

SECTION 9

NATIONAL NORMS AND STANDARDS

- Core Norms and Standards for Health Clinics
- Women's Reproductive Health
- Integrated Management of Childhood Illness
- Diseases Prevented by Immunisation
- Sexually Transmitted Diseases (STD)
- HIV/AIDS
- TB Norms and Standards
- Chronic Diseases and Geriatrics

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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 an 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 machine 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 dearing 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).

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3 Medicines and 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

4.1 Organising the clinic

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.

4.2 Caring for patients

- 4.2.1 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.
- 4.2.2 Staff are positive in their approach to patients, evaluating their needs, correcting misinformation and giving each patient a feeling of always being welcome.
- 4.2.3 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.
- 4.2.4 The rights of patients are observed.

4.3 Running the clinic

- 4.3.1 A clear system for referrals and feedback on referrals is in place.
- 4.3.2 All personnel wear uniforms and insignia in accordance with the South African Professional Councils specifications.
- 4.3.3 The clinic has a strong link with the community, civic organisations, schools and workplaces in the catchment area.
- 4.3.4 The clinic is clean, organised and convenient and accommodates the needs of patients' confidentiality and easy access for older persons and people with disability.
- 4.3.5 Every clinic has a house keeping system to ensure regular removal and safe disposal of medical waste, dirt and refuse.
- 4.3.6 Every clinic provides comprehensive security services to protect property and ensure safety of all people at all times.
- 4.3.7 The clinic has a supply of electricity, running water and proper sanitation.
- 4.3.8 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.

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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

1 Leadership and planning

- 1.1 Each clinic has a vision/mission statement developed and posted in the clinic.
- 1.2 Core values are developed by the clinic staff and posted.
- 1.3 An operational plan or business plan is written each year.

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2 Staff

- 2.1 New clinic staff are oriented.
- 2.2 District personnel policies on recruitment, grievance and disciplinary procedures are available in the clinic for staff to refer to.
- 2.3 The staff establishment for all categories is known and vacancies discussed with the supervisor.
- 2.4 Job descriptions for each staff category are in the clinic file.
- 2.5 There is a performance plan/agreement and training plan made and a performance appraisal carried out for each member of staff each year.
- 2.6 The on-call roster and the clinic tasklist with appropriate rotation of tasks are posted.
- 2.7 An attendance register is in use.
- 2.8 There are regular staff meetings (at least once a month).
- 2.9 Services and tasks not carried out due to lack of skills are identified and new training sought.
- 2.10 In-service training takes place on a regular basis.
- 2.11 Disciplinary problems are documented and copied to supervisor.

3 Finance

- 3.1 The clinic, as a cost centre, has a budget divided into main categories.
- 3.2 The monthly expenditure of each main category is known.
- 3.3 Under and over spending is identified and dealt with including requests for the transfer of funds between line items where permitted and appropriate.

4 Transport and communication

- 4.1 A weekly or monthly transport plan is submitted to the supervisor or transport coordinator.
- 4.2 The telephone or radio is working.
- 4.3 The ambulance can be contacted for urgent patient transport to be available within two hours.

5 Visits to clinic by unit supervisor

- 5.1 There is a schedule of monthly visits stating date and time of supervisory support visits.
- 5.2 There is a written record kept of results of visits.

6 Community

- 6.1 The community is involved in helping with clinic facility needs.
- 6.2 The community health committee is in place and meets monthly.

7 Facilities And Equipment

- 7.1 There is an up-to-date inventory of clinic equipment and a list of broken equipment.
- 7.2 There is a list of required repairs (doors, windows, water) and these have been discussed with the supervisor and clinic committee.

8 Drugs and supplies

- 8.1 Stocks are secure with stock cards used and up-to-date.
- 8.2 Orders are placed regularly and on time and checked when received against the order.
- 8.3 Stocks are kept orderly, with FEFO (first expiry, first out) followed and no expired stock.
- 8.4 The drugs ordered follow EDL principles.

9 Information and documentation

- 9.1 New patient cards and medico-legal forms are available.
- 9.2 The laboratory specimen register is kept updated and missing results are followed up.
- 9.3 Births and deaths are reported on time and on the correct form.
- 9.4 The monthly PHC statistics report is accurate, done on time and filed/sent.
- 9.5 Monthly and annual data are checked, graphed, displayed and discussed with staff and the health committee.

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- 9.6 There is a catchment area map showing the important features, location of mobile clinic stops, DOTS supporters, CHWs and other outreach activities.

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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 (132% 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 Fetoscope
- 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 eg condoms
- 3.5 Vaginal contraceptives eg 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 (eg bleeding), nutrition, child feeding and weaning, STDs / HIV, delivery, newborn and child care, advanced maternal age, family planning and child spacing.

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- 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, advise 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.

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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 and 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).

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INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS

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 and 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.

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DISEASES PREVENTED BY IMMUNISATION

SERVICE DESCRIPTION

Immunisation 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) *Vaccinators Manual Immunisation That Works*.
- 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, eg 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

Staff are able to:

- 4.1 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.
- 4.2 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.
- 4.3 Provide group education for mothers and antenatal care attendants.
- 4.4 Follow up suspected cases of measles at home to determine the extent of a possible outbreak.
- 4.5 Take steps to increase coverage using the self-generated vaccination coverage graph (available in the Vaccinators manual) to address progress during the year.
- 4.6 Implement correct disposal of sharps
- 4.7 Initiate post exposure prophylaxis for HIV in case of needle stick (according to Provincial protocol).
- 4.8 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.

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DISEASES PREVENTED BY IMMUNISATION

- 4.9 Organise immunisation service as a daily component of comprehensive PHC and to minimise waiting/queuing times.
 - 4.10 Community health committees are given the lay case definitions of acute flaccid paralysis, measles and neonatal tetanus and urged to report suspected cases immediately.
 - 4.11 The clinic has a good relationship with the Environmental Health Officer for assistance in outbreak investigations.
 - 4.12 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.
 - 4.13 A 24 hour toll free number for notification - (0800 111 408) is on the clinic wall.
 - 4.14 All HIV positive children must be immunized with all vaccines except for BCG in children with symptomatic AIDS.
 - 4.15 Clinics arrange mass immunisation or mop-up campaigns in their communities as required by the District Manager.
 - 4.16 Remote villages have mobile outreach sessions to provide routine services and to improve coverage where necessary.
 - 4.17 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.

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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

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SEXUALLY TRANSMITTED DISEASES (STD)

- 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.

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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 (eg 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.
- 1.6 Epidemiological Notes- National or Provincial relating to HIV/AIDS.
- 1.7 Strategies to reduce Mother to Child Transmission of HIV and other infections during Pregnancy and Childbirth.
- 1.8 HIV/AIDS Guidelines for home based care.
- 1.9 Policy guidelines and recommendations for feeding of infants of HIV positive mothers.
- 1.10 AIDS pamphlets in the local language.
- 1.11 Illustrated booklets eg Soul City – AIDS in our community
- 1.12 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 female (female condoms if policy)
- 3.3 Post exposure prophylaxis of occupationally acquired HIV exposure eg needle stick injuries with HIV positive blood in accordance with the recommendations of the Essential Drug List.

4 Competence of health staff

4.1 Knowledge and attitudes

- 4.1.1 Staff know the contents of the guidelines on Management of Occupational Exposure to Human Immunodeficiency Virus.
- 4.1.2 Staff relate to patients in a non-discriminatory and non-judgemental manner and maintain strict confidentiality about patient's HIV status.
- 4.1.3 Staff are familiar with regulations and mechanisms to deal with confidentiality in notifying patients with AIDS disease or AIDS deaths.

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HIV/AIDS

- 4.1.4 Staff provide warm, compassionate, counselling on a continuous basis and which is sensitive to culture, language and social circumstances of patients
- 4.1.5 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 clinic catchment area.
- 4.1.6 Staff are aware of the social consequences (orphans, loss of work, family, disruptions, youths schooling and careers) of AIDS.
- 4.1.7 Staff seek to reduce fear and stigma of HIV/AIDS.
- 4.1.8 Staff provide youth friendly services that help promoting improved health seeking behaviour and adopting safer sex practices

4.2 Skills

Staff are able to

- 4.2.1 Take a good history including a sexual history, after establishing a trusting relationship.
- 4.2.2 Undertake a physical examination according to guidelines checklist in good lighting and in privacy.
- 4.2.3 Do pre and post test counselling after informed consent and take laboratory specimens for HIV (two separate blood specimens), and RPR.
- 4.2.4 Perform, after training, rapid HIV and RPR tests in those remote clinics where this has been set up.
- 4.2.5 Continue counselling at suitable times when more time can be allocated.
- 4.2.6 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).
- 4.2.7 Assess the prognosis of HIV to AIDS by recognising and diagnosing the common opportunistic infections.
- 4.2.8 Diagnose acute pneumonia and start on cotrimoxazole or other antibiotic while arranging referral for admission.
- 4.2.9 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
- 4.2.10 Offer periodic check-ups, including weight, to all HIV cases.
- 4.2.11 Discuss voluntary HIV testing with patients with STD or TB, and get consent form signed.
- 4.2.12 Counsel cases of rape and offer HIV test after informed consent and pre- and post test counselling.
- 4.2.13 Use universal precautions
- 4.2.14 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.
- 4.2.15 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.
- 4.2.16 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.
- 4.2.17 Collaborates with traditional healers on HIV/AIDS
- 4.2.18 All clinic staff (professional and cleaning/laundry) are immunised against Hepatitis B.

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HIV/AIDS

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

SECTION 9: NATIONAL NORMS AND STANDARDS

TUBERCULOSIS NORMS AND STANDARDS

DESCRIPTION OF SERVICES

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, treat, dispense and follow-up using DOT and completes the TB register.

NORMS

1. Achieve a minimum of 85% cure rate of new sputum positive TB cases
2. Achieve a minimum of 85% smear conversion rate of new sputum positive cases and 80% smear conversion rate for re-treatment cases
3. Achieve a passive case finding rate per 100 000 population to be defined.
4. Every clinic has at least one staff member who has been trained in TB management
5. Receive a six monthly assessment of quality of care of the TB service by the District TB Coordinator

STANDARDS

1 References, prints and educational material

- 1.1 The latest TB training manual for health workers 1998
- 1.2 The SA TB Control Practical Guidelines 1996
- 1.3 Provincial Circular 22/1999 on "EDL: Implementation of new Tuberculosis Treatment Regimens"
- 1.4 A Training Manual for DOTS supporters
- 1.5 Flow charts on TB diagnosis
- 1.6 The latest EDL manual on TB management
- 1.7 TB posters on walls, leaflets and pamphlets in local languages for distribution

2 Medicines supplies and equipment

- 2.1 Uninterrupted supply of TB drugs as per above Circular
- 2.2 MDR TB drugs only for named patients
- 2.3 Sterile syringes, needles and water for injection of Streptomycin
- 2.4 Screw top sputum containers and sputum label book (GW20/13)

3 Competence of health staff

Staff are able to:

- 3.1 Initiate and follow up treatment of patient using the latest recommended TB management regimen and protocol.
- 3.2 Suspect and identify TB by early symptoms such as chronic cough, loss of weight and tiredness.
- 3.3 Educate with the emphasis on correcting misinformation and seeking to prevent the spread of disease.
- 3.4 Start direct observed treatment (DOT) supported by clinic staff or by volunteers chosen and accepted by the patient.
- 3.5 Enter all patient information and sputum results on the TB register (GW 20/11), the Patient Clinic Card (GW 20/12), the Patient Treatment Card (GW 20/15) and Patient Transfer Form (GW 20/14) as and when required.

4 Referral

- 4.1 Before being transferred to another health facility 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 or in writing.

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TUBERCULOSIS NORMS AND STANDARDS

4.2 Appropriate referrals should be made eg very ill patients, severe complications of TB, adverse drug reactions, MDR TB, children with extensive TB or gross lymphadenopathy, or not improving on treatment etc.

5 Patient education

5.1 Patients, relatives and communities receive high quality information on TB.

5.2 Patients are educated about HIV/AIDS/STDs in addition to TB so that they can recognize predisposing conditions and so prevent them. Voluntary testing for HIV should be promoted.

6 Records and statistics

6.1 All TB Cases to be notified.

6.2 All registers, smear conversion rate forms and quarterly reports are kept up to date.

7 Community and home based activity

7.1 The clinic has an agreement with resulting support from the Clinic Committee about the use of community-based DOT.

7.2 The quality of DOT management within the clinic and the community-based supporters are monitored and evaluated quarterly.

8 Collaboration

8.1 The clinic collaborates with the Department of Welfare for social assistance.

8.2 Staff collaborate with NGO's, schools and workplaces in their catchment area to enhance the promotion of TB prevention and care.

SECTION 9: NATIONAL NORMS AND STANDARDS

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.
- 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.

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CHRONIC DISEASES AND GERIATRICS

- 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.
- 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.