

The Primary Health Care Package for South Africa – a set of norms and standards

Part 1 Norms and standards for health clinics

Part 2 Norms and standards for community based
clinic initiated services

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THE PRIMARY HEALTH CARE PACKAGE FOR SOUTH AFRICA -- A SET OF NORMS AND STANDARDS

INTRODUCTION

Primary health care is at the heart of the plans to transform the health services in South Africa. An integrated package of essential primary health care services available to the entire population will provide the solid foundations of a single, unified health system. It will be the driving force in promoting equity in health care. This document sets out the norms and standards that are to be made available in the essential package of primary care services. For the first time it will be possible for individuals to see what quality of primary care services they can expect to receive. It also acts as guidance for provincial and district health authorities to provide these services.

This introduction describes the background to the work, the way the package and standards have been produced, their potential uses and how they are likely to evolve with time and experience.

THE BACKGROUND

The draft Health Bill requires the production of norms and standards to be used by provinces to provide health services at acceptable levels. Providing acceptable levels of service to all people will help the process of redistribution and reduce inequalities. The Year 2000 targets included the objective of having "*defined comprehensive services which are to be delivered at primary care level of health service delivery*". The task to define and produce norms and standards falls to the Directorate: Quality Assurance, Department of Health.

A primary health care package was defined following detailed consultation over four years with national experts and provincial staff. It forms the basis of this document, which contains norms and standards for clinic and community services. A national task team has undertaken the production of the norms and standards. Norms and standards for community health centres and Level 1 hospitals will follow.

THE CHOICE OF NORMS AND STANDARDS

All necessary components of a comprehensive primary care package are described and norms and standards for each component are provided. The norms and standards are largely derived from existing national policy documents or, if unavailable, other authoritative sources such as WHO and research work undertaken in the country. All the norms and standards are verifiable (some more easily than others) by staff providing the service. Some of the norms were taken from the Year 2000 Objectives and Indicators. An attempt has been made to ensure that the standards are practical, essential and comprehensive and describe the range of services that should be available to all South Africans.

POTENTIAL USES

It is hoped that the norms and standards are comprehensive enough to be used: --

- By local staff to help assess their own performance and that of their clinic.
- By the community who are able to see the range and quality of services to which they are entitled.
- As planning guidelines by district and provincial health planners to help assess the unmet needs of their population and draw up plans to bring services up to national standards.
- By provincial governments to guide resource allocation.

This wide range of uses requires the document to be available in different formats and selecting particular sections. Once this core document is published, it will be widely distributed to all stakeholders. Components can for example be adapted for use as checklists for local staff.

A LIVING DOCUMENT

The document has two parts – one on clinic services, the other on community services. The community health centre and level-1 hospital sections are given a separate document. The choice of separate documents follows the precedent set by the EDL and permits each document to remain of reasonable size.

Not every primary health care component has been fully documented. National policies will change and service standards will be able to be enhanced, as more resources are made available. The document is the first of its kind. The task group believes that, with experience of its use, many things will be found that can be improved. Feedback from patients and staff is essential. Some provinces have set up norms and standards initiatives themselves. This is good as the more experience that is gained with their use the more can be shared.

DEFINITION OF NORMS AND STANDARDS

FOR THE PURPOSE OF THIS DOCUMENT NORMS AND STANDARDS ARE DEFINED THUS:

A NORM is defined as *a statistical normative rate of provision or measurable target outcome over a specified period of time.*

A STANDARD is defined as *a statement about a desired and acceptable level of health care.*

A common framework used to develop these standards addresses health service inputs, processes, outputs and outcomes. This approach has been adopted. Standards are best developed in incremental stages and according to national priorities. These represent the first stage of this process for primary health care.

Standard setting takes place within specific dimensions of quality -- acceptability, accessibility, appropriateness, continuity, effectiveness, efficiency, equity, interpersonal relations, technical competence and safety. The most important dimensions have been chosen for each service.

INTERPRETATION

Two important issues need to be taken into account when interpreting these norms and standards in the local setting. The first relates to the role of national and provincial health authorities. The second relates to staff competency.

WHAT SERVICES ARE REQUIRED NOT HOW SERVICES ARE PROVIDED

The national task is to define **what** services are required to best meet the health needs of the nation. It is for provinces and local government to decide, in the light of local circumstances, **how** these services are to be provided. Because of these different roles this national document is about **what** services at **what** standard are required. The standards do not specify **how** the services are to be provided and at what level the standards will be met. It is for provinces and Local Gto harden up the standards with verifiable time limited measures based on existing performance and anticipated improvements.

Different kinds of facilities will be required to provide the same services in different situations. Take for instance the use of mobile clinics in remote rural areas compared to polyclinics in high-density urban areas. For this reason national standards about facilities and staffing norms are not offered. In some instances some standards about special facilities are included without which a service would be impossible to provide, for example a confidential room to talk to a sexually abused patient.

STAFF COMPETENCY

Many standards are about staff competency. It is to be expected that some staff will not be trained, or if trained, remain competent to provide all the services specified. It is the responsibility of professional staff to seek to rectify the deficit in themselves and their staff by arranging appropriate training. It goes without saying that no members of staff should undertake tasks unless they are competent to do so. The safety of the patient is paramount.

CONTENT

The document is arranged in a logical order. There are two parts; the first deals with health clinics and the second section with community based services. The part on health clinics starts with a chapter on patient rights, which is followed by one on core norms and standards for all clinics whatever services they are providing. For instance all clinics are expected to have and use the Essential Drug List. The standard is therefore included as a core standard. It is not repeated in later

chapters although its use is essential for most if not all services. Chapters succeeding the core standards one do not duplicate core standards.

Then follows chapters on individual services in life cycle order starting with maternity care and women's health through children and adolescent services to communicable diseases and finally non-communicable diseases.

Each chapter has three paragraphs. The first describes the service to be provided and is taken from the document "The Primary Health Care Package. The second paragraph describes the norms, chosen to represent key measures of what is required. All clinics should be aspiring to measure and reach these norms. The third paragraph describes the standards for each service and it is divided into 9 sections. The first three sections describe the essential written material, equipment, supplies and medicines required. Successful performance to meet these standards requires good organisation and logistics.

Sections 4 and 5 are perhaps the most important of all in describing the required competence of staff, without which services will be of poor quality. These sections will be of help to individual professionals as they assess their own capabilities against what is required of them. They will also be of help to managers and training departments in offering a backbone for training curricula and supervisory support.

Sections 6 – 9 relate to other professional tasks required but which are not directly related to individual patient care. They are nevertheless important, as they are to do with improving the health of the local community.

Part 2 is about community based clinic initiated services. The format is similar.

Documentary sources are listed at the back, which together with the documents listed in sections 1 of each chapter, reference the authoritative evidence on which the norms and standards are based.

Your comments and feedback

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PART 1

NORMS AND STANDARDS FOR HEALTH CLINICS

BATHO PELE -- PEOPLE FIRST

INTRODUCTION

Access to decent public services is the rightful expectation of all citizens especially those previously disadvantaged. Communities are encouraged to participate in planning services to improve and optimize service delivery for the benefit of the people who come first.

STANDARDS

All communities will know from displayed posters about the eight principles of Batho Pele, which are:

CONSULTATION

Communities will be consulted about the level and quality of public services they receive and where possible will be given a choice about the services offered.

SERVICE STANDARDS

Citizens would know the level and quality of public service they are to receive and know what to expect

ACCESS

All citizens have equal access to the services to which they are entitled

COURTESY

Citizens should be treated with courtesy and consideration.

INFORMATION

Citizens should be given full accurate information about the public service they are entitled to receive.

OPENNESS & TRANSPARENCY

Citizens should be told how national and provisional departments are run, how much they cost and who is in charge.

REDRESS

If the promised standard of service is not delivered they should be offered an apology, an explanation and an effective remedy, when complaints are made, citizens should receive a sympathetic positive response.

VALUE FOR MONEY

Public services should be provided economically and efficiently in order to give citizens and communities the best possible value for money.

Implications for health staff

In line with these principles the local health services for a community will provide:

- services with a high standard of professional ethics
- a missions statement for service delivery
- services which are measured with performance indicators displayed, so community can understand the level of achievement
- services which are in partnership with or complement other sectors e.g. the private sector and non-government organizations and community based organizations
- services which are customer friendly and confidential
- opportunities for community consultation
- types of outreach which can reach to all communities and to families in greatest need
- easily accessible and effective ways of dealing with complaints or suggestions for improvement
- current information on services available and hours of service, staff changes of movements and extra activities such as health days.

PATIENTS RIGHTS CHARTER

SERVICE DESCRIPTION

The purpose and expected outcome of the patients rights charter and complaints procedure is to deal effectively with complaints and rectify service delivery problems and so improve the quality of care, raise awareness of rights and responsibilities, raise expectations and empowerment of users, change attitudes by strengthening the relationship between providers and users, improve the use of services and develop a mechanism for enforcing and measuring the quality of health services.

STANDARDS

1. Each clinic displays the patients rights charter and patient responsibilities at the entrance in local languages.
2. The twelve patient's rights are observed and implemented. Every patient has the right to:
 - a healthy and safe environment
 - access to health care
 - confidentiality and privacy
 - informed consent
 - be referred for a second opinion
 - exercise choice in health care
 - continuity of care
 - participation in decision making that affect his/her health
 - be treated by a named health care provider
 - refuse treatment and
 - knowledge of their health insurance/medical aid scheme policies
 - complain about the health service they receive.
3. The ten patient's responsibilities are displayed alongside the patients rights charter. These include:
 - Living a healthy lifestyle
 - Care and protect the environment
 - Respect the rights of other patients and health staff
 - Utilise the health system optimally without abuse
 - Know the health services available locally and what they offer
 - Provide health staff with accurate information for diagnosis, treatment, counselling and rehabilitation purposes
 - Advise health staff on his or her wishes with regard to death
 - Comply with the prescribed treatment and rehabilitation procedures
 - Ask about management costs and arrange for payment
 - Take care of the patient carried health cards and records.
4. There is provision for the special needs of people such as a woman in labour, a blind person or a person in pain.
5. Services are provided with courtesy, kindness, empathy, tolerance and dignity.
6. Information about a patient is confidential and is only disclosed after informed and appropriate consent.
7. Informed consent for clinical procedures is based on a patient being fully informed of the state of the illness, the diagnostic procedures, the treatment and its side effects, the possible costs and how lifestyle might be affected. If a patient is unable to give informed consent the family is consulted.
8. When there is a problem the health care user is informed verbally of the health rights charter with emphasis on the right to complain and the complaints procedure is explained and handed over.
9. The clinic has a formal, clear, structured complaint procedure and illiterate patients and those with disabilities are assisted in laying complaints.
10. All complaints or suggestions are forwarded to the appropriate authority if they cannot be dealt with in the clinic.
11. A register of complaints and how they were addressed is maintained.
12. The name, address, telephone number of the person in charge of the clinic is displayed.

CORE NORMS AND STANDARDS FOR HEALTH CLINICS

CORE NORMS

1. The clinic renders comprehensive integrated PHC services using a one-stop approach for at least 8 hours a day, five days a week.
2. Access, as measured by the proportion of people living within 5km of a clinic, is improved.
3. The clinic receives a supportive monitoring visit at least once a month to support personnel, monitor the quality of service and identify needs and priorities.
4. The clinic has at least one member of staff who has completed a recognised PHC course.
5. Doctors and other specialised professionals are accessible for consultation, support and referral and provide periodic visits.
6. Clinic managers receive training in facilitation skills and primary health care management.
7. There is an annual evaluation of the provision of the PHC services to reduce the gap between needs and service provision using a situation analysis of the community's health needs and the regular health information data collected at the clinic.
8. There is annual plan based on this evaluation.
9. The clinic has a mechanism for monitoring services and quality assurance and at least one annual service audit.
10. Community perception of services is tested at least twice a year through patient interviews or anonymous patient questionnaires.

CORE STANDARDS

1 REFERENCES, PRINTS AND EDUCATIONAL MATERIALS

- 1.1 Standard treatment guidelines and the essential drug list (EDL) manual.
- 1.2 A library of useful health, medical and nursing reference books kept up to date.
- 1.3 All relevant national and provincial health related circulars, policy documents, acts and protocols that impact on service delivery.
- 1.4 Copies of the Patients Charter and Batho Pele documents available.
- 1.5 Supplies of appropriate health learning materials in local languages.

2 EQUIPMENT

- 2.1 A diagnostic set.
- 2.2 A blood pressure machines with appropriate cuffs and stethoscope.
- 2.3 Scales for adults and young children and measuring tapes for height and circumference.
- 2.4 Haemoglobinometer, glucometer, pregnancy test, and urine test strips.
- 2.5 Speculums of different sizes
- 2.6 A reliable means of communication (two-way radio or telephone).
- 2.7 Emergency transport available reliably when needed.
- 2.8 An oxygen cylinder and mask of various sizes.
- 2.9 Two working refrigerators one for vaccines with a thermometer and another for medicines. If one is a gas fridge a spare cylinder is always available.
- 2.10 Condom dispensers are placed where condoms can be obtained with ease.
- 2.11 A sharps disposal system and sterilisation system.
- 2.12 Equipment and containers for taking blood and other samples.
- 2.13 Adequate number of toilets for staff and users in working order and accessible to wheelchairs.
- 2.14 A sluice room and a suitable storeroom or cupboard for cleaning solutions, linen and gardening tools.
- 2.15 Suitable dressing/procedure room with washable surfaces.
- 2.16 A space with a table and ORT equipment and needs
- 2.17 Adequate number of consulting rooms with wash basins, diagnostic light (one for each professional nurse and medical officer working on the same shift).

3 MEDICINES & SUPPLIES

- 3.1 Suitable medicine room and medicine cupboards that are kept locked with burglar bars.

3.2	Medicines and supplies as per the essential drug list for Primary Health Care, with a mechanism in place for stock control and ordering of stock.
3.3	Medicines and supplies always in stock, with a mechanism for obtaining emergency supplies when needed.
3.4	A battery and spare globes for auroscopes and other equipment.
3.5	Available electricity, cold and warm water.
4	COMPETENCE OF HEALTH STAFF
	Organising the clinic
4.1	Staff are able to
4.1.1	map the clinic catchment area and draw specific and achievable PHC objectives set using district, national and provincial goals and objectives as a framework.
4.1.2	Organise outreach services for the clinic catchment area.
4.1.3	Organise the clinic to reduce waiting times to a minimum and initiate an appointment system when necessary.
4.1.4	Train community health care promoters to educate caretakers and facilitate community action.
4.1.5	Plan and implement a district focused and community based activities, where health workers are familiar with their catchment area population profile, health problems and needs and use data collected at clinic level for this purpose.
	Caring for patients
4.2	Staff are able to follow the disease management protocols and standard treatment guidelines, and provide compassionate counselling that is sensitive to culture and the social circumstances of patients.
4.3	Staff are positive in their approach to patients, evaluating their needs, correcting misinformation and giving each patient a feeling of always being welcome.
4.4	Patients are treated with courtesy in a client-oriented manner to reduce the emotional barriers to access of health facilities and prevent the breakdown in communication between patients and staff.
4.5	The rights of patients are observed.
	Running the clinic
4.6	A clear system for referrals and feedback on referrals is in place.
4.7	All personnel wear uniforms and insignia in accordance with the South African Professional Councils' specifications.
4.8	The clinic has a strong link with the community, civic organisations, schools and workplaces in the catchment area.
4.9	The clinic is clean, organised and convenient and accommodates the needs of patients' confidentiality and easy access for older persons and people with disability.
4.10	Every clinic has a house keeping system to ensure regular removal and safe disposal of medical waste, dirt and refuse.
4.11	Every clinic provides comprehensive security services to protect property and ensure safety of all people at all times.
4.12	The clinic has a supply of electricity, running water and proper sanitation.
4.13	The clinic has a written infection control policy, which is followed and monitored, on protective clothing, handling of sharps, incineration, cleaning, hand hygiene, wound care, patient isolation and infection control data.
5	PATIENT EDUCATION
5.1	Staff are able to approach the health problems of the catchment area hand in hand with the clinic health committee and community civic organisations to identify needs, maintain surveillance of cases, reduce common risk factors and give appropriate education to improve health awareness.
5.2	Culturally and linguistically appropriate patients' educational pamphlets are available on different health issues for free distribution.
5.3	Appropriate educational posters are posted on the wall for information and education of patients.
5.4	Educational videos in those clinics with audio-visual equipment are on show while patients are waiting for services.
6	RECORDS
6.1	The clinic utilises an integrated standard health information system that enables and assists in collecting and using data.

6.2	The clinic has daily service registers, road to health charts, patient treatment cards, notification forms, and all needed laboratory request and transfer forms.
6.3	All information on cases seen and discharged or referred is correctly recorded on the registers.
6.4	All notifiable medical conditions are reported according to protocol.
6.5	All registers and monthly reports are kept up to date.
6.6	The clinic has a patient carry card or filing system that allows continuity of health care.
7	COMMUNITY & HOME BASED ACTIVITY
7.1	There is a functioning community health committee in the clinic catchment area.
7.2	The clinic has links with the community health committee, civic organisations, schools, workplaces, political leaders and ward councillors in the catchment area.
7.3	The clinic has sensitised, and receives support from, the community health committee.
7.4	Staff conduct regular home visits using a home visit checklist.
8	REFERRAL
8.1	All patients are referred to the next level of care when their needs fall beyond the scope of clinic staff competence.
8.2	Patients with a need for additional health or social services are referred as appropriate.
8.3	Every clinic is able to arrange transport for an emergency within one hour.
8.4	Referrals within and outside the clinic are recorded appropriately in the registers.
8.5	Merits of referrals are assessed and discussed as part of the continuing education of the referring health professional to improve outcomes of referrals.
9	COLLABORATION
9.1	Clinic staff collaborate with social welfare for social assistance and with other health related public sectors as appropriate.
9.2	Clinic staff collaborate with health orientated civic organisations and workplaces in the catchment area to enhance the promotion of health.

CORE MANAGEMENT STANDARDS

10	LEADERSHIP AND PLANNING
10.1	Each clinic has a vision/mission statement developed and posted in the clinic.
10.2	Core values are developed by the clinic staff and posted.
10.3	An operational plan or business plan is written each year.
11	STAFF
11.1	New clinic staff are oriented.
11.2	District personnel policies on recruitment, grievance and disciplinary procedures are available in the clinic for staff to refer to.
11.3	The staff establishment for all categories is known and vacancies discussed with the supervisor.
11.4	Job descriptions for each staff category are in the clinic file.
11.5	There is a performance plan/agreement and training plan made and a performance appraisal carried out for each member of staff each year.
11.6	The on-call roster and the clinic task list with appropriate rotation of tasks are posted.
11.7	An attendance register is in use.
11.8	There are regular staff meetings (at least once a month).
11.9	Services and tasks not carried out due to lack of skills are identified and new training sought.
11.10	In-service training takes place on a regular basis.
11.11	Disciplinary problems are documented and copied to supervisor.
12	FINANCE
12.1	The clinic, as a cost centre, has a budget divided into main categories.
12.2	The monthly expenditure of each main category is known.
12.3	Under and over spending is identified and dealt with including requests for the transfer of funds between line items where permitted and appropriate.
13	TRANSPORT AND COMMUNICATION
13.1	A weekly or monthly transport plan is submitted to the supervisor or transport co-ordinator.
13.2	The telephone or radio is working.
13.3	The ambulance can be contacted for urgent patient transport to be available within two hours.
14	VISITS TO CLINIC BY UNIT SUPERVISOR

14.1	There is a schedule of monthly visits stating date and time of supervisory support visits.
14.2	There is a written record kept of results of visits.
15	COMMUNITY
15.1	The community is involved in helping with clinic facility needs.
15.2	The community health committee is in place and meets monthly.
16	FACILITIES AND EQUIPMENT
16.1	There is an up-to-date inventory of clinic equipment and a list of broken equipment.
16.2	There is a list of required repairs (doors, windows, water) and these have been discussed with the supervisor and clinic committee.
17	DRUGS AND SUPPLIES
17.1	Stocks are secure with stock cards used and up-to-date.
17.2	Orders are placed regularly and on time and checked when received against the order.
17.3	Stocks are kept orderly, with FEFO (first expiry, first out) followed and no expired stock.
17.4	The drugs ordered follow EDL principles.
18	INFORMATION AND DOCUMENTATION
18.1	New patient cards and medico-legal forms are available.
18.2	The laboratory specimen register is kept updated and missing results are followed up.
18.3	Births and deaths are reported on time and on the correct form.
18.4	The monthly PHC statistics report is accurate, done on time and filed/sent.
18.5	Monthly and annual data are checked, graphed, displayed and discussed with staff and the health committee.
18.6	There is a catchment area map showing the important features, location of mobile clinic stops, DOTS supporters, CHWs and other outreach activities.

WOMEN'S REPRODUCTIVE HEALTH

SERVICE DESCRIPTION

Reproductive services for women are provided in an integrated comprehensive manner covering preventive, promotive, curative and rehabilitative aspects of care. The focus is on antenatal, delivery, postnatal and family planning care.

NORMS

1. Increase the percentage of pregnant women receiving antenatal care (ANC) from the existing level to at least 70%.
2. Increase the deliveries in institutions by trained birth attendants from the existing level to at least 75%.
3. Reduce the proportion of pre-term deliveries and low birth weight babies by at least 20%.
4. Reduce the proportion of births in women below 16 years and 16-18 years from the existing level (13.2% in 1998).

STANDARDS

1 REFERENCES, PRINTS AND EDUCATIONAL MATERIALS

- 1.1 Midwifery protocols
- 1.2 Contraception protocols
- 1.3 Termination of pregnancy protocols
- 1.4 Sterilisation act
- 1.5 All Provincial circulars and policy guidelines regarding women's health issues
- 1.6 A library of suitable references and learning material on women's health issues

2 EQUIPMENT AND SPECIAL FACILITIES

- 2.1 Delivery set
- 2.2 Neonatal resuscitation trolley
- 2.3 Specula
- 2.4 Fetalscope
- 2.5 Women's Health charts

3 MEDICINES & SUPPLIES

- 3.1 Ferrous and folic acid tablets
- 3.2 Oxytocin
- 3.3 Vit K injections
- 3.4 Contraceptive barrier methods e.g. condoms
- 3.5 Vaginal contraceptives e.g. spermicidal jelly
- 3.6 Intrauterine contraceptive devices
- 3.7 Injectable hormonal contraceptives
- 3.8 Oral hormonal contraceptives
- 3.9 Post-coital contraceptives

4 COMPETENCE OF HEALTH STAFF

- 4.1 Nurses receive training in the perinatal education programme (PEP), contraception and post-abortion care management.
- 4.2 Staff are able to take a history and perform a physical examination and tests according to protocols and guidelines.
- 4.3 Staff provide routine management, observations and service according to the ANC protocol at each step of the pregnancy including at least three visits during pregnancy.
- 4.4 Staff provide education and counselling to each pregnant woman and partner on monitoring signs of problems (e.g. bleeding), nutrition, child feeding and weaning, STDs / HIV, delivery, newborn and child care, advanced maternal age, family planning and child spacing.
- 4.5 Staff offer appropriate counselling, advice and service to pregnant women requesting termination of pregnancy.

4.6	At least one member of staff is able to:-
4.6.1	Deliver uncomplicated pregnancies.
4.6.2	Make routine observations according to the postnatal care protocol.
4.6.3	Make usual routine observations and select and prescribe appropriate family planning methods according to national protocol.
4.6.4	Screen, advice and refer infertility cases as per national guidelines.
4.6.5	Conduct breast cancer and cervical screening for women older than 35 years as per protocols.
4.6.6	Conduct home visits to provide support and supervise care.
4.6.7	Provide appropriate adolescent/youth services on family planning, sexuality, health education and counselling.
5	PATIENT EDUCATION
5.1	Information is given to mothers on booking for delivery, child preventive care, education about child feeding and the introduction of solid food.
5.2	Further information is given to mothers on the care of breasts, vaginal bleeding and scars, signs of hypertension, diabetes, anaemia, return to usual physical efforts, labour rights, rights of the child and advice on family planning.
5.3	Patients are given group education.
5.4	Patients' relatives and the community receive continuous, appropriate high quality information on the importance of antenatal care and institutional deliveries.
5.5	Information, education and counselling are offered to adolescents and youth.
6	RECORDS
6.1	All information on cases and outcome of deliveries are correctly recorded on the register.
6.2	All registers and monthly reports are kept up to date.
7	COMMUNITY & HOME BASED ACTIVITY
7.1	The clinic has sensitised, and receives support from, the community health committee about the positive encouragement of attendance at clinic of all pregnant women.
7.2	Staff conduct regular home visits using a home visit checklist.
8	REFERRAL
8.1	All referrals within and outside the clinic are motivated and indications for referral written clearly on the referral form.
8.2	Patients with need for additional health or social services are referred according to protocols.
8.3	Referrals from traditional birth attendants (TBA) should be encouraged and associated with the training of the TBAs and follow up of the training.
9	COLLABORATION
9.1	Clinic staff collaborate with social welfare for social assistance and other role players.
9.2	Clinic staff collaborate with clinic health committee, the civic organisations and workplaces in the catchment area to enhance health promotion.

MANAGEMENT AND PREVENTION OF GENETIC DISORDERS AND BIRTH DEFECTS

SERVICE DESCRIPTION

Genetic services are forming part of the integrated maternal, child and women's health care. It aims to assist individuals with a genetic disadvantage to live and reproduce as normally and responsibly as possible. The components include clinical diagnostic services, counseling, laboratory support, prevention strategies and public awareness campaigns in collaboration with NGOs, CBOs and other government sectors.

NORMS

1. At least one clinic staff member trained to recognize, counsel, treat manage and refer most common conditions.
2. Clinic staff receive regular genetic training and update from the regional genetic coordinator.
3. Clinic staff receive support from visiting specialist, clinical geneticist and other academic experts.

STANDARDS

1	REFERENCES PRINTS AND EDUCATIONAL MATERIALS
1.1	The clinic has the latest copy of the Human Genetics Guidelines for Management and Prevention of Genetic Disorders, Birth Defects and Disabilities.
2	EQUIPMENT
2.1	.
3	MEDICINES AND SUPPLIES
3.1	List of drugs in accordance with the Essential Drugs List
4	COMPETENCE OF HEALTH STAFF
4.1	At least one clinic staff is able to recognize, counsel, treat, manage and refer most common genetic conditions
5	REFERRALS
5.1	Referrals for further support as per guidelines
6	PATIENT EDUCATION
6.1	Provide posters, pamphlets and other educational materials on genetics for patients.
6.2	All patients and caretakers receive health education on genetic disorders, birth defects and disabilities.
6.3	Encourage women to procreate at the ideal reproductive age (25-35 years) to reduce the risk of chromosomal abnormalities.
6.4	Educate women to avoid exposure to teratogens during pregnancy e.g. alcohol, recreational drugs and certain chemical and infecting agents.
7	RECORDS
7.1	Notification forms to notify genetic disorders and birth defects in the immediate post-natal period and later in life.
8	COMMUNITY BASED SERVICES
8.1	Clinic staff to work with South African Inherited Disorders Association and other NGOs and CBOs to support affected individuals and families at community level.
9	COLLABORATION
9.1	Clinic staff collaborate with social workers, physiotherapists, speech therapists and other support staff to provide comprehensive care.
9.2	Clinic staff to work with South African Inherited Disorders Association, school teachers, and other NGOs and CBOs to provide information and raise awareness on genetic disorders, birth defects and disabilities.

INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS

SERVICE DESCRIPTION.

Promotive, preventative (monitoring and promoting growth, immunisations, home care counselling, de-worming and promoting breast feeding), curative (assessing, classifying and treating) and rehabilitative services are given in accordance with provincial IMCI protocols at all times that the clinic is open.

NORMS

1. Reduce the infant and under-5 mortality rate by 30% and reduce disparities in mortality between population groups. (National Year 2000 Goals, Objectives and Indicators.)
2. Reduce mortality due to diarrhoea, measles and acute respiratory infections in children by 50%, 70% and 30% respectively. (National Year 2000 Goals, Objectives and Indicators.)
3. Increase full immunisation coverage among children of one year of age against diphtheria, pertussis, Hib, tetanus, measles, poliomyelitis, hepatitis and tuberculosis to at least 80% in all districts and 90% nationally. (National Year 2000 Goals, Objectives and Indicators.)
4. Eradicate poliomyelitis by 2002. (National Year 2000 Goals, Objectives and Indicators.)
5. Increase regular growth monitoring to reach 75% of children <2 years. (National Year 2000 Goals, Objectives and Indicators.)
6. Increase the proportion of mothers who breast-feed their babies exclusively for 4-6 months, and who breast-feed their babies at 12 months. (National Year 2000 Goals, Objectives and Indicators.)
7. Reduce the prevalence of under weight-for-age among children <5 years to 10%. (National Year 2000 Goals, Objectives and Indicators.)
8. Reduce the prevalence of stunting among children <5 years to 20%. (National Year 2000 Goals, Objectives and Indicators.)
9. Reduce the prevalence of severe malnutrition among children <5 years to 1%. (National Year 2000 Goals, Objectives and Indicators.)
10. Eliminate micro nutrient deficiency disorders. (National Year 2000 Goals, Objectives and Indicators.)
11. All children treated at the clinic are treated according to IMCI Guidelines.
12. Every clinic has at least two staff members, who have had the locally adapted IMCI training, based on the WHO/UNICEF Guidelines.
13. Every clinic has a rehydration corner.
14. A supervisor, who also evaluates the degree of community involvement in planning and implementing care, undertakes a six monthly assessment of quality of care.

STANDARDS

1 REFERENCES, PRINTS AND EDUCATIONAL MATERIALS

- 1.1 National and Provincial wall charts and booklets.
- 1.2 A copy of the IMCI Standard Treatment Guidelines, relevant to the Province.
- 1.3 Child Health Charts to supply to new-borns and children without charts.
- 1.4 Copies of the National Essential Drugs List and Standard Treatment Guidelines.
- 1.5 Tick charts stuck to the desk as a reminder.

2 EQUIPMENT

- 2.1 An oral rehydration corner set up for immediate rehydration.
- 2.2 Emergency equipment available for intravenous resuscitation of severely dehydrated children.

3 MEDICINES & SUPPLIES

- 3.1 The clinic has litre measures and teaspoon measures, cups for feeding, sugar and salt (for the child that is not dehydrated) and rehydration powder (for the dehydrated child).

4 COMPETENCE OF HEALTH STAFF

- 4.1 Every clinic has nurse practitioners able to treat clients in accordance with the IMCI guidelines.
- 4.2 IMCI trainer makes regular mentoring/supervision visits, initially 6 weeks after training, thereafter every 3 months.
- 4.3 Each clinic has an annual review of quality of care by IMCI Supervisor.

4.4	At least one member of staff takes overall responsibility for the assessment and management of the child.
4.5	Staff are able to establish trust and credibility through respect, courtesy, responsiveness, confidentiality and empathy, approaching consultations in a patient-centred way.
4.6	Staff are able to organise and implement an effective triage system for clients attending the clinic based on the IMCI protocol.
5	REFERRAL
5.1	Children with danger signs and/or severe disease are referred as described in the IMCI provincial protocol.
6	PATIENT EDUCATION
6.1	The mother or caregiver is counselled in accordance with the IMCI counselling guidelines.
6.2	Key family/household practices to improve child health are promoted as described in the IMCI community component.
7	RECORDS
7.1	An adequate patient record system is in place, using the child-health chart as the basic tool.
7.2	Patient details are recorded using the SOAP format.
8	COMMUNITY & HOME BASED ACTIVITY.
8.1	This takes place in line with the IMCI Guidelines for the Community Component.
8.2	The clinic works in close co-operation with community-based health programmes like community health worker schemes or care-groups.
9	COLLABORATION
9.1	Clinic staff collaborate with social workers, NGOs, CBOs, creches and other sectors to improve child health.

MANAGEMENT OF ASTHMA

SERVICE DESCRIPTION

This service aims at managing chronic asthma in infants, children and adults with treatment schedules for either mild or moderate to severe asthma. The service can also recognize, assess initiate treatment and refer emergency situations of acute bronchospasm associated with asthma and chronic obstructive bronchitis.

NORMS

Reduced incidence of emergency referrals due to asthma

STANDARDS

1	REFERENCES PRINTS AND EDUCATIONAL MATERIALS
1.1	Each clinic has the National and Provincial protocols and policy documents on management of acute and chronic persistent asthma.
1.2	Standard treatment guidelines and essential drugs list manual
1.3	Education materials for patients on allergy and avoidance of allergens and on the use of inhalers with or without spacers
2	EQUIPMENT
2.1	See clinic core standards
2.2	Oxygen and nasal catheters for children and masks for adults
3	MEDICINES AND SUPPLIES
3.1	As per the EDL
4	COMPETENCE OF HEALTH STAFF
4.1	The clinic staff are able to diagnose and treat attacks of bronchospasm and give appropriate health education as per EDL.
4.2	The clinic staff able to take complete patient and family histories on episodes o per week, night time or wheeze, number of times inhalers are used per week and identify possible allergens and other irritants.
4.3	Clinic staff are able to optimize treatment using peak expiry flow rates and give psychological support before referral for further care.
4.4	Staff are able to use inhalers with spacers and masks for infants and small children.
4.5	Clinic staff can interact with caretakers and family of patients to ensure improved control of asthma with emphasis on prevention and early management.
5	REFERRALS
5.1	Refer to assess and confirm diagnosis when in doubt and to optimise therapy.
5.2	Refer severe non-responding attacks of bronchospasm
5.3	Refer pregnant women with worsening asthma
5.4	Refer patients presenting with repeated asthma exacerbations
5.5	Refer patients with previous life threatening exacerbations
5.6	Refer if there are unsatisfactory social and personal factors such as inadequate access to health care, unavailable transport, difficult home conditions or difficulty with the home management plan
6	PATIENT EDUCATION
6.1	All patients and caretakers attending the service receive health education on prevention of exposure to known allergens and inhaled irritants such as cigarette smoke or allergens in animals, nuts or drugs.
6.2	The use and technique of inhalers is taught and demonstrated
6.3	Carers and patients understand the safety of continuous regular therapy and need for follow up
7	RECORDS
7.1	Clinic records are kept up to date with history of episodes, rate of use of drugs and inhalers, identified allergens and periodic PEFr recorded.

8	COMMUNITY BASED SERVICES
8.1	Conduct educational campaigns in school and community during pollen grain seasons
8.2	Community based programmes stress the need for smoke free environment and give guidelines on reducing common household allergens
9	COLLABORATION
9.1	Staff collaborate with other departments like Environmental health, Education and other sectors to educate and support sufferers and their caretakers.
9.2	Staff collaborate with the National Asthma Education program and the Allergy Society of South Africa to obtain their educational materials

DISEASES PREVENTED BY IMMUNISATION

SERVICE DESCRIPTION

Immunization is an essential service that is available whenever the clinic is open and based on an uninterrupted and monitored cold chain of constantly available vaccines.

NORMS

1. All clinics provide immunisations at least for 5 days a week and if the community desires additional periods specifically for child health promotion and prevention.
2. Every clinic has a visit from the District Communicable Disease Control Co-ordinator every 3 months to review the EPI coverage, practices, vaccine supply, cold chain and help solve problems and provide information and skills when necessary.
3. Every clinic has a senior member of staff trained in EPI who acts as a focal point for EPI programmes.

STANDARDS

1	REFERENCES PRINTS AND EDUCATIONAL MATERIALS
1.1	Copies of the latest editions of EPI (SA) <i>Vaccinators Manual Immunisation That Works</i> .
1.2	Copies of the Cold Chain and Immunisation and Operations Manual.
1.3	Copies of the Technical guidelines on immunisation in South Africa.
1.4	Copies of the EPI Disease Surveillance Field Guide.
1.5	Copies of the current Provincial Circulars on particular aspects, e.g. acute flaccid paralysis, flu virus, Haemophilus influenzae type b (HiB surveillance, Adverse Events Following Immunisation (AEFI) investigation and reporting.
1.6	Patient and community information pamphlets in appropriate languages.
1.7	Copies of the EPI Posters and other EPI disease and schedule promotional materials.
2	EQUIPMENT
2.1	Correct needles and syringes according to Vaccinators manual.
2.2	A working refrigerator, properly packed, with thermometer and temperature recorded and a spare gas cylinder if gas operated.
3	MEDICINES AND SUPPLIES
3.1	An uninterrupted and monitored cold chain of constantly available vaccines as recommended by EDL.
4	COMPETENCE OF HEALTH STAFF
4.1	Staff are able to :-
4.1.1	Routinely perform correct immunisation practices according to protocol. Vaccines are checked periodically to ensure no frozen DPT, HBV, TT, HIB and none out of date or indicators showing expiry.
4.1.2	Provide mothers with correct knowledge of what is needed for the child, what is given and possible side effect and when to return for the next immunisation.
4.1.3	Provide group education for mothers and antenatal care attendants.
4.1.4	Follow up suspected cases of measles at home to determine the extent of a possible outbreak.
4.1.5	Take steps to increase coverage using the self-generated vaccination coverage graph (available in the Vaccinators manual) to address progress during the year.
4.1.6	Implement correct disposal of sharps.
4.1.7	Initiate post exposure prophylaxis for HIV in case of needle stick (according to Provincial protocol).
4.1.8	Ensure all reported and notified AFP, measles, NNT and AEFI cases are reported to EPI Coordinator and followed up within 48 hours by district investigation team of which the nurse in clinic is a co-opted member.
4.1.9	Organise immunisation service as a daily component of comprehensive PHC and to minimise

	waiting/queuing times.
4.2	Community health committees are given the lay case definitions of acute flaccid paralysis, measles and neonatal tetanus and urged to report suspected cases immediately.
4.3	The clinic has a good relationship with the Environmental Health Officer for assistance in outbreaks investigations.
4.4	Ensure that appropriate laboratory specimens are taken for the investigation of all AFP, NNT, measles and AEFI investigations are taken or else referred to the nearest hospital where specimens can be taken.
4.5	A 24 hour toll free number for notification - (0800 111 408) is on the clinic wall.
4.6	All HIV positive children must be immunized with all vaccines except for BCG in children with symptomatic AIDS.
4.7	Clinics arrange mass immunisation or mopping up campaigns in their communities as required by the District Manager.
4.8	Remote villages have mobile outreach sessions to provide routine services and to improve coverage where necessary.
4.9	Reduce missed opportunities and ensure that ill children and women in the childbearing age are immunised as appropriate.
5	REFERRALS
5.1	Children with signs and symptoms of the EPI priority diseases (AFP, measles, NNT and AEFI) are referred as in the IMCI Provincial protocols.
6	PATIENT EDUCATION
6.1	All clients attending clinics for immunization services receive the appropriate health education, information and support.
7	RECORDS
7.1	Patient records and patient notification forms.
7.2	Monthly immunisation statistics.
7.3	Case investigation forms for flaccid paralysis.
7.4	Case investigation forms for measles.
7.5	Case investigation forms for neonatal tetanus.
7.6	Case investigation forms for adverse events following immunisation.
7.7	Supply of child road to health charts.
8	COMMUNITY BASED SERVICES
8.1	Communities participate in campaigns and national health days.
8.2	Clinic staff follow up suspected cases of measles at home to determine extent of outbreak.
9	COLLABORATION
9.1	Staff collaborate with other departments like education and other sectors to promote immunization and improve coverage.

ADOLESCENT AND YOUTH HEALTH

SERVICE DESCRIPTION

Adolescents are aged between 10-19 years and youths between 15-24 years as defined by the World Health Organization. The services provided to these specific groups are tailored to ensure a holistic approach with emphasis on special needs.

NORMS

1. Regular visits by Primary Health Care coordinators to review health services for adolescents and youth.
2. Staff has continuing professional education on needs of youth and adolescents.

STANDARDS

1	REFERENCE, PRINTS AND EDUCATIONAL MATERIALS
1.1	Clinic has a copy of rights of the child.
1.2	All legislation relevant to youth and adolescents is kept in the clinic.
1.3	List of relevant NGOs, CBOs and community youth organisations in district.
1.4	Planned Parenthood Association of South Africa booklet and other relevant materials to help parents discuss sexuality with youth.
1.5	IEC materials and a library of youth related materials.
2	EQUIPMENT
2.1	Adequate equipment suitable for a youth friendly service catering for the health needs of this group.
3	MEDICINES AND SUPPLIES
3.1	Provided according to EDL.
3.2	Condoms are placed in areas where it is not necessary to ask for them and where they can be taken without being watched
4	COMPETENCE OF HEALTH STAFF
4.1	Staff are able to
4.1.1	Map catchment area and if relevant prisons, orphanages, street children shelters, sports fields, schools and NGOs.
4.1.2	Provide accessible youth friendly services with times or days to suit youth.
4.1.3	Encourage youth to ask questions and seek information.
4.1.4	Communicate well and avoid asking intrusive, irrelevant questions.
4.1.5	Know and work well with youth organisations, sports coaches, teachers, police and traditional circumcisors in the catchment area of clinic.
4.1.6	Educate parents about parenting and provide guidance on improving intra-family and community relationships.
4.2	Clinic have at least one member of the staff competent in counselling and able to assist an individual (or group) to gain an understanding of the situation and make and implement appropriate decisions.
4.3	Staff ensure no opportunity is missed to assist youth in managing fertility and preventing STDs and HIV/AIDS.
4.4	Staff involves adolescent and youth in planning and implementation of services.
5	REFERRAL
5.1	Referred according to protocols for the relevant conditions.
5.2	Ensure a mechanism for feedback of referred cases
6	PATIENT EDUCATION
6.1	Assist in organizing and participate in awareness campaigns on relevant adolescent and youth health issues
6.2	Involve youth in peer education and support peer education

6.3	Supply of patient information pamphlet in relevant languages on
6.3.1	Growth and development
6.3.2	Gender specific needs of adolescents
6.3.3	Oral care
6.3.4	Nutrition
6.3.5	risks to health of alcohol, smoking, drugs
6.3.6	safe sex, condom use
6.3.7	STD, HIV, AIDS, TB
7	RECORDS
7.1	Staff use information system records to analyse conditions affecting youth (e.g. STD, accidents, infected circumcisions, sports injuries, behaviour problems, teenage pregnancy, TOP, rape, sexual abuse, etc).
7.2	There is a register of disabled youth that indicates all dates of efforts to improve rehabilitation and refer to special school.
7.3	Record is kept of occupational problems of youth in the area e.g. sex work, domestic work, agricultural work etc.
8	COMMUNITY BASED ACTIVITY
8.1	Staff are aware of community based initiatives aimed to prevent and respond to problems of youth.
9	COLLABORATION
9.1	Clinic staff work with social workers, social structures, NGOs and CBOs on adolescent and youth health issues including children at risk problems (adolescents and the law, poor hygiene, sexual abuse, glue sniffing, etc).
9.2	Staff collaborate with other sectors to improve youth health especially with teachers in schools in setting up a child-to-child programme.

MANAGEMENT OF COMMUNICABLE DISEASES

SERVICE DESCRIPTION

This chapter deals with the management of communicable diseases in general with the emphasis on prevention, early diagnosis and initiation of measures to prevent transmission and serious morbidity, disability and death. Separate chapters deal with Tuberculosis, HIV infection and AIDS, sexually transmitted diseases, cholera, rabies, leprosy, shigella dysentery and malaria. These are the diseases, which are either priority national public health diseases or are ones associated with the possibility of causing outbreaks. The communicable diseases, which are included in the South African Expanded Programme of Immunisation, and scabies, are dealt with separately under childhood diseases. Rheumatic fever and helminths are also dealt with separately.

NORMS

1. All clinics are supervised every three months by the District Communicable Disease Control Co-ordinator.
2. All clinics send to the local authority or district health office an immediate telephonic report of acute flaccid paralysis or cholera.
3. Cases referred as notifiable diseases to hospital are notified by the hospitals on a weekly basis on Form GW 17/3.
4. All clinics send an individual notification on Form GW 17/5 to the local authority or district health office as soon as possible.
5. Monthly report on deaths from a notifiable disease are notified on Form GW 17/4.

STANDARDS

1. REFERENCES PRINTS AND EDUCATIONAL MATERIALS

- 1.1 Each clinic has the National and Provincial protocols and policy documents on communicable Diseases and every 6 months reviews them with the Environmental Health Officer of the area.

3. EQUIPMENT

- 3.1 See clinic generic equipment

3. MEDICINES AND SUPPLIES

- 3.1 As per EDL

4. COMPETENCE OF HEALTH STAFF

- 4.1 All clinics have a book of notifiable disease forms GW17/5 and complete a form for every notifiable disease. Cases confirmed in hospital send a copy back to the clinic with the lower part of the form completed.
- 4.2 When the district office receives a notification the communicable disease control co-ordinator initiates a response, together with the District Environmental Health Officer and the local clinic staff. The Infection Control Nurse of the Hospital and in the case of an outbreak, the outbreak teams and the laboratory are also involved.
- 4.3 The clinic staffs are able to commence action by taking more complete patient and family histories and by visiting the home and environment to identify other cases and causes which can be prevented. Clinic staff are responsible for stabilising cases before hospitalisation and for taking initial specimens for the laboratory.
- 4.4 Clinic staff can interact with community health committees to maintain surveillance for cases and to ensure control measures after suitable education.
- 4.5 The emphasis is always on prevention, early diagnosis and initiation of measures to prevent transmission and serious morbidity, disability and death.
- 4.6 In endemic areas for Malaria, Schistosomiasis, Cysticercosis and Trachoma clinics receive extra protocols on management from the District Health Offices.

5. REFERRALS

- 5.1

6. PATIENT EDUCATION

6.1	All patients attending the service receive health education.
7. RECORDS	
7.1	Clinic records of communicable diseases are kept up to date.
8. COMMUNITY BASED SERVICES	
8.1	
9. COLLABORATION	
9.1	Staff collaborate with other departments like Environmental health, Education and other sections within health like MCHW and Health Promotion.

CHOLERA AND DIARRHOEAL DISEASE CONTROL

SERVICE DESCRIPTION

Diarrhoeal disease control is an essential daily element of clinic services as well as an element in outbreak prevention and control.

NORMS

1. Every clinic considers itself part of the Provincial and National Diarrhoeal Disease Control Programme.
2. All staff are trained in the management of diarrhoeal disease and have continuing education every 6 months or when there are reports of cholera outbreaks in neighbouring countries or regions.
3. Every clinic is able to contact and works with the environmental health officer in whose area it falls.
4. Reduce mortality due to diarrhoea in children by 50% (Year 2000 Health Goals and Objectives)

STANDARDS

1	REFERENCES PRINTS AND EDUCATIONAL MATERIALS
1.1	The clinic has the latest copy of Guidelines for Diarrhoeal diseases and Cholera Control.
2	EQUIPMENT
2.1	Cholera packs for diagnosis and the protocol for stool collection.
3	MEDICINES AND SUPPLIES
3.1	List of drugs in accordance with the Essential Drugs List
3.2	The clinic maintains a buffer supply of ORS and intravenous fluids.
3.3	Clinic staff know where extra stocks can be obtained quickly in case of emergency
4	COMPETENCE OF HEALTH STAFF
4.1	Staff have knowledge of the clinical presentation of diarrhoeal diseases and cholera and refer severe cases to hospital having first starting rehydration. Less severe cases are managed at clinic level with oral rehydration.
4.2	Clinic staff are able to manage cases of diarrhoea and dehydration daily during epidemics.
4.3	There is always a state of preparedness for an outbreak of cholera by maintaining a buffer supply of ORS and intravenous fluids.
4.4	Staff are able to recognise the clinical presentation of cholera.
4.5	Suspected cases are reported immediately by phone or other communication method.
4.6	Oral rehydration (with ORS sachets) are used and the patients state of dehydration is monitored while having the ORS.
4.7	Clinic staff encourage use of salt and sugar home-prepared solution when ORD sachets are not available.
4.8	Staff know that cholera infection can be asymptomatic or cases can be mild and indistinguishable from other diarrhoea.
5	REFERRALS
5.1	All severely dehydrated cases should be referred to hospital
6	6. PATIENT EDUCATION
6.1	All patients and caretakers receive health education on oral rehydration therapy, refuse disposal and cleanliness.
7	RECORDS
7.1	Patient's records are kept up to date.
7.2	A weekly chart is kept in clinics showing diarrhoea cases under 5 and cases over five and any undue rise especially of cases over 5 is reported to the District Manager.
8	COMMUNITY BASED SERVICES
8.1	Education is carried out in the community on hygiene, latrine use, hand washing, food safety, boiling of water and milk, chlorination of drinking water if feasible, use of tap water or delivered tanker supplies during an epidemic.
8.2	The value of breast-feeding as a preventive measure is a permanent part of the clinics community health education programme.

9 COLLABORATION

9.1 Staff collaborate with other departments like Environmental health, Education and other sections within health like MCHW, Health Promotion.

DYSENTERY

SERVICE DESCRIPTION

For surveillance and reporting purposes the case definition of dysentery is diarrhea with visible blood in the stool and an outbreak is when there is an unusual increase in the weekly number of patients with or deaths from bloody diarrhoea.

NORMS

Reduce the number of cases of *Shigella dysenteriae* type 1 (sd1) in communities from which it was previously notified.

STANDARDS

1	REFERENCES PRINTS AND EDUCATIONAL MATERIALS
1.1	Copy of Steps in management of a dysentery outbreak.
1.2	Pamphlets in local languages.
1.3	Protocols on management of dysentery.
2	EQUIPMENT
2.1	
3	MEDICINES AND SUPPLIES
3.1	List of drugs in accordance with the Essential Drugs List.
3.2	Oral and intravenous rehydration solutions.
4	COMPETENCE OF HEALTH STAFF
4.1	Clinic staff are able to identify and manage patients with dysentery using the triad of fever, convulsions and bloody diarrhoea.
4.2	Staff increase infection control measures in its premises especially in toilets at times of outbreaks.
4.3	Staff initiate, with the help of the environmental health officer, the collection of stool samples from the clinic patients and from cases in their neighbourhood. Rectal swabs or swabs of fresh stool are collected on Cary-Blair transport media, packed with ice in a box and sent to laboratory, which is warned of their arrival by phone.
4.4	A stool specimen form for all cases is completed and antibiotic sensitivity requested and sent with the specimen.
5	REFERRALS
5.1	Criteria for referral are (1) a severely malnourished or very ill child under 5, (2) a child with measles in the last 6 weeks and (3) patients 50 years or older, dehydrated or having a convulsion.
6	PATIENT EDUCATION
6.1	Clinic staff will intensify preventive measure such as health education on hand washing with soap, breast feeding, food and water safety, home storage, treatment of water and use of latrines at times of outbreaks.
7	RECORDS
7.1	Records are kept up to date.
8	COMMUNITY BASED SERVICES
8.1	The district notifies clinics of any outbreak of dysentery so that clinics are prepared with pamphlets and supplies of drugs to which the organism is sensitive
9	COLLABORATION
9.1	Staff collaborate with other departments like environmental health officer, water affairs and other community based organisations.

HELMINTHS

DESCRIPTION OF SERVICE

Helminths can cause significant morbidity and yet are preventable and treatable. This chapter deals mainly with two of the most important diseases caused by helminths in South Africa – schistosomiasis and cysticercosis.

NORMS

1. Clinics in endemic areas for schistosomiasis receive a visit at least every month during months December to March from an environmental health officer looking specifically at schistosomiasis control.
2. Clinics receive from the laboratory a summary of results of helminth infections identified from their clinics at least every 6 months.
3. Staff have continuing education in helminth infection in children together with integrated management of childhood illness at least once a year.

STANDARDS

1 REFERENCES, PRINT AND EDUCATIONAL MATERIALS

- 1.1 The clinics in endemic areas for schistosomiasis are able to obtain from the district health office a copy of *Bilharzia in South Africa*, JHS Gear and R J Pitchford, latest edition.
- 1.2 The clinic has
 - 1.2.1 Posters and public information handouts in endemic areas on schistosomiasis, hydatid disease, cerebral cysticercosis.
 - 1.2.2 Posters and public information handouts on common intestinal helminths (ascaris, trichuris, necator, enterobius, taenia).
 - 1.2.3 Any dam, river or pond near a clinic in a schistosomiasis endemic area has a notice board about the danger for children of swimming there if the EHO has identified it as having infected snails.

2 EQUIPMENT

- 2.1 Plastic stool jars for urine and stool specimen
- 2.2 Laboratory forms and registers

3 MEDICINES AND SUPPLIES

- 3.1

4 COMPETENCE OF HEALTH STAFF

- 4.1 Staff know whether the clinic is in an endemic area for Schistosomiasis or other helminths.
- 4.2 Staff know the relationship between taenia solium from pigs and neurocysticercosis and epilepsy.
- 4.3 Staff give the correct information to patients on the life cycle of worms and how to prevent future infections.
- 4.4 Staff take a stool specimen for the laboratory and initiate treatment when a mother complains her child has recurrent abdominal pains, occasional blood in stool, recurrent cough, or when mother says she has seen worms.

5 REFERRAL

- 5.1 Referred according to protocols for relevant conditions

6 PATIENT EDUCATION

- 6.1 Staff advise children against swimming in infected pools and especially between 10:00-15:00 hours when *S. haematobium* cercariae are shed especially in warmer months. *S. mansoni* shed earlier 08:00-14:00 so people fetching water or washing are at risk.
- 6.2 Staff advise the community on the danger of, and to store water for 48 hours before, washing or drinking if from an identified schistosoma infected dam or pool.
- 6.3 Staff educate mothers on bringing up children to wash hands, wash fruit and vegetables, use

	a toilet correctly, not swim in dangerous water, not defecate near a river or urinate in water.
7	RECORDS
7.1	All records kept according to protocol.
8	COMMUNITY BASED ACTIVITY
8.1	Staff help with mass prevention or treatment projects initiated by district e.g. deworming pre-school children, treating school children in hyper-endemic areas of schistosomiasis.
9	COLLABORATION
9.1	Staff seek to involve the community with EHO in control measure advocated by District.
9.2	Staff work with schools to involve teacher, pupils and parents in district advocated control measures.
9.3	Staff discuss the importance of the "health promoting school" with teachers and parent-teacher associations in the catchment area.

SEXUALLY TRANSMITTED DISEASES (STD)

SERVICE DESCRIPTION

The prevention and management of STD is a service available daily at a clinic and is a component of services for reproductive health and for control of HIV/AIDS.

NORMS

1. Every clinic has a review of quality of care once a year by a supervisor preferably using the validated DISCA (District STD Quality of Care Assessment) instrument.
2. Every clinic has at least one member of staff but preferably all professional staff trained in the management of STD using the "Training Manual for the Management of a person with a Sexually Transmitted Disease".
3. Every clinic has at least one member of staff (but preferably all who have been trained for STD) trained as a counsellor for HIV/AIDS/STD.

STANDARDS

1 REFERENCES PRINTS AND EDUCATIONAL MATERIALS

- 1.1 Standard Treatment Guidelines and Essential Drug List, latest edition.
- 1.2 Syndromic Case Management of Sexually Transmitted Diseases - guide for decision-makers, health care workers and communicators.
- 1.3 The Diagnosis and Management of Sexually Transmitted Diseases in Southern Africa, latest edition.
- 1.4 Supplies of patient information pamphlets on STD in the local languages.
- 1.5 Posters on STD and condoms in all the local languages.
- 1.6 Wall charts of the 6 protocols of STD management in consultation rooms.

2 EQUIPMENT

- 2.1 A condom dispenser placed in a prominent place where condoms (with pamphlets on how to use) can be obtained without having to request them.
- 2.2 Examination light (or torch if no electricity) for every room with a screened examination couch.
- 2.3 Sterile specula (specula plus steriliser).

3 MEDICINES SUPPLIES

- 3.1 List of drugs in accordance with the Essential Drugs List and latest management protocols.
- 3.2 A supply of male condoms with no period where condoms are out of stock.
- 3.3 Gloves.
- 3.4 Dildos – at least one per clinic but preferably one per consulting room.

4 COMPETENCE OF HEALTH STAFF

- 4.1 Clinic staff provide STD management daily and have extended hours, or on call weekend time, if in an urban or peri-urban area.
- 4.2 The staff are adolescent friendly with friendly communication so as to be accessible and acceptable to shy patients whether male or female.
- 4.3 Patients have friendly, non-judgemental, confidential private consultations.
- 4.4 Staff are able to take a history and examine patients correctly with dignity respected when all patients have skin, mouth, genital and peri-anal areas examined.
- 4.5 The history is taken correctly and partner change inquired about (the gender of partners is not presumed).
- 4.6 Syphilis serology is done on all patients with STD - and twice in pregnancy (if PR available at clinic this is done there), some do VDRL.
- 4.7 Pap smears are done on women over 35 or with a history of vulval warts.
- 4.8 Patients are counselled on safe sex and HIV/AIDS is explained to them.
- 4.9 Treatment is according to the protocol for each syndrome.
- 4.10 Condom use is demonstrated and condoms provided.

4.11	Contact cards in the correct language are given and reasons explained so that at least 60% result in the contact coming for treatment.
5	REFERRALS
5.1	All patients are referred to the next level of care when their needs fall beyond the scope of competence.
5.2	Conjunctivitis in the newborn is referred after initial treatment.
5.3	The patient is referred if pregnant and has herpes in the last trimester.
5.4	Pelvic inflammatory disease is referred if patient is sick, has pyrexia and tachycardia, or severe tenderness, or is pregnant.
5.5	A painful unilateral scrotal swelling age under 18 is referred immediately for a surgical opinion regarding a possible torsion.
6	PATIENT EDUCATION
6.1	All patients receive health education on asymptomatic STD, misconceptions, rationale of treatment, compliance and return visit.
6.2	Time is given during counselling and discussion after treatment about the need for contacts to be treated.
6.3	If the patient's syndrome is vaginal discharge the possibility of it not being sexually transmitted is discussed.
6.4	If pregnant then implications for the baby are discussed (congenital syphilis, ophthalmia, HIV, chlamydia).
6.5	The importance of condom use is stressed.
7	RECORDS
7.1	Patient's records are kept according to protocol with confidentiality stressed.
7.2	Laboratory registers with return time for laboratory specimens not greater than 3 days.
7.3	A register is kept of contact cards issued and returned.
7.4	Partner notification cards are in local languages.
8	COMMUNITY BASED SERVICES
8.1	Staff Liaise with traditional healers about the care of STDs.
9	COLLABORATION
9.1	Staff collaborate with different departments such as schools, churches, traditional healers and community organisations implementing health promotion activities leading to the prevention of STD.

HIV/AIDS

SERVICE DESCRIPTION

A comprehensive range of services is provided including the identification of possible cases, testing with pre-and post-counselling, the treatment of associated infections, referral of appropriate cases, education about the disease to promote better quality of life and promotion of universal precautions with the provision of condoms and the application of occupational exposure policies including needle stick injury.

NORMS

1. The clinic is supervised every three months by the District Communicable Disease Control Co-ordinator and the Senior Infection Control Nurse of the district hospital.
2. Every three months those clinics performing RPR and Rapid HIV tests have a visit by a laboratory technologist for quality control.
3. At least one professional nurse will attend an HIV/AIDS/STD/TB workshop or other continuing education event on HIV/AIDS each year.

STANDARDS

1 REFERENCES PRINTS AND EDUCATIONAL MATERIALS

- 1.1 HIV/AIDS Strategic Plan for South Africa 2000-2005
- 1.2 Summary results of the last (e.g. 1998) National HIV Serological Survey on women attending public health services in South Africa.
- 1.3 Management of Occupational Exposure to Human Immunodeficiency Virus (HIV).
- 1.4 Paediatric HIV/AIDS Guidelines.
- 1.5 HIV/AIDS Clinical Care Guidelines for Adults. Primary AIDS Care, latest edition.
- 1.1 Epidemiological Notes - National or Provincial relating to HIV/AIDS.
- 1.2 Strategies to reduce Mother to Child Transmission of HIV and other infections during Pregnancy and Childbirth.
- 1.3 HIV/AIDS Guidelines for home based care.
- 1.4 Policy guidelines and recommendations for feeding of infants of HIV positive mothers.
- 1.5 AIDS pamphlets in the local language.
- 1.6 Illustrated booklets e.g. Soul City – AIDS in our community
- 1.7 Posters on HIV/AIDS/STD in the local languages and preferably depicting local culture settings.

2 EQUIPMENT

- 2.1 Remote clinics have laboratory equipment for RPR and Rapid HIV.

3 MEDICINES AND SUPPLIES

- 3.1 Gloves and protective aprons and goggles
- 3.2 Condoms - male and dildo (female condoms if policy)
- 3.3 Post exposure prophylaxis of occupationally acquired HIV exposure e.g. needle stick injuries with HIV positive blood in accordance with the recommendations of the Essential Drug List.

4 COMPETENCE OF HEALTH STAFF

Knowledge and attitudes

- 4.1 Staff know the contents of the guidelines on Management of Occupational Exposure to Human Immunodeficiency Virus.
- 4.2 Staff relate to patients in a non-discriminatory and non-judgemental manner and maintain strict confidentiality about patient's HIV status.
- 4.3 Staff are familiar with regulations and mechanisms to deal with confidentiality in notifying patients with AIDS disease or AIDS deaths.
- 4.4 Staff provide warm, compassionate, counselling on a continuous basis and which is sensitive to culture, language and social circumstances of patients.
- 4.5 Staff are aware of the effects of factors such as unprotected sexual intercourse, multiple sexual partners, poverty, migrant labour, women's socio-economic conditions, lack of education, the high

	incidence of STD, lack of recreational facilities, violence and rape, drugs and alcohol, discrimination, lack of relevant knowledge in relation to HIV transmission in the clinics catchment area.
4.6	Staff are aware of the social consequences (orphans, loss of work, family, disruptions, youths schooling and careers) of AIDS.
4.7	Staff seek to reduce fear and stigma of HIV/AIDS.
4.8	Staff provide youth friendly services that help promoting improved health seeking behaviour and adopting safer sex practices
Skills	
4.9	Staff are able to
4.9.1	Take a good history including a sexual history, after establishing a trusting relationship.
4.9.2	Undertake a physical examination according to guidelines checklist in good lighting and in privacy.
4.9.3	Do pre and post test counselling after informed consent and take laboratory specimens for HIV (two separate blood specimens), and RPR.
4.9.4	Perform, after training, rapid HIV and RPR tests in those remote clinics where this has been set up.
4.9.5	Continue counselling at suitable times when more time can be allocated.
4.9.6	Promote optimal health and safer sexual practices (wellness management to include mental attitude, nutrition, healthy lifestyle, vitamins, no drugs or alcohol, avoidance of re-infection with HIV and STD by practising safer sex, early treatment if infectious including TB).
4.9.7	Assess the prognosis of HIV to AIDS by recognising and diagnosing the common opportunistic infections.
4.9.8	Diagnose acute pneumonia and start on cotrimoxazole or other antibiotic while arranging referral for admission.
4.9.9	Refer to Tuberculosis and HIV/AIDS clinical guidelines and initiate directly observed tuberculosis treatment after obtaining positive sputum results or send for x-ray when in doubt and also send sputum for culture, while starting INH prophylaxis 300mg daily
4.9.10	Offer periodic check-ups, including weight, to all HIV cases.
4.9.11	Discuss voluntary HIV testing with patients with STD or TB, and get consent forms signed.
4.9.12	Counsel cases of rape and offer HIV test after informed consent and pre- and post test counselling.
4.9.13	Use universal precautions.
4.9.14	Use policy guidelines and recommendations for feeding infants of HIV positive mothers and assess mothers' circumstances and counsel appropriately and abide with mothers' rights to choose after informed counselling.
4.9.15	Know all community structures in the clinic catchment area that can assist HIV positive mothers and infants and be able to differentiate between slow and rapid progressors.
4.9.16	Provide education, counselling and supportive care for child and child carer (including treatment of intercurrent illness, advise about feeding, Road to Health chart, immunisation, Vitamin A) and facilitate access to social services.
4.9.17	Collaborates with traditional healers on HIV/AIDS
4.10	All clinic staff (professional and cleaning/laundry) are immunised against Hepatitis B.
5	REFERRALS
5.1	Refer cases of Herpes zoster, oesophageal candidiasis and severe continued diarrhoea (after trial of symptomatic treatment).
5.2	Refer suspected TB cases with negative sputum for further investigation
6	PATIENT EDUCATION
6.1	All education vigorously addresses ignorance, fear and prejudice regarding patients with HIV/AIDS attending clinics.
6.2	Increase acceptance and use of condoms among the youth and other sexually active populations
7	RECORDS
7.1	Patient's records are kept according to protocol with emphasis on confidentiality.
8	COMMUNITY BASED SERVICES
8.1	The clinic has a working relationship with Community Health Committees, political leaders, ward councillors, NGOs and CBOs in the catchment area of the clinic.
8.2	Clinics keep track of HIV positive patients in their catchment areas while keeping information confidential.

8.3	Staff help in meeting needs of the individual and family - preventing problems, assisting in care and knowing when and where to seek assistance.
8.4	Staff inform and train family and community groups in home-based care.
8.5	Staff seek to de-stigmatise HIV disease in community through education.
8.6	Staff assist in integrating home based care services from industry, traditional organisations, church, NGO, welfare, and provide guidelines to community health committees on situation analysis and needs assessment in the community.
8.7	Staff work with traditional healers on improved advocacy of HIV/AIDS and STDs.
8.8	Staff provide simple home kits if possible.
8.9	Staff undertake home visits to supervise care and provide support.
9	COLLABORATION
9.1	Staff collaborate with other departments like education and other sectors.
9.2	Staff collaborate with Community Health Committees, political leaders, ward councillors, NGOs and CBOs in the catchment area of the clinic.
9.3	Staff collaborate with traditional healers in the clinic catchment area

MALARIA

SERVICE DESCRIPTION

South Africa has an effective control programme for malaria although seasonal outbreaks occur in endemic areas. In addition to public health measures treatment of cases aims at preventing mortality and complications and eliminating parasitaemia to minimise transmission.

NORMS

1. Members of the Provincial or District Malaria Control teams visit clinics in endemic areas every month during spraying activities throughout the year.
2. During peak transmission times October – May visits are more frequent.

STANDARDS

1	REFERENCES PRINTS AND EDUCATIONAL MATERIALS
1.1	Malaria Control Policy in South Africa – Latest version.
1.2	Latest Guidelines for the Prophylaxis of Malaria.
1.3	Latest Guidelines for the Treatment of Malaria.
1.4	Pamphlets on Malaria control Programme.
1.5	Pamphlets on Malaria diagnosis and treatment and prevention in local languages.
1.6	Posters in local languages.
2	EQUIPMENT
2.1	Laboratory equipment – rapid diagnostic tests on microscopic slides of blood smears.
3	MEDICINES AND SUPPLIES
3.1	List of drugs in accordance with the Essential Drugs List.
4	COMPETENCE OF HEALTH STAFF
4.1	Staff receive training and periodic continuing education on malaria control and malaria clinical management.
4.2	Staff know if the clinic is in an endemic area of Northern Province, Mpumalanga, N-E KwaZulu-Natal, or in an occasional focal limited epidemic area of N-W Province and N Cape.
4.3	Staff know the highest transmission period (e.g. Oct-May) and its relation to rainfall and abnormal seasonal patterns.
4.4	Staff keep a high level of suspicion of fevers, persons coming from other endemic countries (e.g. Mozambique) and are thus capable of making early diagnosis to offer rapid treatment.
4.5	Staff regard all South Africans as non-immune and prone to severe complications.
4.6	Staff provide information on personal preventive measures and prophylactic treatment to travellers and tourists in high risk areas.
4.7	Staff treat suspected uncomplicated malaria as per malaria protocol.
4.8	Staff refer urgently to hospital all suspected severe cases.
4.9	Staff confirm diagnosis with blood test either by blood smear for microscopy to laboratory or rapid diagnostic tests.
4.10	Staff repeat blood test if negative and symptoms persist.
5	REFERRALS
	The following are referred:
5.1	All children after initial treatment with tepid sponging and rehydration.
5.2	Patients not responding to treatment within 4 days.
5.3	Patients with symptoms of severe and complicated malaria (recording blood glucose, weight and what treatment if any already given on the referral form).
5.4	Pregnant patients.
5.5	Patients with skin reactions to treatment.
6	PATIENT EDUCATION
6.1	All patients receive in high risk areas health education on preventative measures: use of

6.2	impregnated bed nets/curtains, use of repellents on skin, aerosols, coils, vaporisers with insecticides, use of prophylactic drugs and about continuing precautions all year. Clinic staff discuss the purpose of vector control measures and house spraying and larval control in endemic areas, reasons for active detection of cases and treatment in homes by malaria control field teams.
7	RECORDS
7.1	Patients records are kept up to date.
7.2	All confirmed cases of malaria are notified to the malaria control programme.
8	COMMUNITY BASED SERVICES
8.1	Clinic staff co-operate with the Malaria Control team and Environmental Health Officers by recording community responses to residual insecticide (e.g. replastering) and any social changes (e.g. influx of migrant workers).
9	COLLABORATION
9.1	Clinic staff collaborate with other departments like environmental health, water affairs and education.

RABIES

SERVICE DESCRIPTION

The services for rabies are provided in hospital, but the clinic is aware of the different categories: CATEGORY 1 includes feeding, touching and licking of intact skin by an infected animal. This will not have treatment, but if the history is unreliable the patient gets vaccine.

CATEGORY 2 includes licking broken skin, but no bleeding by infected animal. This is treated by vaccine.

CATEGORY 3 patients are treated at the hospital with immunoglobulin and rabies vaccine. It includes bites and scratches, which penetrate skin and licking mucus membrane by infected animal.

NORMS

Every clinic has a member of staff conversant with the "Guidelines for Medical Management of Rabies in South Africa.

STANDARDS

1	REFERENCES PRINTS AND EDUCATIONAL MATERIALS
1.1	Guidelines for Medical Management of Rabies in South Africa.
2	EQUIPMENT
2.1	
3	MEDICINES AND SUPPLIES
3.1	List of drugs in accordance with the Essential Drugs List.
3.2	Rabies vaccine and anti-rabies immunoglobulin are only available at certain centres – each clinic is aware of its nearest source.
4	COMPETENCE OF HEALTH STAFF
4.1	Staff provide correct presumptive diagnosis and referral for post exposure treatment if possible and use the telephone hotline to obtain information if needed or to request vaccine.
4.2	Treatment according to exposure and rabies risk of area starts the same day and does not wait for laboratory results.
4.3	Treatment is free from district medical officers, hospitals and clinics.
4.4	The clinic takes details about the animal (e.g. dog, jackal, and yellow mongoose), whether there is an outbreak of rabies, if the animal was immunised, if there was abnormal behaviour and what degree of exposure the patient had (bites, licking, etc).
4.5	Management of the animal involved is by the local veterinary officer who is phoned to provide definitive diagnosis by transmission of the animal's head to the correct laboratory after first deciding if tying up and observation is not indicated.
4.6	Immediate management if category 3 includes cleaning the wound with cetrimide or betadine, administering anti-tetanus vaccine, no suturing but antibiotic and referral if possible or telephoning for vaccine to be sent if patient cannot be referred.
4.7	Vaccine is given on day 0, 3, 7, 14 and 28. The vaccine is kept in the refrigerator. If more convenient for the patient vaccine is sent to the clinic to administer - it is given intramuscularly into the deltoid in adults and into the thigh in children.
4.8	Significant human exposure is notifiable.
4.9	Cases of rabies and deaths are also notifiable.
4.10	Staff dealing with such a patient and exposed to bites, scratches or saliva are immunised.
5	REFERRALS
5.1	All patients are referred to the next level of care when their needs fall beyond the scope of competence. A suspected case of rabies is managed in hospital.
5.2	Staff suspect and refer urgently by ambulance if there is a history of dog or animal bite with or without post-exposure management.
6	PATIENT EDUCATION

6.1	All patients are educated on all matters relating to rabies.
7	RECORDS
7.1	Patients' records kept up to date.
8	COMMUNITY BASED SERVICES
8.1	Immediate action in the community is carried out with the veterinary services, the nurse of the clinic and the environmental health officer, and aims at checking for other people in contact with the animal, arousing awareness of the condition, need for immunisation of dogs and urgency of seeking health service care if bitten by a dog.
9	COLLABORATION
9.1	Staff collaborate with the local veterinary services.

TUBERCULOSIS

DESCRIPTION OF SERVICE

Following national protocols, the clinic staff diagnose TB on clinical suspicion using sputum microscopy, provide IEC and active screening of families of patients with TB, promote voluntary HIV testing, treat, dispense and follow-up using DOT and complete the TB register.

NORMS

- 1 Achieve a minimum of 85% cure rate of new sputum positive TB cases.
- 2 Achieve a passive case finding rate per 100,000 population to be defined.
- 3 Achieve two days turn around times of sputum results in more than 90% of cases.
- 4 Every clinic has at least one staff member who has or has had opportunities for continuing education in TB management.
- 5 Receive a six monthly assessment of quality of care by a supervisor who also evaluates the degree of community involvement in planning and implementing care.

STANDARDS

1 REFERENCES, PRINTS AND EDUCATIONAL MATERIALS

- 1.1 The latest edition of the TB training manual for health workers.
- 1.2 The South African TB control programme practical guidelines.
- 1.3 TB register manual, latest edition.
- 1.4 Tackling TB at work – Guidelines from South Africa's national TB control programme.
- 1.5 A resource list of HIV/AIDS services.
- 1.6 DOTS and training material (e.g. Provincial or NGO). A hospital referral protocol.
- 1.7 Leaflets and pamphlets in local languages for distribution.
- 1.8 TB posters on the walls in local languages changed yearly.
- 1.9 Flow charts on TB diagnosis
- 1.10 The latest EDL manuals on TB management.

2 EQUIPMENT

- 2.1 Screw top sputum containers

3 MEDICINES AND SUPPLIERS

- 3.1 Uninterrupted supply of TB drugs recorded on bin cards.
- 3.2 Clinic knows how to get emergency supplies of TB drugs.
- 3.3 Combination and single TB tables as per protocols.
- 3.4 Sterile syringes and needles and water for injection.

4 COMPETENCE OF HEALTH STAFF

Staff are able to

- 4.1 Initiate and follow up treatment of patient using the latest recommended TB management regimen and protocol.
- 4.2 Suspect and identify TB by early symptoms such as chronic cough, loss of weight and tiredness.
- 4.3 Educate with the emphasis on correcting misinformation and seeking to prevent spread of the disease.
- 4.4 Start direct observed treatment (DOT) supported by volunteers chosen and accepted by the patient.
- 4.5 Enter all sputum results on TB register and forms.

5 REFERRAL

- 5.1 Only patients sick enough to require hospital care are referred for hospitalisation and then sent with a completed TB register form and proposed discharge plan.
- 5.2 Patients referred to the clinics after discharge from hospital and with a discharge plan are followed up immediately to ensure the discharge plan is effectively implemented.
- 5.3 Before being transferred to another area the patient receives a completed transfer form and a

	sufficient supply of medication and when possible the facility to which he/she is transferred is notified by telephone.
5.4	If HIV positive the patient is given a confidential sealed letter with relevant data to give to the new facility.
5.5	Any severe complication of TB or adverse drug reaction is referred for admission.
5.6	Children with extensive TB or gross lymphadenopathy or not improving on treatment are referred.
5.7	Patient with need for additional health or social services are referred as appropriate.
5.8	All cases of MDR TB are referred to the Provincial MDR Committee/Unit.
6	PATIENT EDUCATION
6.1	Patients, relatives and the community receive high quality information on TB.
6.2	Patients are given group education each month when their situation is reviewed.
6.3	Patients are educated about HIV/AIDS/STDs in addition to TB so that they can recognise predisposing conditions and so prevent them.
7	RECORDS
7.1	As TB is a notifiable disease the cases are correctly classified by location of disease, result of sputum smear and by the treatment regimen.
7.2	All registers, smear conversion rate forms and quarterly reports are kept up to date.
8	COMMUNITY AND HOME BASED ACTIVITY
8.1	The clinic has an agreement with resulting support from the community health committee about the use of DOT.
8.2	The quality of DOT management within the clinic and the community-based supporters are monitored and evaluated quarterly.
8.3	Active case finding is done on all chronic cough patients and TB contacts through home visits.
8.4	In exceptional cases some MDR cases are allowed by MDR Committee to receive guaranteed intensive care treatment by DOT at community level.
9	COLLABORATION
9.1	The clinic collaborates with social welfare for social assistance.
9.2	Staff collaborate with NGOs, schools and workplaces in the catchment area to enhance the promotion of TB prevention and care.

LEPROSY

SERVICE DESCRIPTION

The service provides multi drug treatment to rapidly cure patients, interrupt further transmission and make elimination of the disease a global possibility.

NORMS

1. Decrease the current prevalence of leprosy in order to move towards its eradication.
2. Each clinic has each year at least one staff member who has had some continuing training in Leprosy from a supervisor.

STANDARDS

1	REFERENCES PRINTS AND EDUCATIONAL MATERIALS
1.1	The clinic has a copy of Leprosy Control in South Africa and a plasticised copy of Diagnosis of Leprosy, Skin Lesions in Leprosy, and Treatment of Leprosy.
2	EQUIPMENT
2.1	
3	MEDICINES AND SUPPLIES
3.1	List of drugs in accordance with the Essential Drugs List including prepacked MDT in combi/bubble packs.
4	COMPETENCE OF HEALTH STAFF
4.1	A supervisor checks progress of each case every 3 months and arranges for hospital review if needed.
4.2	Staff are able to suspect leprosy by testing for sensation and enlarged nerves and to refer to the correct hospital for biopsy diagnosis and notification if positive for leprosy.
4.3	Close contacts are examined and referred.
4.4	Files of patients are kept in related designated hospitals, supplies of combination bubble packs for multi-drug treatment are provided and clinics supervise continuity of care.
4.5	Clinic staff care for ulcers, educate patients to prevent deformity and seek help from the Leprosy Mission for help with rehabilitation, footwear and protection devices.
4.6	Sensation and motor function are tested every 3 months.
4.7	Reactions are recognised and referred to hospital.
4.8	Staff attitudes, both towards patients and in the community, are friendly, caring and help reduce stigmatisation.
5	REFERRALS
5.1	
6	PATIENT EDUCATION
6.1	All patients attending clinics for service receive health education, information and support.
7	RECORDS
7.1	All newly diagnosed cases are notified to the Provincial Health Department.
7.2	Patient's records are kept up to date.
7.3	All leprosy patients are on a register at the referral centre in each province.
8	COMMUNITY BASED SERVICES
8.1	Clinic staff once a year on International Leprosy Day (3rd Sunday in January) arrange health education about leprosy to reduce stigma and to arouse awareness of early symptoms and of the fact that leprosy can be cured in their communities.
9	COLLABORATION
9.1	For purposes of rehabilitation (and contact tracing in some areas) the Leprosy Mission is informed of all newly diagnosed cases by telephone or fax.

PREVENTION OF HEARING IMPAIRMENT DUE TO OTITIS MEDIA

SERVICE DESCRIPTION

Otitis media is an infection of middle ear which if not well treated leads to hearing impairment.

NORMS

STANDARDS

1	REFERENCES PRINTS AND EDUCATIONAL MATERIAL
1.1	Health education material for public (posters and pamphlets).
1.2	Copy of the latest edition of the "Guidelines for the prevention of hearing impairment due to otitis media at clinic level".
1.3	Standard Treatment Guidelines on Treatment of Acute and Chronic Otitis Media at PHC
2	EQUIPMENT
2.1	Basic equipment: auroscope with spare batteries and bulbs.
3	MEDICATION AND SUPPLIES
3.1	According to EDL.
4	COMPETENCE OF HEALTH STAFF
4.1	Staff have continuing education on acute respiratory infections (upper and lower) as part of integrated management of childhood illnesses
4.2	Staff are able to:
4.2.1	Elicit an adequate history from mother and child (e.g. irritable, difficulty sleeping, pulling on ear, runny nose, fever, discharge of pus, snoring, delayed language development, allergy to penicillin).
4.2.2	Use an auroscope and evaluate the eardrum; always palpate lymph nodes, examine throat and test for neck stiffness and mastoid for pain, oedema or tenderness.
4.2.3	Use two hearing tests such as the Voice test and the Swart Questionnaire for babies younger than 12 months.
4.2.4	Distinguish acute otitis media, otitis media with effusion and chronic otitis media and provide relevant management for each, according to protocol.
4.2.5	Use eardrops and dry mops a discharging ear and teach mother how to do it.
5	REFERRAL:
5.1	Persistent or worsening signs of acute otitis media after 5 - 7 days of treatment.
5.2	Those who on first follow up still have pain or complications.
5.3	Those with effusion who have moderate or severe hearing loss, or where effusion has persisted for more than a month.
5.4	Patients with pain associated with an ear that has been discharging for more than 2 weeks.
5.5	If there is an inflammatory swelling or tenderness over mastoid.
5.6	If there is neck stiffness or vomiting or drowsiness.
5.7	Large central perforation with significant hearing loss.
5.8	Dry perforation or perforation due to trauma.
5.9	If there is pus discharge suspected to be due to a cholesteatoma.
5.10	Patients with speech, language and/or auditory perceptual problems.
6	PATIENT EDUCATION
6.1	Staff provide mother with instruction and follow up.
6.2	Opportunities are taken to inform community health committee and women groups that middle ear problems are very common and if not treated early can lead to hearing loss with effects on a child's development and language skills.
7	RECORDS
7.1	All information on cases is correctly recorded in the appropriate register.
7.2	Registers are kept up to date to ensure continuity of care and recall.
8	COMMUNITY BASED ACTIVITY

8.1	The clinic has sensitised the community and receives support from the community health committee.
9	COLLABORATION
9.1	The clinic staff collaborate with schools, crèches to identify children with ear infection.
9.2	Clinic staffs collaborates with the clinic health committee, the civic organisations and workplaces in the catchment area to enhance health promotion.

RHEUMATIC FEVER AND RHEUMATIC HEART DISEASE

SERVICE DESCRIPTION

Rheumatic fever can have serious cardiac complications and can be prevented by active treatment of throat infections and prophylactic penicillin of known cases.

NORMS

Young child curative care will be provided daily by clinics using an integrated approach to childhood illness.

STANDARDS

1	REFERENCES PRINTS AND EDUCATIONAL MATERIAL.
1.1	National Guidelines on primary prevention and Prophylaxis of rheumatic fever and rheumatic Heart Disease
1.2	Current protocols on rheumatic fever and its primary and secondary prevention.
1.3	Suitable library of reference and journals on rheumatic fever.
2	EQUIPMENT
2.1	
3	MEDICINES AND SUPPLIES
3.1	As per EDL
4	COMPETENCE OF HEALTH STAFF
4.1	Staff are able to
4.1.1	Suspect streptococcal infection of the throat following a complaint of acute sore throat with the finding of pharyngeal exudate and tender cervical glands.
4.1.2	Suspect and refer acute rheumatic fever by recognition of polyarthrits, heart murmur, arthralgia, fever, erythema marginatum, chorea, subcutaneous nodule, history of sore throat in last month or previous rheumatic heart disease.
4.1.3	Recognise and refer possible rheumatic disease by murmurs and previous history.
4.1.4	After definitive diagnosis in hospital and notification ensure patient receives prophylactic treatment.
5	REFERRAL
5.1	
6	PATIENT EDUCATION
6.1	Patient and their families receive education on the disease, its effect on the heart and the need for continued prophylaxis.
7	RECORDS
7.1	Acute Rheumatic Fever is a notifiable disease
7.2	Records are kept according to protocol.
7.3	Register of patients who receive monthly (or 3 weekly) penicillin is accurate and up to date.
7.4	Register and record of patients on regular prophylaxis after a first attack kept for at least five years.
8	COMMUNITY AND HOME BASED ACTIVITY
8.1	Health education and information with other childhood diseases campaigns
9	COLLABORATION
9.1	The clinic collaborate with other health workers e.g. school health nurses and community groups.

TRAUMA AND EMERGENCY

SERVICE DESCRIPTION

Clinics provide emergency and resuscitation service, treatment and referral of patients that have experienced trauma and/or injury and have arrangements to deal with disaster situations.

NORMS

1. All clinics provide trauma and emergency services.
2. Reduce intentional and unintentional injuries among adolescents, including teenage suicide. (National Year 2000 Goals, Objectives and Indicators.)
3. Increase the proportion of emergency health staff who has basic ambulance assistance qualifications, and who are able to provide emergency care to victims of poisoning, injuries and maternal emergencies. (National Year 2000 Goals, Objectives and Indicators.)

STANDARDS

1 REFERENCES, PRINTS AND EDUCATIONAL MATERIALS

- 1.1 Wits University PHC Training Manual for Trauma.
- 1.2 Primary Health Care Manual of the Essential Drugs Programme.
- 1.3 The South African Medicines Formulary.
- 1.4 Any local protocols as decided by the medical directorate of clinic services.

2 EQUIPMENT:

- 2.1 There is an "Emergency Box", containing those items which are needed in an emergency, and a system in place for replenishing it when it has been used.
- 2.2 The following equipment is kept available:
 - 2.2.1 Clean, preferably sterile, instruments for suturing, with adequate replacements or a sterilising system.
 - 2.2.2 Suture materials
 - 2.2.3 Equipment and IV solutions according to the Essential Drug List.
 - 2.2.4 Stretchers, with or without wheeled trolley.
 - 2.2.5 Crutches.
 - 2.2.6 Wheeled chair.
 - 2.2.7 Body bags / shrouds for dead bodies.

NOTE: Even where skills are not routinely available it is still worth having emergency equipment that can be used by visiting staff.

3 MEDICINES & SUPPLIES:

- 3.1 The following drugs should be kept, as part of an "emergency box" according to EDL

4 COMPETENCE OF HEALTH STAFF

- 4.1 A clinic has staff capable of dealing with any anticipated trauma in a safe and effective way and to stabilize and refer patients as appropriate.
- 4.2 Staff have skills to identify the nature of injury, and decide on the management needed and its urgency.
- 4.3 Assess the significance of possible poisoning and institute appropriate counter-measures
- 4.4 Understand the psychological implications of attempted suicide and ability to render effective immediate care.

5 REFERRAL

- 5.1 Staff have a clear understanding of:
 - 5.1.1 Indications for transfer and degrees of urgency, as outlined in local policy.
 - 5.1.2 The mechanism of transfer and the immediate referral channel.
 - 5.1.3 The management of seriously ill patient during transfer.
 - 5.1.4 The management of less severe injuries without transfer.
- 5.2 A reliable means of communication and transport is available when required.

6	PATIENT EDUCATION
6.1	A mechanism is in place at District level to identify the significant causes of trauma locally.
6.2	Staff identify possible interventions that might be made, involving the community in discussion of implementation and education both in schools and communities.
6.3	The consultation in the clinic is used as an opportunity for talking about prevention and first aid of burns.
7	RECORDS
7.1	A reliable patient-held record system is available.
7.2	Data is routinely recorded and used to anticipate and prepare for disasters
8	COMMUNITY & HOME BASED ACTIVITY.
8.1	
9	COLLABORATION
9.1	The clinic staff collaborate with the Police & Social Welfare Departments.
9.2	The clinic have clear guidelines on referral and support from the District Hospital and Ambulance Service.

ORAL HEALTH

SERVICE DESCRIPTION

The Basic Primary Oral Health Care Services at clinic level should as a minimum consist of promotive and preventive oral health services (oral health education, tooth-brushing programmes, fluoride mouth rinsing programmes, fissure sealant applications, topical fluoride application); and basic treatment services (an oral examination, bitewing radiographs, scaling and polishing of teeth and simple fillings of 1-3 tooth surfaces including atraumatic restorative treatment (ART)) and emergency relief of pain and sepsis (including dental extractions).

NORMS

1. Expose at least 50% of primary schools to organised school preventive programmes.
2. Everybody in the catchment area is covered by basic treatment services.

STANDARDS

1	REFERENCES PRINTS AND EDUCATIONAL MATERIALS
1.1	National Oral Health Policy
1.2	National Norms, Standards and Practise Guidelines for Primary Health Care
1.3	Provincial Operational Health Policy
1.4	Oral health educational material (posters, pamphlets etc).
2	EQUIPMENT.
2.1	Dental unit complete with chair, light, hand piece unit with hand pieces, suction and compressor
2.2	Aseptic trolley
2.3	Dental Autoclave
2.4	Amalgamator
2.5	Dental X-ray unit
2.6	Intraoral X-ray film processor
2.7	X-ray view box
2.8	Lead apron
2.9	Ultrasonic scaler
2.10	Dental operating stool (2)
2.11	Dental hand instruments (refer 1.2 above) Portable dental equipment where fixed facilities are not available.
3	MEDICINES AND SUPPLIES
	For details of material required, refer to 1.2 above
3.1	Medicine according to the EDL
3.2	Local anaesthetic materials
3.3	Exodontia and oral surgery procedure materials
3.4	Prophylaxis materials
3.5	Conservative procedure materials
4	COMPETENCE OF HEALTH STAFF
4.1	Community health workers offer oral health education to patients.
4.2	The dental assistant is competent to do patient administration, surgery cleanliness and infection control as well as chair-side assisting.
4.3	The oral hygienist is competent to conduct oral examination, apply fissure sealants, topical fluorides, scaling and polishing and taking of intra-oral x-rays.
4.4	The dental therapist is able to carry out oral hygienist competencies as well as tooth extractions and simple 1 to 3 surface filling of teeth.
5	REFERRALS

5.1	All patients whose needs fall beyond the scope of services provided at the clinic are referred to the next level of care.
6	PATIENT EDUCATION
6.1	All patients receive oral health education.
7	RECORDS
7.1	Patients records.
7.2	Patient register.
7.3	Statistics.
8	COMMUNITY BASED SERVICES
8.1	School oral health programmes consist of oral health education, tooth brushing and fluoride mouth rinsing and ART.
9	COLLABORATION
9.1	Collaboration with other departments: Education, Water Affairs, and Forestry and other sections within health such as Child Health, Health Promotion, Environmental Health, Nutrition, Communication etc..

MENTAL HEALTH

SERVICE DESCRIPTION

Mental health services form part of integrated comprehensive Primary Health Care. The service seeks to improve mental health and social wellbeing of individuals and communities. Promotion of community mental health is included in clinic and community based IEC. Preventive measures for mental disability are included in all services such as antenatal, infant, child, reproductive health and curative care.

NORMS

1. All clinics have regular visits (for patient care, training, supervision and support) from dedicated mental health or psychiatric nurses from health centers, hospitals or mobile teams based in the district.
2. All clinics have access (by referral or by periodic clinic visits) to specialist mental health expertise (psychiatrists, psychologists, occupational therapists) and social workers from district or regional level at least once a month.
3. In every clinic there is a member of staff who has had continuing education in psychiatry or mental health (including community aspects) in the last year.
4. In every clinic there is at least one person trained in counselling and the management of victims of violence and rape.

STANDARDS

1 REFERENCES, PRINTS AND EDUCATIONAL MATERIALS

- 1.1 Mental health policy document for provinces.
- 1.2 List of visiting psychiatric staff at nearest health centre, district hospital, psychiatric specialist hospital or outreach service.
- 1.3 Mental health assessment guidelines.
- 1.4 Psycho-social rehabilitation checklist for community work.
- 1.5 Checklist for daily living skills for rehabilitated patients.
- 1.6 Admission procedures under current Mental Health Act.
- 1.7 Emergency medication protocol.
- 1.8 Essential drug list for Primary Health Care.
- 1.9 24 Hour ability to telephone or use radio to psychiatric unit of district hospital or nearest Mental Hospital.
- 1.10 Posters and pamphlets on mental health, severe psychiatric conditions, available services and user rights.

2 EQUIPMENT

- 2.1

3 MEDICINES AND SUPPLIES

- 3.1 Emergency and routine medication provided according to protocol and EDL.

4 COMPETENCE OF HEALTH STAFF**Recognising mental illness**

- 4.1 Clinic staff consider risk factors for mental health within their catchment area: poverty, social power, unemployment, ill health, homelessness, migrancy, immigrants, isolated persons, HIV positives etc.
- 4.2 Staff identify and provide appropriate interventions for patients with depression, anxiety, stress related problems, male violence, substance abuse and special needs of women (childbearing, abortion, sterilisation, disability, malignancy etc.)
- 4.3 Clinic staff recognise the expression and signs of emotional distress and mental illness early (especially in young patients or in relapse of a psychiatric condition).
- 4.4 Clinic staff participate in the promotion of healthy life style in clinic attendees and the community.

Organising services

- 4.5 Staff organise the clinic to have quarter periods of the day set aside for booked interviews.
- 4.6 Staff provide prompt help from or at the clinic if a patient's condition in the community deteriorates.
- 4.7 Staff ensure time is allocated for home visits to patients who have returned from mental hospital.
- 4.8 Staff ensure there is no segregation or stigmatisation at the clinic of patients who have to use other services e.g. family planning, antenatal care, etc.
- 4.9 Staff arrange access to a consistent member of staff for each consultation.

Managing care

- 4.10 Specially trained staff are able to
 - 4.10.1 Maintain relationships with patients that are just, caring, and based on the principles of human rights.
 - 4.10.2 Perform an adequate medical examination which:-
 - 4.10.2.1 Identifies the general mental state e.g. psychotic or depressed.
 - 4.10.2.2 Identifies the severity and level of crisis.
 - 4.10.2.3 Rules out systematic illness.
 - 4.10.2.4 Records temperature and blood glucose level.
 - 4.10.3 Take a history that includes previous service use such as admission to hospital.
 - 4.10.4 Take a family history and evaluate support.
 - 4.10.5 Develop a sustained therapeutic relationship with patients and their families.
 - 4.10.6 Know and implement standard treatment guidelines especially the section on delirium with acute confusion and aggression, acute psychosis and depression.
- 4.11 General nurses are able to:-
 - 4.11.1 Detect and provide services for severe psychiatric conditions as a component of comprehensive Primary Health Care.
 - 4.11.2 Make appropriate and informed referrals to other levels of care.
 - 4.11.3 Provide basic psychiatric care and assess urgency and severity of symptoms.
 - 4.11.4 Provide individual community maintenance and care for stable long-term patients who have severe psychiatric conditions and have been discharged from hospital.
 - 4.11.5 Provide each stable long-term user with individualised comprehensive care which includes:-
 - 4.11.5.1 An ongoing assessment of mental state, functional ability and social circumstances.
 - 4.11.5.2 Familiarity with the internationally recognised diagnostic system.
 - 4.11.5.3 An ability to detect and monitor distress and relapse.
 - 4.11.5.4 An ability to provide basic counselling and support to patient and family.
 - 4.11.5.5 A basic knowledge, criteria and pathways for referral for disability grants.
 - 4.11.5.6 Knowing community referral and support organisations.
 - 4.11.5.7 The follow-up of all cases returned to community after hospitalisation and keeping a register.
 - 4.11.5.8 An ability to use records to facilitate continuity of care, such that:-
 - 4.11.6 The condition of patients in the community is monitored and poor compliance,

	functional deterioration, substance abuse and family conflict community ridicule are identified.
4.11.7	The onset of mental deterioration in HIV positive patients is recognised.
4.11.8	The prescription of sedation for aggressive or violent patients only as appropriate when other measures fail.
4.11.9	Coping with disturbed, intoxicated, aggressive suicidal behaviour without resorting to violence, abuse of undue physical restraint.
4.12	Clinic staff provide patient and caregiver satisfaction with assistance in alleviating family burden, achieving social integration, improving quality of life and general functioning while improving symptoms.
4.13	Clinic staff conduct consultations in privacy and in a confidential way and informed consent is obtained for communication to others.
5	REFERRAL
5.1	Referral pathways to other levels or types of care are known and expedited.
6	PATIENT EDUCATION
6.1	Patients, relatives and the community receive high quality information on mental health and mental illness.
6.2	Patients and their supporters are given individualised education when their situation is reviewed.
6.3	Patients and their supporters are educated on how to recognise predisposing factors and conditions to prevent relapse.
6.4	Clinic staff use education in the family and community to address ignorance, fear, and prejudice regarding patients with severe psychiatric conditions attending the clinic.
7	RECORDS
7.1	Records are kept according to protocol with emphasis on confidentiality and accuracy.
7.2	A register of psychiatric patients in the community is maintained.
7.3	Staff record mental health indicators on:-
7.3.1	The number and mix of cases
7.3.2	The frequency of contact
7.4	Staff analyse indicators and develop appropriate action.
8	COMMUNITY AND HOME BASED ACTIVITY
8.1	Staff participate in community awareness programmes for mental health according to the national and international calendar.
8.2	Staff participate in the training of family and carers of patients to plan an active role in their rehabilitation.
8.3	Staff encourage patient and caregiver support groups in community.
8.4	Staff keep the addresses and phone numbers of people assisting with mental health and social problems (e.g. women's shelters, community self-help groups).
9	COLLABORATION
9.1	Staff respect and where appropriate seek collaborative association with local traditional healers.
9.2	Staff collaborate with all community services e.g. crisis counselling (lifeline, priests with counselling skills) and mental health groups especially those for youth.
9.3	Staff collaborate with the hospital for planning discharges to the community.

VICTIMS OF SEXUAL ABUSE, DOMESTIC VIOLENCE AND GENDER VIOLENCE

SERVICE DESCRIPTION

The service, requires co-operation between the health sector, the police and the Department of Justice, provides counselling and referral of victims, STD prophylaxis and HIV testing, emergency contraception, care of injuries, medico-legal advice and documentation of evidence.

NORMS

1. Every clinic has established working relationships with the nearest police officer and social welfare officer by having visits from them at least twice a year.
2. A member of staff of every clinic has received training in the identification and management of sexual, domestic and gender related violence. The training includes gender sensitivity and counselling.

STANDARDS

1 REFERENCES PRINTS AND EDUCATIONAL MATERIALS

- 1.1 All relevant guidelines / protocols related to women health issues.
- 1.2 A suitable library of references and journals on sexual offences, domestic and gender violence.
- 1.3 The clinic has a list of names, addresses and telephone numbers of the nearest accredited health care practitioners, police and social workers who would be involved in dealing with these cases.
- 1.4 The clinic has a list of names and addresses of NGOs or other organisations (e.g. CBO) which undertake appropriate counselling (e.g. FAMSA, ATIC) for violence, child abuse and sexual offences.

2 EQUIPMENT

- 2.1 There is a room available at short notice for private, confidential consultations.

3 MEDICINES AND SUPPLIES

- 3.1 Emergency contraceptive pills.

4 COMPETENCE OF HEALTH STAFF

- 4.1 The clinic staff fast track in a confidential manner any rape victim to a private room for appropriate counseling and examination.
- 4.2 The staff always include a question on gender violence in the history taking from women with depression, headaches, stomach pains or a known abusive partner.
- 4.3 The staff include diplomatic probing of the domestic situation in taking histories of children with failure to thrive, recurrent episodes of trauma or behavioural problems.
- 4.4 All cases of sexually transmitted disease in children are managed as cases of sexual offence or abuse.
- 4.5 When a person presenting at a clinic alleges to have been raped or sexually assaulted the allegation is assumed to be true and the victim is made to feel confident they are believed and are treated correctly and with dignity.
- 4.6 A detailed medical history is recorded on the patient record card and a brief verbal history of the alleged incident is taken and noted - with an indication that these are not a full account. These notes are kept for 3 years.
- 4.7 Staff explain that referral is necessary to an accredited health practitioner and arrangements are made expeditiously and while awaiting referral emergency medical treatment is given with the consent of the victim: prophylactic treatment against STD and post-coital contraception.
- 4.8 The victim is given information on the follow-up service and the possibilities of HIV infection and what to discuss with the accredited health practitioner at the hospital or health centre.
- 4.9 The staff even though non-accredited are not prohibited from dealing with rape victims but must keep patient records.
- 4.10 Victims are not allowed to wash before being seen by an accredited health practitioner.

4.11	Women who have been raped or abused are attended to by a female health worker and if this is not possible (e.g. a male district surgeon comes to the clinic) then another woman is present during the examination.
4.12	The victim is given brief information about the legal process and the right to lay a charge.
4.13	If the victim now indicates a desire to lay charges the police are called to the clinic.
4.14	Clinic staff inquire if charges will or have been laid with the SA Police Service.
4.15	
5	REFERRALS
5.1	All patients are referred to the next level of care when their needs fall beyond the scope of competence of clinic staff.
6	PATIENT EDUCATION
6.1	All patients, community, and children attending clinic are educated and informed on abuse.
7	RECORDS
7.1	Patients records are kept according to protocol with emphasis on confidentiality and accuracy.
7.2	The clinic keeps a confidential record of all claims of sexual offences, wife battering and child abuse (sexual, physical, emotional and nutritional).
8	COMMUNITY BASED SERVICES
8.1	Clinic staff establish links with relevant organisations already operating and providing services for victims of abuse.
8.2	Staff encourage community participation on health promotion to curb domestic and gender violence.
9	COLLABORATION
9.1	Staff collaborate with other departments like the police, relevant NGOs and CBOs to reduce the violence and give reassurance and support.

SUBSTANCE ABUSE

SERVICE DESCRIPTION

By preventing and managing substance abuse in the clinic, the service aims to reduce substance abuse among adolescents and also to reduce alcohol related motor vehicle morbidity and mortality. Prevention and management of substance abuse also has relevance for tuberculosis, STDs and HIV/AIDS, mental illness, family violence and educational attainment.

NORMS

1. Reduce school attendees admitting to drink alcohol and smoke tobacco.
2. Reduce the use of illegal substances including cocaine, mandrax, heroin and marijuana.
3. Reduce the consumption of alcohol and other drugs among women and especially pregnant women.

STANDARDS

1	REFERENCES PRINTS AND EDUCATIONAL MATERIALS
1.1	The latest Report of Mental Health and Substance Abuse.
1.2	Health learning materials on alcohol, cannabis, mandrax and other drugs in local languages.
2	EQUIPMENT
2.1	
3	MEDICINES AND SUPPLIES
3.1	
4	COMPETENCE OF HEALTH STAFF
4.1	Clinics have regular visits by mental health trained staff where training includes care of substance abusing patients.
4.2	Patients are able to request visits by social workers.
4.3	In problem (urban) areas staff attend workshops on relevant substance abuse.
4.4	Patients needing detoxification for substance abuse withdrawal symptoms have entry to clinic care via NGOs, teachers, employers, traditional healers, police and are referred rapidly to general hospitals with detoxification facilities and have a social worker to arrange follow up and social reintegration on discharge.
4.5	Patients referred to clinics by NGO, teachers, employers, traditional healers and police (not requiring detoxification) are given appointments with periodically visiting specially trained mental health nurses.
4.6	Clinic staff have rapport with their communities and are culturally accessible to substance-abusing patients to discuss their problems or have their families discuss their problem with them.
4.7	Patients with TB, STD/HIV, mental disorders and families with violence are sufficiently at ease with staff to be able to bring out any problem of alcohol or drug abuse.
4.8	In the clinic catchment area or district of the clinic, staff are able to work when required with correctional services, educators, labour, welfare and NGOs (e.g. Alcohol Anonymous).
4.9	Staff can identify tobacco, alcohol and marijuana abuse and provide basic counselling for behaviour changes and referral to NGOs specialising in substance abuse.
4.10	Staff are aware of the age groups at risk and the predominant social settings in the community for substance abuse: e.g. male youth of 10 – 15 age, limited social integration in the family, shebeens and people who have been in prison.
4.11	The clinic arranges meetings between SANCA and parents and teachers to initiate a drug prevention, education and early identification programme.
4.12	Staff participate in life skills programmes in schools and discuss substance abuse.
4.13	Staff mount community awareness programme with youth, NGOs and CBOs.
4.14	The clinic is maintained as a smoke free zone.
4.15	Staff are able to recognise the problem of foetal alcohol syndrome and include education on this with antenatal groups.

4.16	Staff identify patients needing referral, do this with patient compliance, accept patients back for follow up and assist with family reintegration.
4.17	Staff identify school children with behaviour problems and discuss with parents and teachers the possibility of drug involvement.
5	REFERRALS
5.1	All patients are referred to the next level of care when their needs fall beyond the scope of competence of clinic staff.
6	PATIENT EDUCATION
6.1	All patients attending clinics for service receive health education.
7	RECORDS
7.1	Patients records kept up to date.
8	COMMUNITY BASED SERVICES
8.1	Community encouraged to initiate community based services.
8.2	In client and community discussion staff advise on harm reduction strategies (cigarette smoking, alcohol, glue sniffing) and collaborate with traditional healers who assist substance-abusing clients.
9	COLLABORATION
9.1	Staff collaborate with other sectors like education, correctional services, labour, welfare as well as other relevant NGOs and CBOs to improve mental health.
9.2	Staff collaborate with traditional healers for involvement in improving mental care at community level.

CHRONIC DISEASES AND GERIATRICS

SERVICE DESCRIPTION

Chronic diseases may be inherited, but many lifestyle and environmental factors such as smoking, inappropriate diet, sedentary lifestyle and heavy alcohol consumption are known to increase risks. These are to some extent within the control of a well-informed individual but there are often other factors such as poverty, under-nutrition in utero and in infancy, genetic predisposition, over which the individual has little control.

Besides early diagnosis, management and harm reduction there are opportunities at every stage for prevention and for promoting healthy behaviour.

Priority chronic diseases are hypertension, diabetes type 2, asthma, epilepsy, stroke, renal disease and obstructive lung disease.

NORMS

1	Increase by 50% the proportion of clinics providing comprehensive services for persons with chronic diseases.
2	Assess patient satisfaction and quality of care 6 monthly by a supervisor who also evaluates the degree of community involvement in care planning.
3	Reduce the number of people with BMI greater than 30.
4	Minimise patient travel by prescribing supplies of drugs to last 1-3 months.

STANDARDS

1	REFERENCES PRINTS AND EDUCATIONAL MATERIALS
1.1	Copy of National Guideline on Primary Prevention of Chronic Diseases of Lifestyle.
1.2	Management protocols on Type II diabetes at primary health care level.
1.3	Health promotion and educational materials relating to chronic diseases of lifestyle, ageing and cancer in local languages.
2	EQUIPMENT AND SPECIAL FACILITIES
2.1	Working sphygmomanometer with range of cuffs, and stethoscope.

National norms and standards for primary health care

2.2	Urine test strips for glucose, protein and ketones.
2.3	Blood glucose testing equipment.
2.4	Snellen Chart.
2.5	Clinics have easy access for the aged, those in wheelchairs and those with arthritis.
3	MEDICINES AND SUPPLIES
3.1	Arrangements are made by the clinic to minimise patient travel by prescribing supplies of drugs to last 1-3 months.
4	COMPETENCE OF HEALTH STAFF
4.1	Every clinic has a staff member who has skills to prevent, diagnose and manage chronic conditions including geriatrics, nutrition, genetics, mental health and reproductive health.
4.2	Patients are able to see the same nurse for repeat visits and a system of recall on cards or calendars is used to ensure continuity of care.
4.3	Staff are able to provide counselling and motivation on disease acceptance, continuity of care and compliance.
4.4	Staff are able to establish in patients a feeling of always being welcome even though they keep coming frequently over the years.
4.5	All staff show respect and concern for the elderly and the disabled.
4.6	Staff have the skills and attitude to protect and promote the rights of patients with regard to a full knowledge of health status, participation in decisions, access to own health records and becoming a partner in own health care.
4.7	Staff know that the prevalence of diabetics in South Africa is high (10% in Indian community and 5 - 6% in black community) and are able, using epidemiological skills, to estimate how many cases there are in the clinic catchment areas and are alert to identify them early.
4.8	Staff are receptive to periodic visits from doctors or district surgeons/medical officers and use the visits to review chronic disease patients.
5	REFERRALS
5.1	All patients are referred to the next level of care when their diagnosis and needs fall beyond the scope of competence as recommended by the protocols.
5.2	Staff know where to phone the nearest hospital/doctor for advice.
5.3	Detailed information is kept on the frequency of follow-up visits 1 -3 monthly and yearly for detailed examination by doctor.
5.4	Patients suspected of having diabetes are referred to hospital for diagnosis.
6	PATIENT EDUCATION
6.1	After diagnosis patients and caretakers are supported and their capacity developed regarding self care, self-monitoring, compliance, prevention of complications and management of the disease.
6.2	Education activities are sensitive to the cultural and economic realities of the patient and home.
7	RECORDS
7.1	Patient register of chronic conditions and treatment record.
7.2	Patient carried cards.
7.3	Home-based care records.
8	COMMUNITY BASED SERVICES
8.1	Staff work with any district NGO and CBO dealing with chronic conditions.
8.2	After analysis of the chronic disease register attempts are made to provide education in the community on modifiable risk factors, healthy food plans, less salt (iodised), weight control, sport and exercise, substance abuse especially alcohol, smoke (tobacco, smoke in houses), UV protection for albinos, early recognition of symptoms and periodic check-ups.
8.3	Educational activities are culturally and linguistically appropriate.
9	COLLABORATION
9.1	Staff collaborate with other departments and sectors whose activities have a bearing on chronic diseases.
9.2	Staff facilitate the initiation of clubs and special groups for people with chronic diseases.

National norms and standards for primary health care

9.3	Clinic staff approach the catchment area population through community health committees, NGOs, CBOs, youth groups and the church to reduce common risk factors operating in the community.
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DIABETES

SERVICE DESCRIPTION

Norms and standards on materials, equipment, supplies and general competencies are dealt with in the chapter on chronic diseases. This chapter deals specifically with competence and referral standards for diabetes.

NORMS

STANDARDS

1. REFERENCE PRINTS AND EDUCATIONAL MATERIAL

1.1 See chronic diseases

2. EQUIPMENT

2.1 Sphygmomanometer with different size cuffs

2.2

3. MEDICINE AND SUPPLIES

3.1 As per EDL list

4. COMPETENCE OF HEALTH STAFF

4.1 Staff know that prevalence of diabetics in South Africa is high (10% in Indian community and 5 – 6% in the black community) and estimate how many cases there are in clinic catchment areas and are alert to identify them early.

4.2 The interrelationship between abdominal obesity, hypertension and cardiovascular disease and initial presentation with complications of diabetics are known. Hypertension patients are investigated for diabetes.

4.3 All pregnant women have urine examined for glycosuria.

4.4 Patients suspected of having diabetes (history and risk factors, clinic blood and urine testing indicating diabetes) are referred to hospital for diagnosis.

4.5 Nurse knows where to phone the nearest hospital/doctor for advice.

4.6 Staff counsel on disease acceptance, continuity of care and compliance.

4.7 On return from diagnosis the patient is further educated in an inter-active problem solving way on:

4.8 Prevention detection and management of complications

4.9 Principles of nutrition, physical activity, hygiene and weight control

4.10 Self-monitoring with urine glucose strips or preferably blood glucose strips and maintaining urine glucose free.

4.11 Maintaining a body mass of (kg/m) for men 20 - 27 and women 19 - 26.

4.12 The drugs used.

4.13 The symptoms and treatment for hypoglycaemia.

4.14 Contraception and pregestational counselling.

4.15 Not smoking.

4.16 Six monthly or annual referral for assessment of progress, depending on the control of diabetes mellitus and complications.

5 INDICATORS FOR REFERRAL

5.1 Urgent referral to the nearest hospital :

5.1.1 If nausea and vomiting, dehydration and hypotension, ketonuria (>2+) significant hyperglycaemia with symptoms, stupor, confusion, coma, deterioration in vision, gangrene, severe infections (TB, pneumonia)

5.2 As soon as possible:

5.2.1 Pregnancy

5.2.2 Newly diagnosed cases

5.2.3 Recurring hypoglycaemic symptoms

5.2.4 Foot problems

5.2.5 Recurring hyperglycemia/glycosemia

5.2.6 Persistent infections.

6 PATIENT EDUCATION

DIABETES

6.1	all hypertensive or obese patients or those with a family history of hypertension are given non-pharmacological advice
7	RECORDS
7.1	See chronic diseases
8	COMMUNITY BASED SERVICES
8.1	See chronic diseases
9	RECORDS
9.1	See chronic diseases

HYPERTENSION

SERVICE DESCRIPTION

The service aims at increasing detection, treatment and control of hypertension and preventing target organ damage, cardiovascular disease and strokes and adverse interaction with diabetes.

NORMS

1. Reduce the incidence of strokes and congestive cardiac failure and renal failure.
2. Reduce the prevalence of overweight and obese clients.
3. The majority of patients are compliant and on continuous treatment.

STANDARDS

1	REFERENCE PRINTS AND EDUCATIONAL MATERIAL
1.1	Patients health learning materials available on hypertension diet, exercise and weight reduction.
2	EQUIPMENT
2.1	Sphygmomanometer with different size cuffs
2.2	Urine test strips (blood, protein and glucose)
3	MEDICINE AND SUPPLIES
3.1	
4	COMPETENCE OF HEALTH STAFF
4.1	All adults entering clinic have blood pressure measured routinely every five years.
4.2	All patients with high normal values (135-139/85-89mm Hg) or previous high reading have blood pressure measured yearly.
4.3	At least two measurements of blood pressure are made at each of several visits to determine blood pressure.
4.4	Staff measure blood pressure seated but standing if patient elderly or diabetic.
4.5	Referral is made to a doctor for the start of treatment for all people with sustained systolic blood pressure 160mm Hg or sustained diastolic blood pressure > 100mm Hg.
4.6	Patients with a systolic pressure between 140-159mm Hg or sustained diastolic pressure between 90-99 are referred if they are obese, diabetic or have a strong family history.
4.7	The stepwise treatment outlined in the Standard Guidelines and Essential Drug list is followed.
4.8	Target blood pressure during anti-hypertensive treatment is less than 140 systolic and less than 85mm diastolic and is maintained with minimal side effects.
4.9	Combinations of drugs are prescribed by the hospital or visiting doctors.
4.10	Staff identify hypertensive emergencies (neurological signs, pulmonary oedema) and treat with oral nifedipine 5mg and refer.
4.11	Staff check compliance and ensure continuity.
5	REFERRAL
5.1	Patients on treatment are referred if there is no therapeutic response.
5.2	All pregnant women are referred.
5.3	All children with hypertension are referred.
5.4	All hypertensive emergencies are referred.
6	PATIENT EDUCATION
6.1	All hypertensive or obese patients or those with a family history of hypertension are given non-pharmacological advice :
6.1.1	Weight reduction via reduced fat and total caloric intake, regular brisk physical exercise and limited alcohol consumption.
6.1.2	Reduced intake of salt.
6.1.3	Increased consumption of fruit and vegetables.
6.1.4	Stopping smoking.
7	RECORDS
7.1	Blood pressure and weight recorded regularly.
7.2	A chronic disease register maintained showing patient's dates and monitoring monthly returns.

8	COMMUNITY AND HOME-BASED ACTIVITY
8.1	Community-based education programmes are initiated in all areas with high levels of obesity.
8.2	Community-based life-style improvement programmes are carried out with youth groups.
9	COLLABORATION
9.1	Staff collaborate with NGO or CBO dealing with obesity, diabetes and heart disease.

REHABILITATION SERVICES

BASIC CONSIDERATIONS

Rehabilitation services are an integral part of the services provided at the primary level. This constitutes a reorientation of rehabilitation from mainly institution-based services to community oriented and community based services. Communities and particularly people with disabilities should be involved in designing, implementing and monitoring services for people with disabilities. This precludes a disability service from being seen narrowly as a therapy service provided only by a certain category of staff. All health personnel in co-operation with all other sectors and the communities/people themselves are responsible for making society inclusive of all people including people with disabilities.

The clinic is the first point where people with disabilities, their family members or caregivers meet health staff. Clinics need to become creative in their approach to the problems experienced by these patients.

SERVICE DESCRIPTION

The purpose of rehabilitation at clinic level is to provide a service to prevent disabling conditions, to detect disabilities early so to prevent complications and the worsening of the effects of a disability on a person's functional ability, to treat disabling and potentially disabling conditions and to provide access to rehabilitative services for people with disabilities, making them appropriate and acceptable.

The pivotal person at the clinic, through whom people with disabilities will access the rehabilitation service, is the PHC Nurse. The Therapy Assistant (Community) is the person providing the rehabilitation service at this level, in consultation with the visiting Therapist. The visiting generalist doctor is important in providing access to treatment of potentially disabling conditions, which would otherwise be difficult for people to access on a regular affordable basis.

Specific rehabilitative services include a basic assessment of people with disabilities e.g. stroke, spinal injury, cerebral palsy, developmental delay, blindness, communication problems, arthritis, amputations, backache, followed by an appropriate treatment programme, in consultation with the disabled person and his family. Consumable assistive devices e.g. continence devices, rubber ferrules and other aids to daily living are prescribed, provided and people trained in their use. Management of continence problems of patients with spinal cord injury, spina bifida, mental retardation, traumatic conditions and the elderly includes the supply of continence devices and devising continence programmes.

Patients are assessed for disability and care dependency grant applications.

NORMS

1. Improve access to comprehensive health services for the disabled. (National: Year 2000 Goals, Objectives and Indicators.)
2. Have a responsive and area-specific disability information system in place, which will feed into the general information system of the district and clinic.
3. Institute a functional referral system between the community-clinic-district hospital, as well as other relevant sectors.
4. Institute a system of obtaining, repairing and maintaining essential assistive devices for rehabilitation

at clinic level.

STANDARDS

1 REFERENCES, PRINTS AND EDUCATIONAL MATERIALS:

- 1.1 A register of all local, regional, provincial and national resources for referral for rehabilitation, education and training.
- 1.2 OT reference pack.
- 1.3 "Disabled village children" by David Werner, as reference book

2 EQUIPMENT:

2.1

3 MEDICINES & SUPPLIES:

- 3.1 Consumables such as axillary rubbers, rubber ferrules and cane tips.
- 3.2 Ready-made packs on order per specified patient:

4 COMPETENCE OF HEALTH STAFF

Clinic Staff are able to:

- 4.1 Use of standardised questionnaire for the detection of hearing loss.
- 4.2 Identify and refer patients requiring rehabilitation.

The Therapy Assistant is able to

- 4.3 Teach prevention of pressure sores and pressure sore care.
- 4.4 Identify and implement techniques in a walking re-education programme.
- 4.5 Construct simple aids for daily living from locally available materials and teach the patient how to make and use them.
- 4.6 Teach mobility and daily living skills to a blind person.
- 4.7 Identify articulation, language and fluency disorders.
- 4.8 Plan, implement and monitor language stimulation programmes.
- 4.9 Use augmentative and alternative communication methods with appropriate patients, construction of simple communication boards, and teach the family how to use them.
- 4.10 Plan, implement and monitor basic programmes for the rehabilitation of people with neurogenic disorders of communication.
- 4.11 Counsel the family and teachers of a person with hearing impairment on simple measures to improve communication.
- 4.12 Have knowledge of available resources for rehabilitation.
- 4.13 Construct and instruct in the making of corner chairs with table, standing frames and walkers out of Appropriate Paper Technology.
- 4.14 Construct and instruct in the making of toys out of locally available waste materials and plan, implement and monitor play and stimulation activities to facilitate development.
- 4.15 Teach basic maintenance of wheelchairs, hearing aids, callipers and crutches.
- 4.16 Teach an exercise programme for the prevention and treatment of backache.
- 4.17 Instruct on back care and joint protection principles to decrease pain and maintain the range of movement in the treatment of back pain and other conditions involving joints.

Visiting Therapist are able to

- 4.18 Design treatment/rehabilitation programmes for people with stroke, spinal injury, spina bifida, cerebral palsy, barriers to learning, sports injuries, backache, arthritis, amputations, blindness, to be implemented by the therapy assistant or family members of the person with a disability.
- 4.19 Assess people with disabilities for the need for Specialised Assistive Devices, and prescribe and order these from the District, Regional or Tertiary Hospital.
- 4.20 Assess patients with burn scar tissue, and prescribe and order pressure garments.
- 4.21 Assess scholars with barriers to learning
- 4.22 Guide doctor in assessment of degree of disability for applications for disability and care

	dependency grants.
4.23	Design and direct needs driven awareness raising, education and prevention programmes.
4.24	Assess the need for surgical release of contractures and other corrective procedures.
4.25	Supervise and arrange the continuing education of community therapy assistants.
The visiting PHC doctor is able to	
4.26	Assess continence problems, and advise suitable continence management in consultation with the therapist or therapy assistant, patient and family.
4.27	Manage spasms related to spinal injury with drug treatment and/or detection and treatment of stress factors.
4.28	Assess persons for disability grants and care dependency grants.
4.29	Use a Schiotz Tonometer.
4.30	Diagnose disabilities as early as possible, and develop a system of referral. (National Year 2000 Goals, Objectives and Indicators.)
4.31	Clinics are accessible to wheelchairs and trolleys and have toilet facilities for people on wheelchairs.
4.32	People with disabilities are given preference when queuing for services and, where feasible, appointments are given to patients to reduce waiting times.
5	REFERRAL
5.1	From district hospital to clinic:
5.1.1	All patients with newly acquired disabilities, who have completed the acute phase of their rehabilitation for follow up by the therapy assistant.
5.1.2	All newly detected patients with disabilities, who have been assessed by a therapist, doctor or specialist, for follow up and rehabilitation at the nearest clinic.
5.2	In the clinic to the rehabilitation service:
5.2.1	All children detected with a developmental delay for assessment.
5.2.2	Patients with healed burns that cover a joint surface for the prevention of contractures and treatment of scarring.
5.2.3	Patients with disabilities for alleviation programmes and rehabilitation.
5.2.4	All patients with chronic deforming arthritis.
5.3	Referral of patients to doctor or multidisciplinary team:
5.3.1	Patients with spinal chord injury with troublesome spasms.
5.3.2	Patients with continence problems for institution of an adequate continence programme.
5.4	From clinic for specialist assessment or treatment:
5.4.1	Patients with physical disabilities amenable to corrective surgery, assuming that a therapy follow-up service is available.
5.4.2	Patients with chronic disabling rheumatoid arthritis for assessment and monitoring.
5.5	From clinic to hospital:
5.5.1	Patients requiring intensive daily rehabilitative therapy.
5.5.2	Patients with extensive bedsores.
5.5.3	Patients in need of more assistive devices not available at district level.
5.5.4	Complicated burns (facial, perineal, burns involving a joint or over 10% of body surface).
5.5.5	Patients with spinal injury and sudden increase in spasms, temperature and high blood pressure.
5.6	From clinic to other sectors:
5.6.1	Children with sensory loss to LSEN schools.
5.6.2	Patients with disabilities who are capable of working, to department of labour for employment opportunities
5.6.3	Patients with disabilities for training in suitable occupational skills.
5.6.4	Patients with disabilities that are not suitable for the open labour market, to community groups for disabled people, self-help groups, or protected workshops.
5.6.5	Any other sectors which are deemed useful for the development of social and economic independence of the disabled person e.g. training centres for the blind.

5.6.6	Peer support groups.
5.6.7	Patients with disability who are not acceptably cared for in the community to the welfare department
5.6.8	Severely disabled children, who are not accepted at schools to community day care centres
6	PATIENT EDUCATION
6.1	Prevention of bedsores in debilitated patients and patients with sensory loss.
7	RECORDS
7.1	Data collected at clinics to be used for development of a district data base on disability for use for programme planning
7.2	Patient information recorded using the SOAP Format.
7.3	Initial assessment and follow up forms standardised for the district, and kept in the chronic file of the patient at the clinic.
7.4	A summary note of the diagnosis, referral and treatment is in the patient held record.
7.5	The visiting therapist ensures that data and information, and records are accurately and consistently maintained.
7.6	Data fields for clients referred for rehabilitation are included in the clinic register.
8	COMMUNITY & HOME BASED ACTIVITY.
8.1	Refer patients to community monitoring programmes, mobilise community support, where indicated by the patients' social circumstances to ensure compliance with treatment.
8.2	Needs analysis for rehabilitation in the community, to plan appropriate and effective intervention programmes.
8.3	Home visits on patients to gain insight into their social situation.
8.4	Devise home based rehabilitation programmes for people requiring extended rehabilitation, in collaboration with the disabled person, his family, and/or community.
8.5	Maintain contact with clients through follow up visits.
8.6	Identify and mobilise community resources for groups and peer support, skills training and income generation.
8.7	Supervise, advice and assist community therapy assistants.
8.8	Recommend and assist with implementation of adaptations to client's homes, communities, work areas, or schools.
9	COLLABORATION
9.1	Develop a responsive disability information system and database in consultation with PHC Nurse, Generalist Doctor, Disabled People's Organisations and Community

**NB : IN COLOR THAT WILL REPEAT ITSELF TROUGHOUT PART 2
PREFERABLY A DIFFERENT COLOR FROM PART 1**

PART 2

**NORMS AND STANDARDS FOR COMMUNITY BASED
CLINIC INITIATED SERVICES**

**PART 2 - NORMS AND STANDARDS FOR COMMUNITY
BASED**

COMMUNITY LEVEL WATER & SANITATION

INTRODUCTION

A water supply and sanitation project is part of a comprehensive development strategy. It is people driven and is not sustainable unless people themselves are directly involved. Communities are involved in the planning, design, financing, construction and maintenance of improved water supplies with women's groups taking the leading role. Public and private sector resources provide initial training and long-term support to create an environment in which community management can function. Technology is affordable and sustainable. Development activities are demand driven, community based and of a level to provide a healthy environment which is a human right.

NORMS

1. There are functioning community participation structures.
2. There is access to district health expertise including the services of an environmental health officer.
3. Reduce the under 5 mortality rate by 30%.
4. Reduce the mortality of children under 5 due to diarrhea by 50%.
5. Eradicate poliomyelitis by 2002.
6. Reduce the prevalence of underweight for age among children under the age of 5 to 10%.
7. Reduce the prevalence of stunting among children less than 5 to 20%.
8. Reduce the prevalence of severe malnutrition in children under 5 to 1%.
9. Eliminate micro deficiency disorders.
10. Ensure 9.5 liters of water per person per day.
11. The maximum distance that a person has to cart water to their dwelling is 200m.
12. The flow rate of water from the outlet is not less than 10 liters per minute and water is available on a regular daily basis.
13. A water service does not fail due to drought more than once in 50 years and there is no more than one week's interruption in supply per year.
14. Once minimum quality of water is available, health related quality is important and in accordance with currently acceptable minimum standards with respect to chemical and microbial contaminants and acceptable to consumers in terms of its potability.
15. Adequate basic provision of sanitation is one well-constructed VIP toilet to agreed standards per household.
16. Phase out the bucket system over 5 years.
17. Responsibility for sanitation services lies with the local authority or, if not, the local water committee is the vehicle for sanitation development.

STANDARDS

- 1 The capacity building hygiene education and training of the community health committee is achieved through linkage with the health sector as well as other development sectors such as water affairs and forestry.

The competence of Environmental Health Officers (EHO)

- 2 The EHO working with the community has the following competencies and hence able to:
 - 2.1 Work with other sectors in development projects.
 - 2.2 Work with local clinic staff for teamwork in motivating community committees to improve water and sanitation.
 - 2.3 Work with health staff of clinics, NGOs and local government structures if present to provide hygiene education and training and build capacity of communities.
 - 2.4 Empower committee through training, technical advice and continuing support and monitoring to undertake and manage their own development including water and sanitation.
 - 2.5 Provide information to schools on undertaking water and sanitation and personal and public health.
 - 2.6 Monitor that sanitation and water systems do not create environmental problems.
 - 2.7 Assist communities develop the capacity to use the cycle of participation --- assessment, analysis, and action -- and provide particular assistance in preliminary assistance through environmental surveys.

- 2.8 Work with DWAF personal to explain to communities through individual leadership dialogue or community, workshops the contents of the White Paper:
- 2.8.1 Water supply and Sanitation Policy 1994
- 2.8.2 National Sanitation Policy White Paper Oct. 1996, Guidelines for ground water protection for Community water supply and sanitation programme.

Communities

- 3 Through education, training and improved communication communities develop the following competencies and hence are able to:
- 3.1 Get rid of human excreta, dirty water and household refuse in a sustainable way without harm to the environment.
- 3.2 Improve personal habits and behavior relating to water and sanitation.
- 3.3 Relate diarrhoeal disease and its effects on nutrition, growth and development of children, skin disease, trachoma, periodic outbreaks of diarrhoea, dysentery, worm infections (including schistosomiasis) to poor water and sanitation in their community.
- 3.4 Through women's groups work together to achieve both water and sanitation norms for their community and be more competent in rearing their children with good hygiene behavior.
- 3.5 Ensure that sanitation systems in their community do not pollute rivers, dams and underground water supplies.
- 3.6 Understand the reasons for and be able to pay for maintenance of their water and sanitation services.
- 3.7 Conduct assessments or surveys of the state of water supply and sanitation in their own community.
- 3.8 Analyse the behavioural, cultural and socioeconomic factors leading to their health problems related to inadequate water and sanitation.
- 3.9 Through community based education (through schools, churches, groups) ensure that the transmission pathways of disease from waste and excreta are known. These are hands, flies, food, fluids, and soil. The ways of blocking transmission by personal hygiene, household and community hygiene are also known.
- 3.10 Achieve community hygiene through a high percentage of homesteads improving household hygiene so that there is no environmental contamination from excreta, dirty water and solid waste.
- 3.11 Improve community hygiene by food vendors and other food handlers being educated about food hygiene based on the WHO Ten Golden Rules for Safe Food Preparation.
- 3.12 Be aware of community problems created by keeping animals next to homes and of problems arising from blocked drains.

Health Personnel

- 4 Clinical staff working with the EHO have the following competencies and are thus able to:
- 4.1 Ensure that health facilities are models for the community with respect to water and sanitation including patient toilets, staff toilets, and hand washing facilities.
- 4.2 Lead school or community programme in environmental cleaning days.
- 4.3 Provide health education on personal hygiene and health to patients, community groups, pre schools and schools.
- 4.4 Initiate behaviour change dialogue with the community on the use of toilets and use of water to improve health.
- 4.5 Feedback to the community information of the burden of water / sanitation related illness in the community as shown by analysis of the health information system.
- 4.6 Ensure that all schools in the catchment area of the clinic are health-promoting schools (good toilets, good water supply, hygienic school feeding programme, hand-washing facilities, continuing education on hygiene).
- 4.7 Work with community committees to ensure improved sanitation facilities at churches, sports grounds, markets, bus stops and crèches.
- 4.8 Assist communities obtain government subsidies after having organized themselves and planned a project.
- 4.9 Provide advice to farmers on improvement of water and sanitation to their workers while also providing hygiene education to the workers.
- 5 Clinic teams and District Health Management Teams have the capacity to work with local NGOs in sanitation programmes and to assist them
- 5.1 In their training and capacity building,
- 5.2 In helping communities plan and implement projects,
- 5.3 provide health and hygiene education,

5.4	Prepare communication material.
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COMMUNITY LEVEL HOME-BASED CARE

NORMS

- 1 Every community provides some home-based care and has access to community-based care through partnership of community-based and clinic-based health services.
- 2 All clinics serving communities in their catchment areas identify home-based carer co-ordinators for formal and informal sector activities.
- 3 All communities with home-based care have access to a referral system and to comprehensive support services.
- 4 All clinics have access to home-based care guidelines and palliative care guidelines so that they can assist communities and families.

STANDARDS

- 1 Home-based care is comprehensive and holistic, person centered, sensitive to culture, religion, values and respects privacy and dignity and maintains self-esteem.
- 2 It empowers and promotes functional independence of the individual and family.
- 3 The patient, the carer and the community are provided with appropriate targeted education.
- 4 Home-based care assists in reducing unnecessary visits and admissions to health facilities.
- 5 Community groups and individual home-based carers receive training from the nearest competent resource – NGOs or the local clinics or visiting health team.
- 6 Community groups and clinics maintain records of home-care and it's continuity and consistency.
- 7 Patients referred from a health facility for home care have the homestead carer prepared and given adequate instruction on medication and daily living care. Referring facilities also provide prescribed medicine and assistive devices.
- 8 Protocols or manuals of care are provided to home-care patients from the local clinic on palliative care and the management of pain.
- 9 Community-based training of home-carers is based on adult education principles and practical simple guidelines.
- 10 Health staff assist in the development of case management plans which consider physical and psychological needs, environment social networks, diet, exercise and rest, personal habits, sexuality, recreation, dressing, washing, feeds, toilet, continence, hearing, seeing and home layout.
- 11 Community groups, family, neighbours or volunteers assist with continuing home needs.
- 12 Social workers assist with arranging legal assistance (e.g. wills) and application for disability grants and other social support.
- 13 Integrated community home-based services have a mosaic of categories, (medical, counselling, pastoral, rehabilitation and traditional) brought together around the individual and family through professional co-ordination.

Home Care for AIDS

- 14 Home care for AIDS in the community includes access to common drugs, emotional support, consideration of families, help with households, kind relationships from clinic staff and financial support if available through social welfare or self-help groups.
- 15 The community care of AIDS patients involves a continuum of care, which links all available resources in a community.
- 16 The continuum of care starts from initial counselling to include care of psychosocial needs, medical and nursing needs and family needs such as care of children, legal advice and assistance.
- 17 Clinics, hospices, NGOs and community groups are linked in a network and this can be initiated by the clinic, NGOs or community groups.
- 18 The aims of AIDS home care are the same as for any home-based health care programme:
 - 18.1 to prevent problems when possible
 - 18.2 to take care of existing problems
 - 18.3 to know when and how to get help.

DIRECTLY OBSERVED TREATMENT (SHORT COURSE) STRATEGY "DOTS"

SERVICE DESCRIPTION

The national TB control strategy of directly observed treatment short course 5 key elements, are :-

- Directly observed treatment by the clinic/treatment supporter for 6 months.
- Short course chemotherapy and uninterrupted drug supply
- Standard reporting and recording system.
- Diagnosis based on positive sputum microscopy.
- Commitment to the DOTS programme by all.

NORMS

Achieve a minimum community-based directly observed tuberculosis treatment cure rate of new sputum positive TB cases of 85%.

STANDARDS

Accessibility

- 1 DOTS supporters for TB cases are as near to the home of cases as is convenient to ensure regular treatment and periodic clinic supervision.

Equipment

- 2 Community supporters of DOTS will have:
 - 2.1 a box in which to store the supply of drugs specific for each patient being supported,
 - 2.2 a supply of green cards for recording (as a duplicate) the treatment given while the patient keeps the original card issued by the clinic,
 - 2.3 patient education material in the correct language.

Training

- 3 All community DOTS supporters have received a course of training equivalent to at least one week, either continuous or in sessions.
- 4 Training covers knowledge, attitude change and skills in communication, simple counselling and problem solving in providing correct continuous directly observed treatment.
- 5 Suitable training manuals and health learning materials are provided.

Supervision

- 6 DOTS supporters in the community receive supportive supervision by regular contact with the clinic nurse who will also record continuity of progress in the clinic TB register.

Evaluation

- 7 Success is measured by recording:
 - 7.1 The number of missed treatments and
 - 7.2 The rapidity of re-establishing continuous treatment and sputum conversion at 2 months for new cases and 3 months for re-treatment cases and at 6 months and 8 months for new and re-treatment cases respectively.
 - 7.3 % of patients on DOT.
 - 7.4 smear conversion rate at 2/3 months of treatment.
 - 7.5 % of patients who are cured.

Community Support

- 8 The community health committee participates in identifying new potential DOTS supporters. This is a partnership between supporter, patient and clinic with the patient deciding who his supporter will be.
- 9 Committees may provide non-financial incentives such as community recognition of outstanding voluntary DOTS support.

Referrals and Transfers

- 10 All referrals and transfers of community based DOTS patients are documented on the correct forms and followed up by the referring or transferring health facility.

INTEGRATED NUTRITION PROGRAMME

BASIC CONSIDERATIONS

The vision for nutrition is optimum nutrition for all South Africans. It is recognised that nutrition is multi-sectoral and complex. Nutrition status is improved through a mix of direct and indirect nutrition interventions implemented at various points of service delivery such as clinics, hospital and communities and aimed at specific target groups.

NORMS

1. Ensure that 25% of all health facilities are baby friendly.
2. Increase the proportion of mothers who breastfeed their babies exclusively for at least six months of age and who breastfeed their babies for at least 12 months of age.
3. Contribute to the reduction of mortality due to infectious diseases particularly diarrhoea, measles, and acute respiratory infections in children <5 years of age by 50%, 70% and 30% respectively, through nutritional support and counseling.
4. Contribute to the prevalence of low birth weight to 10% of all live births.
5. Increase regular growth monitoring to reach 85% of children <2 years of age.
6. Reduce the prevalence of under weight (weight-for-age) among children <5 years of age to 10%.
7. Reduce the prevalence of severe underweight (weight-for-age) among children <5 years of age to 1%.
8. Reduce the prevalence of stunting (height-for-weight) among children <5 years to 20%.
9. Reduce the prevalence of wasting (weight-for-height) among children <5 years of age to 2%.
10. Eliminate micro nutrient malnutrition:
 - ◆ Reduction of Vitamin A deficiency in children under 5 years of age with serum retinol <20ug/dl,
 - ◆ Reduction of Iron deficiency anaemia rates in children and women.
 - ◆ Reduction of Iodine deficiency rates.
11. Reduce disease of lifestyle related to over-nutrition.

STANDARDS

1. REFERENCES, PRINTS, AND EDUCATIONAL MATERIALS

- 1.1 The South African Breastfeeding Guidelines for Health Workers.
- 1.2 Policy Guidelines and Protocols on Vitamin A Supplementation.
- 1.3 Vitamin A Brochures for Health Workers.
- 1.4 Guidelines for Health Facility Based Nutrition Interventions to Prevent Malnutrition in South Africa.
- 1.5 Integrated Management of Childhood Illnesses Manuals (Nutrition Module in the IMCI Manuals).
- 1.6 Integrated Nutrition Programme for South Africa. Broad Guidelines for Implementation- Draft Document 5 January 1998 (Being Reviewed).
- 1.7 National Food Service Management Guidelines (Draft)
- 1.8 National Guidelines on Nutrition for People Living with HIV/AIDS (Draft)
- 1.9 Growth Monitoring and promotion guidelines and manuals (draft)

2. EQUIPMENT

- 2.1 Road-to-Health Charts
- 2.2 Weighing scales
- 2.3 Non-stretch tape measures
- 2.4 Dolls for demonstration purposes.
- 2.5 Nutrition Education tools.

3. MEDICINE & SUPPLIES:

- 3.1 Vitamin A capsules.
- 3.2 Iron and folate capsules
- 3.3 Nutrition supplements. ("PEM" scheme)

4. COMPETENCIES:

4.1 Staff working at the district level have the following competencies, particularly applied to community-based, integrated nutrition (the competencies listed below are applicable to health workers other than dietitians and nutritionists):

- 4.1.1. An understanding of the principles of nutrition.
- 4.1.2 An understanding of the conceptual framework for the analysis of nutrition problems in communities.
- 4.1.3. The ability to design, implement and evaluate intersectoral programmes.
- 4.1.4. The capacity for project management and application of innovative approaches to nutrition issues.
- 4.1.5. The ability to communicate with a target group, analyse its needs and make appropriate choices of communication media and materials.
- 4.1.6. The ability to train at community and other levels using good educational practice.
- 4.1.7. The ability to follow-up and monitor the growth of children using the Road to Health Chart
- 4.1.8. The ability to recognise under-nutrition, micronutrient deficiency and obesity, and appropriately counsel and advise clients.
- 4.2. The ability to give basic nutrition advice and counseling particularly on the following:
 - Nutrition during pregnancy, breast feeding and complementary feeding
 - Infant feeding options for HIV positive mothers
 - Feeding during illness such as diarrhoea and other infections
 - Young child feeding practices
 - Importance of micro-nutrients and choice of micro-nutrient rich foods
 - Food hygiene
- 4.3. The ability to recognise severe signs of malnutrition and take appropriate action

5. REFERRAL:

There is effective and efficient referral and counter referral system between district health facilities and community based services.

- 5.1. Mothers are referred to breastfeeding support groups
- 5.2. Clients on the Supplementation Programme are referred to the next level of care.
- 5.3. Severe cases of malnutrition are referred to the next level of care.
- 5.4. Patients with a need for additional health and social services are referred as appropriate.

6. PATIENT EDUCATION:

- 6.1 Appropriately counsel and advise clients on under-nutrition, micronutrient deficiency and overnutrition.
- 6.2 Appropriately counsel and advise clients on breastfeeding and complementary feeding.
- 6.3 Appropriately counsel and advise clients on infant feeding options for HIV positive mothers.
- 6.4 Counselling and support of current coping strategies.
- 6.5 Counseling on growth promotion
- 6.6 Counseling on nutrition during the life cycle as appropriate.

7. RECORDS:

- 7.1 Children's weight and height is recorded and graphed accurately on the Road to Health Chart.
- 7.2 Charting of weight and other appropriate parameters by the client on a home monitoring programme.
- 7.3 Supplement provided recorded on statistical returns

8. COMMUNITY & HOME BASED ACTIVITY:

- 8.1 The active participation of households, community leaders and structures, NGOs, CBOs and other community role players are mobilised in the district.
- 8.2 Household coping strategies already in place are supported.
- 8.3 Communities are empowered with the necessary skills and knowledge to become self-reliant with regard to their food and nutrition needs and to be in control of factors affecting their nutritional well being.
- 8.4 Community health workers are utilised to initiate community growth monitoring and identification of nutrition problems.

9. COLLABORATION:

- 9.1 Intersectoral collaboration of line departments and other sectors are mobilised at all levels to ensure joint action to ensure nutrition problems are addressed
- 9.2 Collaboration between health-facilities and community-based programmes to implement the community component of the Integrated Management of Childhood Illness.

SCHOOL HEALTH SERVICES

BASIC CONSIDERATIONS

The School Health Service is expected to provide a health promoting services by acting in a co-ordinating role, making use of the skills and capacity in different sectors of society, including the community, the learners themselves, educators and NGOs.

Standards set for the School Health Service need to take into account the diverse situation of schools and school health services at present and the changing philosophy introduced by the education sector, including outcomes based education and inclusive education. The introduction of the philosophy of inclusive education means that children with barriers to learning will be included in ordinary schools and that these schools and communities will have to be develop to provide acceptable services for these children. Teachers generally do not have the capacity to deal with these children and the school health services can play a role in enabling teachers to identify and integrate these children into the classroom. School Health personnel may not have the capacity to implement their new role so a transformation-training programme is required. New resources for school health promotion need to be developed and funded. The School Health Teams are becoming an integral part of the primary health team and intrasectoral (i.e. they work with other sections of the Health Department).

These recommended standards are based on the assumption that the Primary Health Service is built on the Sub-district approach to service delivery.

SERVICE DESCRIPTION

The school health service is a health promotive service dealing with the individual in the context of the family and community and with the school environment. The service encourages the school to seek to develop and implement school policies that promote and sustain health, improve the physical and social environment within which children learn and develop and improve children's capacity to become and stay healthy.

NORMS:

1. Each sub-district has a minimum of one School Health Promoting Team.
2. Every clinic will be able to access a specially trained nurse on school health within the district
3. District School Health Promoting Teams are supported from provincial level with an appropriate, effective transformation training programme, and the development of standardised resource packs and the training occurs during those times of the year when schools are closed. The transformation is completed by the year 2003.
4. Screening Programmes are provided to give adequate coverage to identify all children at risk of barriers to learning and are not limited to certain age groups.
5. The School Health Promoting Service creates a positive learning environment, by identifying barriers to learning, and developing ways to remove these barriers in a community inclusive way.
6. School Health Promotion Programmes promote acceptance and celebration of diversity among individuals through a learner centred approach.
7. An accessible, healthy physical and social environment in which children can learn is promoted.

STANDARDS

1 REFERENCES PRINTS AND EDUCATIONAL MATERIAL

- 1.1 A standardised questionnaire for use by teachers to screen for the presence of factors causing barriers to learning in the individual (e.g. "School Readiness Screening Pilot: April – July 1997, School and Youth Health Directorate" and a questionnaire developed by an Intersectoral team in the Ladysmith Region of Kwazulu-Natal).
- 1.2 A standardised questionnaire for use by school health promoting teams to assist them detecting barriers to learning in the environment of the learner (e.g. the draft of "The Index - an

1.3	instrument to assess Health Promoting Schools in South Africa"). A resource register for the district for use by School Health Promotive Teams and Educators, by which available health services can be identified, and how they can be accessed, to be compiled by each district and regularly updated.
1.4	Health promoting educational materials in the local language and accessible to people with disabilities, including films, videos, posters, booklets, visual aids and audiotapes.
2	EQUIPMENT
2.1	As for mobile teams
2.2	Projector, video recorder, slide projector, white boards and audiotapes.
2.3	Access to administrative support, including typing services, telephone and fax, photocopying services, stationary and appropriate transport for the environment.
3	MEDICINES, SUPPLIES AND ASSISTIVE DEVICES
3.1	Access to medication for control of specific disease conditions identified at district level, e.g. prevention of blindness from trachoma, treatment of scabies outbreak.
3.2	Assistive devices for daily living for people with disabilities. (Assistive devices required to access education is supplied by the Education Department).
4	COMPETENCIES
4.1	The School Health Promoting Team is able to:
4.1.1	Function as an effective and efficient team.
4.1.2	Promote the whole person and life-style skills development of pupils and educators.
4.1.3	Identify resource people and involve them to promote the transformation.
4.1.4	Promote community participation and the participation of all stakeholders in programmes e.g. Participatory Learning and Action (PLA) skills.
4.1.5	Plan and implement health promoting programmes.
4.1.6	Apply and interpret the screening questionnaires for individuals and schools and transfer these skills to the teachers.
4.1.7	Identify gaps in the service and barriers to learning.
4.1.8	Promote healthy nutrition, mental health and reproductive health.
4.1.9	Counsel for substance abuse and victims of violence including rape.
4.1.10	Identify and seek to reduce stress.
4.1.11	Promote healthy sexuality and deal with the results of unhealthy sexual behaviour.
5	PATIENT EDUCATION
5.1	Address health risk behaviours with the provision of behaviour specific knowledge and opportunities to practice knowledge and skills.
6	REFERRAL
6.1	Refer to nearest clinical service, the students that require more intense clinical assessment and management.
7	RECORDS
7.1	An information system at all levels of the service, which informs the different sectors to make effective use of existing services, identifies gaps in the service and monitors the progress toward the development of Health Promoting Schools.
8	COMMUNITY BASED ACTIVITIES
8.1	Promote the development of child-to-child programmes as an important resource.
8.2	Work with school boards to promote activities in the community such as libraries and sport activities.
9	COLLABORATION
9.1	Clinic staff collaborate with and involve officials from health, welfare, education, agriculture sectors, educators, learners, parents, community leaders CBOs and NGOs,
9.2	School Health Promoting Teams are intra- and intersectoral.

COMMUNITY BASED REHABILITATION

SERVICE DESCRIPTION

The philosophy of Community Based Rehabilitation (CBR) is to promote the concept of shared governance, namely the active participation of people with disabilities and their family members in:

- Developing of a vision for their lives within the society in which they live,
- Identifying the needs and resources of people with disabilities within the community,
- Planning and implementing the vision and
- Monitoring and evaluating its implementation.

This participatory approach to governance and service implementation takes place at all levels of society from central government down to community groups and home based care. This chapter describes what happens in the community and at home, after listing the norms and standards that apply at all levels in society.

NORMS

STANDARDS

1 REFERENCES, PRINTS, AND EDUCATIONAL MATERIALS:

- 1.1 Disabled Village Children: David Werner
- 1.2 WHO Manual on Community based Rehabilitation.

2 EQUIPMENT:

2.1

3 MEDICINE & SUPPLIES:

- 3.1 Medical and surgical supplies and assistive devices are accessed from the nearest health facility.

4 COMPETENCIES:

- 4.1 Community groups skills are available
 - 4.1.1 To organise and run regular, focused and functional meetings.
 - 4.1.2 In record keeping and minutes taking.
 - 4.1.3 To run committees and resolve conflicts.
 - 4.1.4 In bookkeeping, financial reporting and operating a bank accounts.
 - 4.1.5 In writing proposals and fund-raising.
 - 4.1.6 In developing job descriptions and monitoring the services of employees like cooks, day-care providers, drivers, etc.
- 4.2 Day caretakers have
 - 4.2.1 Basic training in early education and can carry out a basic rehabilitation programme under the guidance of a therapist or therapy assistant.
 - 4.2.2 The ability to
 - 4.2.2.1 do a basic assessment of the rehabilitation needs of the children in their care, and record this in the local vernacular in a standardised format.
 - 4.2.2.2 keep a progress record of a child in his/her care in the local vernacular.
 - 4.2.2.3 keep a daily journal of their activities, attendance and incident registers and write half-yearly reports of the child's progress to the parents.
 - 4.2.2.4 construct toys from locally available material and plan stimulation programmes for a group of children.
 - 4.2.2.5 counsel parents on handling of the child.
 - 4.2.2.6 Identify children who are not adequately cared for by their families, even with support from community services, and refer these to welfare services.
 - 4.2.2.7 Know which social grants are available to people with disabilities and how to apply for such assistance.
 - 4.2.3 Self-help and Income Generating Groups have skills are available in financial management and marketing products made.

Organising the service at all levels

- 4.3 Districts have a community-based level of service for rehabilitation, which is provided in partnership with people with disabilities and their caregivers.

4.4	Councils are in place at district and community level, based on the shared governance structure described as the model in the white paper on disability.
4.5	Health Department representatives at these levels participate in, and actively promote, the shared governance structures, in an empowering way, putting the leadership into the hands of the people with disabilities.
4.6	Health forums, hospital boards and community health committees have at least one member with a disability.
4.7	Meetings of the committees and boards are conducted in barrier free circumstances.
4.8	Services for people with disabilities are given priority.
4.9	The Health Sector gives technical support to shared governance structures and community-based services.
4.10	People with disabilities are involved in setting up and implementing disability information systems at all levels of service provision, and this information is used to prioritise and plan services.
Organising the service at community level	
4.11	Opportunities are developed for care givers of disabled children, or people with disabilities to be involved in providing community based services.
4.12	Community based services include day care facilities for children with multiple severe disabilities, support groups, self help groups, protected workshops, home based care, sport opportunities and instruction for people with disabilities.
4.13	Each sub-district has a centre for rehabilitation with, as a minimum, facilities for day care and a workshop.
4.14	Community based service points are visited by a therapist or therapy assistant.
4.15	Suitable space is available for these services to be provided on or within health service facilities, if needed.
5	REFERRAL:
5.1	There is effective and efficient referral and counter referral system between district health facilities and community based and owned facilities.
6	PATIENT EDUCATION:
6.1	Assist in empowering people by them recognising their self-worth.
6.2	Handling of behavioural problems.
7	RECORDS:
7.1	A progress record of a child in his/her care in the local vernacular.
7.2	Daily journal of day care centres, their activities, attendance and incident register.
7.3	Regular reports on the child's progress to the parents.
7.4	Record of a basic assessment of the rehabilitation needs of the children in their care in the local vernacular in a standardised format
8	COMMUNITY & HOME BASED ACTIVITY:
8.1	Needs driven community training, counselling and awareness raising programmes to address issues concerning people with disabilities operate from these centres.
8.2	Community groups are actively involved in awareness raising activities within the district, especially the International Day of Disabled and other special days with related topics.
9	COLLABORATION:
9.1	People with disabilities are involved in the planning, setting of standards and monitoring of the services of which they are the main benefactors.
9.2	Issues pertaining to disability are addressed, through intersectoral collaboration, with the community at community based service points.
9.3	Community based services are provided within a framework of accountability to a committee made up of stakeholders, which receives technical support from a service provider.
9.4	Rehabilitation centres are further developed to provide contact/service points with other sectors, e.g. welfare, labour, education, agriculture, as well as community gardens and adapted gardens for people with disabilities, sports facilities for disabled persons, and short term half way house boarding facilities.
9.5	Therapists and therapy assistants assist community-based groups to contact services from other sectors, NGOs and Disabled People's Organisations (DPO's).
9.6	District maintenance personnel provide technical support for these services e.g. construction of aids for daily living for individual clients.
9.7	Opportunities to contract the provision of services for the health sector to people with disabilities are developed e.g. making of pressure garments, sewing or repair of hospital linen, making of special chairs from Appropriate Paper Technology, garden services.

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| <p>9.8 The education sector makes use of the resources within the Community Based Rehabilitation service to cater for the educational needs of children and adults with barriers to learning, and provides technical support to the groups.</p> <p>9.9 Community Groups remain in contact with the Department of Labour, and are given priority in suitable skills training programmes.</p> |
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ABBREVIATIONS

AEFI	Adverse Effects Following Immunisation
AFP	Acid Fast bacillus
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante natal care
ARI	Acute Respiratory Infections
ART	Atraumatic Restorative Treatment
ATICC	Aids Training and counseling center
BCG	Bacillous
CBO	Community Based Organisation
CBR	Community Based Rehabilitation
CDL	Chronic Diseases of Lifestyle
CHW	Community Health Worker
CSF	Cerebro Spinal Fluid
DISCA	District STD Quality of Care Assessment
DOTS	Direct Observed Treatment
DPO	Disabled People's Organisation
DPT	Diphtheria-Pertussis-Tatanus
EDL	Essential Drug List
EHO	Environmental Health Officer
EPI	Expanded Programme of Immunisation
FEFO	First expiry, first out
FP	Family Planning
HBV	Hepatitis B Virus
HIB	Haemophilus vaccine
HIV	Human immunodeficiency Virus
IEC	Information Education and Counselling
IMCI	Integrated Management of Childhood Illnesses
INH	Isoniazid
MCWH	Maternal Child and Women's Health
MTCT	Mother To Child Transmission
NCSNET	National Commission of Special Needs in Education and Training
NCESS	National Committee on Education Support Services
ORS	Oral Rehydration Solution
OT	Occupational Therapy
PEP	Perinatal Education Programme
PHC	Primary Health Care
PLA	Participatory Learning and Action
PNC	Post Natal Care
POP	Plaster of Paris
RPR	A syphilis test
SOAP	Subjective, Objective Assessment Plan
STD	Sexually Transmitted Diseases
TB	Tuberculosis
TBA	Traditional Birth Attended
TOP	Termination of Pregnancy
TT	Tetanus toxoid
UV	Ultra Violet
UNICEF	United nations Childrens Fund
VDRL	Venreal Diseases Research Laboratory Test for Syphilis
VIP	Ventilated latrine
WHO	World Health Organisation