

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.

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).

	<p>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.</p> <p>4.7 Pap smears are done on women over 35 or with a history of vulval warts.</p> <p>4.8 Patients are counselled on safe sex and HIV/AIDS is explained to them.</p> <p>4.9 Treatment is according to the protocol for each syndrome.</p> <p>4.10 Condom use is demonstrated and condoms provided.</p> <p>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.</p>
5	<p>REFERRALS</p> <p>5.1 All patients are referred to the next level of care when their needs fall beyond the scope of competence.</p> <p>5.2 Conjunctivitis in the newborn is referred after initial treatment.</p> <p>5.3 The patient is referred if pregnant and has herpes in the last trimester.</p> <p>5.4 Pelvic inflammatory disease is referred if patient is sick, has pyrexia and tachycardia, or severe tenderness, or is pregnant.</p> <p>5.5 A painful unilateral scrotal swelling age under 18 is referred immediately for a surgical opinion regarding a possible torsion.</p>
3	<p>PATIENT EDUCATION</p> <p>6.1 All patients receive health education on asymptomatic STD, misconceptions, rationale of treatment, compliance and return visit.</p> <p>6.2 Time is given during counselling and discussion after treatment about the need for contacts to be treated.</p> <p>6.3 If the patient's syndrome is vaginal discharge the possibility of it not being sexually transmitted is discussed.</p> <p>6.4 If pregnant then implications for the baby are discussed (congenital syphilis, ophthalmia, HIV, chlamydia).</p> <p>6.5 The importance of condom use is stressed.</p>
7	<p>RECORDS</p> <p>7.1 Patient's records are kept according to protocol with confidentiality stressed.</p> <p>7.2 Laboratory registers with return time for laboratory specimens not greater than 3 days.</p> <p>7.3 A register is kept of contact cards issued and returned.</p> <p>7.4 Partner notification cards are in local languages.</p>
3	<p>COMMUNITY BASED SERVICES</p> <p>8.1 Staff Liaise with traditional healers about the care of STDs.</p>
3	<p>COLLABORATION</p> <p>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.</p>

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

I	REFERENCES PRINTS AND EDUCATIONAL MATERIALS <ol style="list-style-type: none"> 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. 1.6 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 e.g. 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 <ol style="list-style-type: none"> 2.1 Remote clinics have laboratory equipment for RPR and Rapid HIV.
3	MEDICINES AND SUPPLIES <ol style="list-style-type: none"> 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 <ol style="list-style-type: none"> 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

MALARIA

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.
a	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.

STANDARDS

	<ul style="list-style-type: none"> 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	<p>EQUIPMENT</p> <ul style="list-style-type: none"> 2.1 Laboratory equipment - rapid diagnostic tests on microscopic slides of blood smears.
3	<p>MEDICINES AND SUPPLIES</p> <ul style="list-style-type: none"> 3.1 List of drugs in accordance with the Essential Drugs List.
4	<p>COMPETENCE OF HEALTH STAFF</p> <ul style="list-style-type: none"> 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	<p>REFERRALS</p> <p>The following are referred:</p> <ul style="list-style-type: none"> 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	<p>PATIENT EDUCATION</p> <ul style="list-style-type: none"> 6.1 All patients receive in high risk areas health education on preventative measures: use of impregnated bed nets/curtains, use of repellents on skin, aerosols, coils, vaporisers with insecticides, use of prophylactic drugs and about continuing precautions all year. 6.2 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	<p>RECORDS</p> <ul style="list-style-type: none"> 7.1 Patients records are kept up to date. 7.2 All confirmed cases of malaria are notified to the malaria control programme.
8	<p>COMMUNITY BASED SERVICES</p> <ul style="list-style-type: none"> 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

■	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.
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	<ul style="list-style-type: none"> 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	<p>EQUIPMENT</p> <ul style="list-style-type: none"> 2.1 Screw top sputum containers
3	<p>MEDICINES AND SUPPLIERS</p> <ul style="list-style-type: none"> 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	<p>COMPETENCE OF HEALTH STAFF</p> <p>Staff are able to</p> <ul style="list-style-type: none"> 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	<p>REFERRAL</p> <ul style="list-style-type: none"> 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	<p>PATIENT EDUCATION</p> <ul style="list-style-type: none"> 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	<p>RECORDS</p> <ul style="list-style-type: none"> 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	<p>COMMUNITY AND HOME BASED ACTIVITY</p> <ul style="list-style-type: none"> 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

1.2	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, creches 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 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

<p>4 Competence of health staff</p> <p>4.1 Staff are able to</p> <p>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.</p> <p>4.1.2 Suspect and refer acute rheumatic fever by recognition of polyarthritis, heart murmur, arthralgia, fever, erythema marginatum, chorea, subcutaneous nodule, history of sore throat in last month or previous rheumatic heart disease.</p> <p>4.1.3 Recognise and refer possible rheumatic disease by murmurs and previous history.</p> <p>4.1.4 After definitive diagnosis in hospital and notification ensure patient receives prophylactic treatment.</p>
<p>5 REFERRAL</p> <p>5.1</p>
<p>6 PATIENT EDUCATION</p> <p>6.1 Patient and their families receive education on the disease, its effect on the heart and the need for continued prophylaxis.</p>
<p>7 RECORDS</p> <p>7.1 Acute Rheumatic Fever is a notifiable disease</p> <p>7.2 Records are kept according to protocol.</p> <p>7.3 Register of patients who receive monthly (or 3 weekly) penicillin is accurate and up to date.</p> <p>7.4 Register and record of patients on regular prophylaxis after a first attack kept for at least five years.</p>
<p>8 COMMUNITY AND HOME BASED ACTIVITY</p> <p>8.1 Health education and information with other childhood diseases campaigns</p>
<p>9 COLLABORATION</p> <p>9.1 The clinic collaborate with other health workers e.g. school health nurses and community groups.</p>

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

<p>1. All clinics provide trauma and emergency services.</p>
<p>2. Reduce intentional and unintentional injuries among adolescents, including teenage suicide. (National Year 2000 Goals, Objectives and Indicators.)</p>
<p>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.)</p>

STANDARDS

<p>1 REFERENCES, PRINTS AND EDUCATIONAL MATERIALS</p> <p>1.1 Wits University PHC Training Manual for Trauma.</p>

- 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.