions of the quality of care received from PGPs differ from one person to the next. It emerged that some participants have had good experiences and some negative experiences in terms of the care given. The STI care provided by PGPs does not always include client education or counselling, as prescribed in the guidelines

for the syndromic management of STIs, which could then contribute to the development of resistance to some drugs used to treat STIs. This could be the case because the Medical and Dental Council has no system in place to monitor PGPs' business conduct, due to a lack of skilled human resources at the Council.

The respondents believe that going to a PGP for treatment is as a matter of affordability that goes hand in hand with the expectations of receiving high quality of care and confidentiality. The study revealed that the quality of care does not reflect in the care provided and that there is no tangible difference between the care provided to patients with medical aid or those without medical aid.

It was evident that the PGPs are in favour of a cordial relationship and cooperation with the Ministry of Health and Social Services, especially in terms of STI management.

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