National Department of Health

Clinic Supervision Manual

2003

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INTRODUCTION AND POLICY

INTRODUCTION

The purpose of this manual is to provide a set of flexible, adaptable tools and guidelines to facilitate quality clinic supervision. Extensive resources are available which deal with improving supervisor-supervisee relationships. This manual does not attempt to repeat the ideas in those resources, but rather to provide concrete tools for organising and carrying out the complex and multi-faceted task of the clinic supervisor. Materials provided here have been drawn from a number of sources, all of which have been field tested to at least some degree. The ultimate aim of the manual is to support supervisors in their role of improving the quality of care in the clinics.

Clinic supervisors can influence quality of care at clinic level through both their administrative roles and their technical support role to service providers in guiding the provider-client interaction by:

Ensuring that **resources** are in place to ensure technically correct care

- adequate numbers of staff with appropriate skills
- drugs, clinical supplies and equipment
- procedures, guidelines, norms and standards
- a maintained infrastructure

Ensuring quality services from the **client perspective**:

- services are available at adequately convenient hours with enough staff
- respect, dignity and consideration from all staff for privacy and confidentiality

Tools are available in this manual to address these various aspects of quality. Supervisors or teams of supervisors in different authorities are encouraged to adapt the tools to meet local needs. For instance, some clinics are small and others very large, some urban and some rural, some are visited regularly by doctors some never, some are supervised by provincial authorities others by local government or even private agencies.

Experience has shown that a clear supervisory policy governing all elements of the supervisory process is vital to enable the development of good quality supervision. The Draft Policy on the following pages has been developed by Eastern Cape Province to clarify important issues found to be an impediment to effective supervisory processes. We have found that such a policy is essential before regular well structured supervision of clinics can be expected. Each province must develop its own policy but the enclosed Eastern Cape Policy on Supervision maybe helpful in identifying the issues that need to be clarified for all before effective supervision can begin.

PROVINCIAL POLICY ON CLINIC SUPERVISION

The clinics of Eastern Cape provide the first level of care to a population of six million. Some 650 clinics in the public sector depend upon personal interactions with supervisory personnel visiting from a higher authority on regular basis to enable them to improve the quality of services, to solve problems, and to introduce new policies, programmes and approaches into clinic primary health care.

It is recognised that there are numerous authorities overseeing the work of these clinics and that clinics vary in size, complexity, staffing, patient load and range of activities. This diversity of responsibility make a uniform policy on supervision all the more important to assure that each and every clinic receives the support, encouragement and guidance that a supervisor can and must provide. This policy has been developed through extensive discussions with clinic nurses, supervisors, district, regional and provincial managers, comprising both provincial and local government staff. It provides uniformity on essential elements of clinic supervision while maintaining the principle of decentralised management and flexibility in terms of the relationships of supervisors to their own authorities and to other resources required to support work in the clinics.

Aims of the policy:

- to describe the structure of the clinic supervisory system
- to define the regularity and duration of supervisory visits
- to define the activities and components of a supervisory visit
- to define the responsibilities of provincial and district authorities to ensure effective supervisory practises

The structure of clinic supervisory system

- Each clinic will be supervised by a single person, multi-purpose nurse who will be the single liaison between that clinic and higher authorities.

- The relationship of the supervisor within the district structure[1] may vary and should be defined. Clinic supervisors may be drawn from the staff of a hospital, from local government, from a municipal health service, from the district office staff, or other authorities. In each case the relationship of the supervisor to other institutions and the district will be defined in writing.

- Personnel from health and related authorities may visit clinics, both in company with the supervisor and at other times, but at all times the supervisor should be informed enabling scheduling of such visits and should be informed in writing of the findings and outcomes and suggestions. Instructions to the clinic should come through the clinic supervisor and not directly from other authorities.

The regularity of supervisory visits

- Clinic visits will occur on a regularly scheduled date and time. This will enable optimal use of the time of the supervisor and assure that clinic personnel have adequate opportunity to interact with the supervisor and to participate in the various activities for which she is responsible. In consultation with the community, clinics may decide on a scheduled “closure” (defined as time set aside when clinic is open only for urgent cases) of the clinic for 2 hours to enable staff to interact with the supervisor.

[1] This structure may change as the governance of health districts change in future (devolution to local government).

PROVINCIAL POLICY ON CLINIC SUPERVISION

- Supervision visits to the clinic will occur no less often than once monthly for a period of at least four hours. This may be broken into shorter, multiple visits as mutually determined. It is also possible that large, urban clinics, may designate a senior clinic nurse as the on-site multi-purpose supervisor whose major function will be oversight of clinic activities, liaison with higher authorities and serve the general functions of the multi-purpose supervisor.

The activities and components of a supervisory visit

- A draft description detailing the components of a supervisory visit to the clinic is appended. (Annexure 1). This provides a general guideline on the expected responsibilities of clinic supervisors and may be modified by appropriate authorities to enable more efficient and effective supervision.

- A clear statement of the authority of clinic supervisors will be provided to enable the clinic supervisor to have direct contact with needed resources required in support of the clinics. The authority to contact those bodies on behalf of the clinics will be provided for each supervisor in written form (see Section 2 "*Organising your work as a supervisor*" for an example).

The responsibilities of provincial and district authorities to ensure effective supervisory practises

- All health authorities will provide transport on regularly scheduled priority basis to enable clinic supervisors to visit their clinics on a regular and fixed schedule. Provision of such dedicated transport will be a priority claim on transport facilities of the appropriate administrative authority.

- Clinic supervisors may have other responsibilities for a portion of their time. However, in their role as clinic supervisors they will be given adequate time for preparation, travel, clinic visits and clinic visit follow-up and report writing to enable them to carry out the responsibilities to their clinic and to report to their own higher authorities in an orderly way.

- Supervisors will be trained by provincial authorities in order to enable them to understand, carry out their work and to carry on a program of continuing education and quality improvement in their work and in the primary health care provided at their clinics.

- A set of instruments will be prepared to guide, facilitate, and document the clinic supervisor's work. These will be used, recorded and kept in an orderly file to document supervisory activities and be available for evaluation of outcomes.

- The District Manager will provide the Director of Primary Health Care with quarterly reports on clinic supervisory activities within the district. The Director expects to receive information on the regularity of clinic visits and any problems experienced during the clinic supervision process, which warrant the attention of the Director PHC.

Annexure 1

ELEMENTS OF THE SUPERVISORY VISIT

The clinic supervisor (CS) creates a vital link between service management and service delivery through clinics. In order to sustain this linkage, the CS needs to focus on a number of key areas during an on site clinic visit. These areas include:

1 Clinic Administration Review

The CS should review certain administrative aspects related to the clinic. This would include staff matters, financial matters, infrastructural aspects of the clinic (building, water supplies, electricity, grounds), equipment, supplies and legal issues (OHS Act requirements, collection of vital statistics).

2 Information System Review

A functioning PHC information system is essential for the effective management of District Health Services. The CS plays a very important role in ensuring the accuracy and validity of the information system. The CS concentrates on ensuring the proper use of the clinic registers, the correct completion of the monthly PHC report, the correct graphing of important data and the use of data for health service planning and monitoring accomplishments at the clinic level.

3 Referral System Review

Dealing with referral problems is an important element of the supervisory visit. Any problems with referrals, both in terms of patient movement as well as communication between clinics and higher levels will be investigated and facilitated,

4 Quality of Clinical Care Review

The correct application of standard treatment guidelines and use of the approved list of essential drugs is of great importance to ensure high quality care. The CS will concentrate on the correct use of STG's by clinic staff, reinforcing correct practises and insuring adherence to established standards.

5 Community Involvement Review

The CS will enquire about issues related to community involvement during each visit. Regularity and participation of clinic staff in clinic committee meetings will be assured. Concerns of the clinic committee which should be brought to the attention of the District Management and any community problems which need urgent attention (malnutrition, disease outbreaks, etc) will be noted. She will also encourage clinic staff to plan and conduct specific community outreach activities on a regular basis.

6 In-depth Program Review

During the course of the year the CS will conduct in-depth reviews of all important health programmes. Key programmes for review include – TB, STD, EPI, IMCI, maternal and perinatal care, chronic diseases including AIDS, family planning and the essential drug programme. Standard review lists will be provided by the province for each of these programmes.

7 Training

The CS carries a major responsibility to ensure that clinic staff are updated, trained and appropriately coached. She will conduct educational sessions during each visit designed to address specific needs of the clinic staff, covering elements of clinical service provision (updating and implementing programmatic changes), staff management (new rules and regulations related to government service) and clinic administration.

Annexure 1

ELEMENTS OF THE SUPERVISORY VISIT

8 Problem solving

Solving problems related to all aspects of the clinic is an integral part of the supervisory process. The CS should engage with clinic staff around problems, which are being experienced. Many problems can be dealt with on the spot at the clinic whilst others will have to be taken to the District or other responsible areas. A note will be made of problems requiring solutions at a higher level and actions taken will be reviewed at the subsequent CS visit. The CS will be authorised to contact relevant authorities on behalf of the clinic.

9 Other

Clinic staff often have personal issues/problems which need to be addressed. The CS should be available to sympathetically listen to these issues and support and assist staff as far as she can in dealing with personal problems/issues.

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ABBREVIATIONS - ACRONYMS

AA	Alcoholics Anonymous
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
BP	Blood Pressure
CBO	Community Based Organisation
CHC	Clinic Health Committee
CHW	Community Health Worker
CS	Clinic Supervisor
DHIS	District Health Information System
DM	District Manager
DOTS	Directly Observed Treatment Short Course
RTH	Road to Health Card
EDL	Essential Drug List
EHO	Environmental Health Officer
EN	Enrolled Nurse
ENA	Enrolled Nurse Assistant
EPI	Expanded Programme on Immunisation
FEFO	First Expiry, First Out
FP	Family Planning
GA	General Assistant
HBP	High Blood Pressure
HBV	Hepatitis B Virus
HIV	Human Immunodeficiency Virus
IMCI	Integrated Management of Childhood Illnesses
IUCDs	Intra Uterine Contraceptive Devices
IV	Intravenous
MCH	Maternal and Child Health
NGO	Non Governmental Organisation
OHS Act	Occupational Health and Safety Act
ORS	Oral Rehydration Solution
PEM	Protein Energy Malnutrition
PHC	Primary Health Care
PN	Professional Nurse
PUD	Penile Urethral Discharge
Rx	Treatment
SANCA	South African National Council against Alcohol
STD	Sexually Transmitted Disease
STG's	Standard Treatment Guidelines
TB	Tuberculosis
TOP	Termination of Pregnancy

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SECTION 1

HOW TO USE THE SUPERVISOR'S MANUAL

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HOW CAN THIS MANUAL HELP YOU

PURPOSE OF THIS SECTION

The purpose of this section is to explain how to use the manual. The manual has been designed to support the key elements of a clinic supervisory visit as well as the supervisory process followed during a supervisory visit. This support is provided through the provision of tools designed to strengthen both the elements of supervision and the supervisory process.

ELEMENTS OF THE SUPERVISORY VISIT

1. **Clinic Administration Review**
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6. **In-depth Program Review**
   During the course of the year the CS will conduct in-depth reviews of all important health programmes. Key programmes for review include – TB, STD, EPI, IMCI, maternal and perinatal care, chronic diseases including AIDS, family planning and the essential drug programme. Standard review lists will be provided by the province for each of these programmes.

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9. **Other**
   Clinic staff often have personal issues/problems which need to be addressed. The CS should be available to sympathetically listen to these issues and support and assist staff as far as she can in dealing with personal problems/issues.

Specific tools have been developed to support each set of activities, which should receive attention during the visit. These tools include checklists (programme review lists, community participation assessment checklists, etc), guidelines (information system) and information, which may support certain activities (problem solving diagrams).

PROCESS OF DOING THE VISIT

The supervisory process consists of five steps:

1 **Regular review of clinic performance** - this includes the completion of the red flag checklist and monthly checklist. This step will cover and integrate the review of clinic administration, the information system, referral system, clinical services and community participation activities. This step should last between 60 – 90 minutes. These checklists are very important as they allow systematic and standardised assessment of important elements of service provision. The checklists also allow similar review processes to be conducted at different clinics – clinics are assessed in the same way.

2 **In depth programme review** - during this step individual program reviews are done and should take about 45 minutes.

3 **Training** - the focus of this step is to do in-service training and the main purpose of the clinical tips is to support this. Duration about 45 minutes.

4 **Problem solving discussion** - duration 30 minutes.

5 **Review of previous actions taken during last month and new actions for forthcoming month** - an essential element step in the supervisory process is to reflect on progress made since the last supervisory visit and identify activities, which should be completed by the next supervisory visit. The monthly checklist provides an opportunity to document progress and the number of planned activities for the next period. Duration 30 minutes.

The duration of the visit should be between 03h15 minutes to about four hours. All steps do not necessarily have to be completed during one supervisory visit but all steps should be completed at least once per month.

HOW TO USE THIS MANUAL

The table on the following pages gives an overview of each step of the process, individual activities contained within each step, the purpose of the activities, the tools available to support the steps/activities, the regularity of use of various tools and the section where specific tools are to be found in the manual.

QUICK REFERENCE TO THE SUPERVISORY MANUAL

Supervisory steps and activities	Objective	Tools	Regularity of use	Section in manual
1. Regular review				
1.1 Red flag list	To identify critical elements which can bring a service/service element to a halt and to identify steps to rectify the matter	Checklist	Monthly	Supervisor's support lists
1.2 Routine review list	To review areas which need monthly review	Checklist	Monthly	Supervisor's support lists
Staff management	Ensure that key staff management activities are done	Clinic managers checklist	Used when appropriate	Administration and management
Clinic management	Ensure that key clinic management activities are done	Clinic managers checklist	Used when appropriate	Administration and management
Information review	To ensure that the requirements of the information system are met and up to date	• Information Guide for Supervisors. • Information manual. • Monitoring forms. • Indicator set. • Data definitions	Revised monthly Tools used when appropriate	Information system guidelines
Referral review	To ensure that the referral system is functional	Referral form		Referral system guidelines
Clinical review	To ensure that clients receive a high quality clinical service	Guide to use of STG's	Used when appropriate	Guide to use of STG's
Public health impact	To ensure that services provided from the community are felt in the community	See Information system guidelines for information on specific indicators which may be used.	Used when appropriate	
Community involvement review	To ensure that there is an effective relationship between clinic and community	• The role of supervisors in community participation. • Role of the CHC - checklist. • CHC rapid situation analysis checklist. • CHC community-based care assessment checklist	Used when appropriate	Community participation guidelines

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QUICK REFERENCE TO THE SUPERVISORY MANUAL

Supervisory Steps and activities	Objective	Tools	Regularity of use	Section in manual
2. In depth Program review	To provide an in depth review of specific programme areas	• TB checklist • STD Checklist • EPI checklist • FP checklist • EPI checklist • ANC checklist • Chronic disease checklist • Drug management checklist • National norms and standards	• One programme area per month. • Quarterly review checklist - quarterly	• In-depth programme reviews • National norms and standards
3. Training	To provide regular and appropriate in-service training to staff	Clinical Tips – one page guides to improving clinical diagnosis and management	Monthly	Clinical Tips
4. Problem solving discussion	To discuss problem areas with staff and find ways of dealing with the problems	Problem solving cycle. Other manuals/guides contained in manual or supplied from other source	Monthly	Problem solving and practical solutions to common problems
5. Review of actions/ expectations	Discussion pulling together plans for the next month and indicating who is responsible to deal with various activities	Visit report form	Monthly	Supervisors support lists
OTHER: **Clinic supervisors – staff relationships**	To assess the quality of the relationship between clinic supervisor and the staff she supervises as well as her supervisory practices.	Checklists	Monthly or as required	Supervisors support lists

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SECTION 2

ORGANISING YOUR WORK AS A SUPERVISOR

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ORGANISING YOUR WORK AS A SUPERVISOR

INTRODUCTION

The clinic supervisor is responsible to manage a number of clinics. This management entails a number of different components – performing important administrative tasks, scheduling visits, planning the supervisory components of individual visits and monitoring the performance of clinics. The purpose of this section is to identify key aspects of managing a group of clinics and to provide tools and advice in support of this management.

1. MAKING ADMINISTRATION EASIER

One of the first tasks is to open a file for each individual clinic. Here administrative records are kept – policies provided to clinics, requests for repairs, important notes following supervisory visits and other matters which require some form of documentation.

A second important task is to complete the supervisor's list of contacts which will enable you to deal with important issues without having to follow complicated bureaucratic lines of communication. This list should be completed between you and your District Manager, showing the various authorities from who you may seek help in carrying out your supervision responsibilities. The purpose of the list is to have previous authorization to enable you to contact appropriate persons directly on behalf of the clinics you supervise when assistance is needed in each of the areas listed on the enclosed form. Ultimately the District Manager is responsible for identifying who you should contact in each of these areas and indicating to those people in a formal fashion that you may be doing so and that they should give you full help and co-operation when you request it. In certain instances, they may actually be authorized persons in the private sector such as plumbers, electricians or other persons needed to attend to specific areas at one or more of your clinics. Increasingly you will be able to solve problems on behalf of the clinic simply with a phone call and the use of this list. Keep the list up to date for many of the contact details may change from time to time.

2. SCHEDULING VISITS

The form "Clinic Supervision Schedule" will allow you to schedule clinic visits one year in advance. This is to record the dates of which you expect to visit each of the clinics for which you are responsible. Ideally these dates will be set well in advance, perhaps even a fixed day each month such as the second Tuesday of the month or the first Thursday etc. Should a change in schedule be necessary the clinic should be notified as far in advance as possible. This form also enables you to record the date that you actually visited that clinic. This will be particularly helpful for you to submit to the Transport Officer in charge of the vehicle that will be assigned to you for visiting each of these clinics. A copy of the annual schedule should be provided to the district manager and individual clinics.

3. PLANNING THE CONTENT OF YOUR VISIT

The form "**Clinic Planning Schedule**" will enable you to plan the content of your clinic visits in advance. You will have to photocopy this form to enable you to fill out one form for each clinic for which you are responsible. This form will help you plan ahead the contents of your supervision visit as well as to record what you actually do during the supervision visit: the subjects discussed for in-service training, the programme reviews you conduct, the findings under each of the main categories. It serves as a reminder to you for follow up actions and things that you have promised that you would handle at a future time. As each clinic has its own page to record your visits, this is a consolidated recording of your findings and of the jobs that you wish to do back at your office. A copy of each individual clinic form should be provided to DM and to individual clinics.

ORGANISING YOUR WORK AS A SUPERVISOR

4. MONITORING PERFORMANCE OF THE CLINICS

An important component of the supervisor's role is to monitor the performance of clinics. One way of doing this is by direct visits at the clinic and the other important way is to compare the performance of the clinics you are supervising. This is typically done by graphing key aspects of clinic performance – examples being EPI coverage and numbers of drug stock outs. This method allows you to identify poorly performing clinics and together with clinic staff working out ways of correcting problem areas. On the other hand, lessons could be learnt from clinics doing very well in certain areas which could be used to improve service provision in other clinics supervised by you.

5. REPORTING

The provincial policy on supervision indicates that the district manager will report quarterly on supervisory visits within the district. A form titled **"Quarterly Districts Report on Clinic Supervision" on page 4** can be used. In order to support the District Manager to compile this report a form **"Monthly Supervisors Report on Supervisory Activities"** on page 3 has been designed to provide reports to the appropriate person at provincial level. Each clinic supervisor completes this form monthly and submits it to the District Manager. Important issues which need the inputs of the District Management Team should be indicated here for further follow up.

SECTION 2: ORGANISING YOUR WORK AS A SUPERVISOR

MONTHLY SUPERVISOR'S REPORT ON SUPERVISORY ACTIVITIES

MONTH		NAME OF SUPERVISOR	

	NAME OF CLINIC VISITED VISITED AS PER SCHEDULE	SUPERVISORY ACTIVITIES	ACHIEVEMENTS / PROBLEM AREAS / COMMENTS / INTERVENTIONS
1	Name _____ Date visited _____ Visited per schedule Y N	Routine review done Y N In Depth Programme Review: In service training topic:	1 2 3 4
2	Name _____ Date visited _____ Visited per schedule Y N	Routine review done Y N In Depth Programme Review: In service training topic:	1 2 3 4
3	Name _____ Date visited _____ Visited per schedule Y N	Routine review done Y N In Depth Programme Review: In service training topic:	1 2 3 4
4	Name _____ Date visited _____ Visited per schedule Y N	Routine review done Y N In Depth Programme Review: In service training topic:	1 2 3 4
5	Name _____ Date visited _____ Visited per schedule Y N	Routine review done Y N In Depth Programme Review: In service training topic:	1 2 3 4
6	Name _____ Date visited _____ Visited per schedule Y N	Routine review done Y N In Depth Programme Review: In service training topic:	1 2 3 4

QUARTERLY DISTRICT REPORT ON CLINIC SUPERVISION

DISTRICT		**DISTRICT MANAGER**	
SIGNED		**DATE**	

Month	No of clinics visited	No of clinics visited on scheduled date	No of clinics in district
1			
2			
3			

Comments on important aspects of clinic supervision

1. Staff

Clinic	Issues

2. Clinic infrastructure (telephone, electricity, water, sanitation/refuse disposal

Clinic	Issues

3. Service provision

Clinic	Issues

4. Drug stock outs

Clinic	Issues

5. Essential Clinic supplies

Clinic	Issues

6. Clinic committees

Clinic	Issues

7. Other

Clinic	Issues

CLINIC SUPERVISOR SCHEDULE

SUPERVISOR NAME _____ YEAR _____

Clinic Name	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

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CLINIC PLANNING SCHEDULE

CLINIC NAME _____ **SUPERVISORS NAME** _____

Checklist	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Red flag list												
Routine review list												
Staff management												
Clinic management												
Information review												
Referral review												
Clinical review												
Public health impact												
Community involvement review												
Programme Review												
In service training topic												

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CLINIC SUPERVISORS LIST OF CONTACTS

SUPERVISOR NAME

BUILDING & MAINTENANCE

Problem Area	Worker	Name/Surname	Authorised By	Telephone No
Roof repairs	Maintenance handyman			
Doors and windows	Handyman			
Plumbing – toilets, water	Plumber			
Electrical problems	Electrician			
Fencing and access	Handyman			
Walls	Building			

EQUIPMENT

Problem Area	Worker	Name/Surname	Authorised By	Telephone No
Refrigerator repair/maintenance	Cold chain maintenance			
Sphygmomanometer	Equipment repair workshop			
Other minor equipment	Equipment repair workshop			

SUPPLIES AND DRUGS

Problem Area	Worker	Name/Surname	Authorised By	Telephone No
Gas	Stores			
Vaccines	Pharmacist and Depot			
Stationary	Person in charge of Stationary/ Registers/ Forms			
Essential Drugs	Pharmacist			

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CLINIC SUPERVISORS LIST OF CONTACTS

TRANSPORT AND COMMUNICATION

Problem Area	Worker	Name/Surname	Authorised By	Telephone No
Ambulance Service	Emergency Ambulance			
	Hospital Vehicle Officer			
	District Transport Officer			
Telkom	Telkom Area Manager			
Radio	Maintenance Officer			

PERSONNEL PROBLEMS

Problem Area	Worker	Name/Surname	Authorised By	Telephone No
Salaries	Personnel Officer			
Allowances	Personnel Officer			
Leave	Personnel Officer			
Disciplinary matters	Personnel Officer			
Maternal Child	MCH Co-ordinator			
Womens Health	District/Hospital			
Adolescence	Provincial names/addresses			
	Maternity wards			
	Doctors			
EPI	MCH Co-ordinator			
HIV/AIDS & STDs	Communicable Disease Co-ordinator			
	Doctors			

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CLINIC SUPERVISORS LIST OF CONTACTS

PERSONNEL PROBLEMS (continued)

Problem Area	Worker	Name/Surname	Authorised By	Telephone No
Nutrition Program	Nutritionist			
Mental Health & Substance Abuse	Psychiatrist			
	Mental Health Nurse			
	NGOs eg AA, SANCA			
Tuberculosis	SANTA			
	Local Hospital Doctor			
	Communicable Disease Co-ordinator			
	DOTS Trainer			
Outbreak	Environmental Health Officer			
	District Manager			
Social Welfare	Welfare Officer			
Disability/Rehabilitation	Physiotherapist			
	Social Welfare			
Oral Health	Oral Therapist			
	Dentist			
Laboratory Services	Head of Laboratory			

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SECTION 3

SUPERVISORS SUPPORT LISTS

- Guideline to use of Supervisors Support List
- Red Flag List
- Regular Review List – Albany Version
- Regular Review List – Blank Version
- Supervision Support List - Notes
- Quarterly Review List
- Checklist: Clinic supervisors – staff relationship

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GUIDELINES TO USE SUPERVISORY SUPPORT LISTS

INTRODUCTION

The checklists should be seen as a tool to support you as you conduct a supervisory visit. It really supports you to systematically review important aspects related to clinic service provision. It consists of three sections:

RED FLAG SECTION (Completed Monthly)

This section allows for a rapid review of key elements of critical importance for service delivery. The absence of any of these elements implies that an important health programme cannot be provided and needs to be rectified as a matter of urgency. The list is completed by rapidly checking of with a yes or a no whether there are stock outs, problems with the refrigerator, broken equipment or absent staff (the number of days of staff not on duty for the last month is totalled). There is space for a monthly note to be made to record the monthly actions required to deal with these key problems.

REGULAR REVIEW LIST (Completed Monthly)

This list encourages the regular monthly review of important elements involved in service delivery. Districts/sub-districts can take this list and customize it to support district needs for supervision.

An uncompleted list is included as well as a completed list from the Albany District to serve as an example.

- **Y/N** - blocks containing a Y/N should be ticked depending on the outcome of review process. A tick through the **Y** indicates that the desired outcome is appropriate/correct/done; a tick through the **N** indicates that the desired outcome is not appropriate/correct/done.

- **# (Number of)** - rows headed by this symbol indicate that the number of events occurring during that month should be counted and entered into the appropriate block.

- **RTH Cards** - collect five cards and indicate how many of the five are correctly completed. Enter this number on checklist.

- **STG use** - from register/minor ailments book pick five interesting curative care cases managed at the clinic – using the Standard Treatment Guidelines ("*Green Book*") check for the correctness of the treatment for that specific case. Indicate the diagnosis/symptom complex of the case reviewed in the appropriate block and whether it was correctly managed. When finished add up the number of correctly managed STG's and enter the number in the row titled STG's followed # correct.

- **Public Health Impact** - generally, this section will be completed by indicating a percentage taken from an appropriate graph on the wall for the month (previous month if visit occurred during early or mid-month) during which the visit took place.

- **Clinic Visits** - indicate whether the doctor or other persons (district manager, EHO, program manager, etc) visited the clinic in the last month.

- **Supervisory Actions** - from your notes, observations and discussions with staff determine how many actions need to be completed subsequent to your visit. Enter this figure into the area before the forward slash of the next month. Ie if you visit the clinic in February the number of actions should be written in the column under March. During March you will review how many of the identified actions were carried out and indicate this in the area behind the forward slash of the March block.

GUIDELINES TO USE SUPERVISORY SUPPORT LISTS

NOTES

The note section allows you to write important notes/comments and identify actions by both supervisor and clinic staff over the next month. The number of actions are totalled and entered into the row **"Supervisory Actions Completed".** See Above.

QUARTERLY SUPERVISORY SUPPORT LIST

This list is completed once every three months and provides a more in depth perspective on the functioning of the clinic.

CLINIC SUPERVISORS STAFF RELATIONSHIP

This checklist is used by the CS to assess her relationship with the staff she supervises. It may be used monthly or as required.

SECTION 3: SUPERVISORS SUPPORT LISTS

RED FLAG LIST

CLINIC NAME _____

DRUG STOCK OUTS

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
FP												
STD												
TB												
ANC												
EPI												
Chronic												
HIV												

REFRIGERATOR NOT FUNCTIONING

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Mechanical												
Electricity												
Gas												

STAFF NOT ON DUTY (LEAVE, TRAINING, ABSENT WITHOUT LEAVE)

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Professional												
Non-Professional												

BROKEN EQUIPMENT

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Baumenometer												
Scale												

RED FLAG ACTIONS*

January	February	March
April	May	June
July	August	September
October	November	December

***The supervisor and clinic manager will decide how to deal with the red flag item needing attention**

REGULAR REVIEW LIST – ALBANY VERSION

CLINIC NAME _____ **SUPERVISOR NAME** _____

ROUTINE REVIEW	Jan	Feb	Mar	Apr	May	Jun
Staff Management						
Leave forms completed	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Attendance reg. correct	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Staff meetings took place	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
# In-service training activities						
# Days people absent (*)						
Clinic Management						
Fridge packing correct	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Fridge T correct	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Sharps disposal correct	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Bin cards correct	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Drug stock outs	Depot/Local	Depot/Local	Depot/Local	Depot/Local	Depot/Local	Depot/Local
Monthly stock take done						
# Report breaks repaired						
Information Review						
Statistical return correct	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Referral Review						
Back referrals received	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Clinical care						
RTH Card correct	/5	/5	/5	/5	/5	/5
STG's followed						
1 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
2 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
3 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
4 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
5 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Public Health Impact						
Fully immun children rate						
FP coverage rate						
STD contact tracing rate						
TB contact tracing rate						
Clinic committee						
Meeting held last month	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
New projects initiated	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Clinic visits						
Doctor visits	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Other						
Supervisory visit actions completed	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

(*) Please indicate the number of days each category absent ie Professional nurse (PN) 5, Enrolled Nurse (EN) 5, Enrolled Nurse Assistant (ENA) 8 and General Assistant (GA) 2

REGULAR REVIEW LIST – ALBANY VERSION

CLINIC NAME _____ **SUPERVISOR NAME** _____

ROUTINE REVIEW	Jul	Aug	Sep	Oct	Nov	Dec
Staff Management						
Leave forms completed	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Attendance reg. correct	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Staff meetings took place	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
# In-service training activities						
# Days people absent (*)						
Clinic Management						
Fridge packing correct	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Fridge T correct	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Sharps disposal correct	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Bin cards correct	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Drug stock outs	Depot/Local	Depot/Local	Depot/Local	Depot/Local	Depot/Local	Depot/Local
Monthly stock take done						
# Report breaks repaired						
Information Review						
Statistical return correct	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Referral Review						
Back referrals received	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Clinical care						
RTH Card correct	/5	/5	/5	/5	/5	/5
STG's followed						
1 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
2 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
3 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
4 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
5 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Public Health Impact						
Fully immun children rate						
FP coverage rate						
STD contact tracing rate						
TB contact tracing rate						
Clinic committee						
Meeting held last month	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
New projects initiated	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Clinic visits						
Doctor visits	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Other						
Supervisory visit actions completed	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

(*) Please indicate the number of days each category absent ie Professional nurse (PN) 5, Enrolled Nurse (EN) 5, Enrolled Nurse Assistant (ENA) 8 and General Assistant (GA) 2

REGULAR REVIEW LIST – BLANK VERSION

CLINIC NAME _____ **SUPERVISOR NAME** _____

ROUTINE REVIEW	Jan	Feb	Mar	Apr	May	Jun
Staff Management						
Clinic Management						
Information Review						
Referral Review						
Clinical care						
STG's followed						
1 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
2 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
3 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
4 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
5 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Public Health Impact						
Clinic committee						
Clinic visits						
Supervisory visit actions completed	Y/N/P	Y/N/P	Y/N/P	Y/N/P	Y/N/P	Y/N/P

P = Partially

REGULAR REVIEW LIST – BLANK VERSION

CLINIC NAME _____ **SUPERVISOR NAME** _____

ROUTINE REVIEW	Jul	Aug	Sep	Oct	Nov	Dec
Staff Management						
Clinic Management						
Information Review						
Referral Review						
Clinical care						
STG's followed						
1 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
2 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
3 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
4 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
5 Dnosis/Correct Manag	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Public Health Impact						
Clinic committee						
Clinic visits						
Supervisory visit actions completed	Y/N/P	Y/N/P	Y/N/P	Y/N/P	Y/N/P	Y/N/P

P = Partially

SUPERVISION SUPPORT LIST – NOTES

CLINIC NAME _____ SUPERVISOR NAME _____

MONTH	NOTES	ACTIONS	DONE
JANUARY			
FEBRUARY			
MARCH			
APRIL			
MAY			
JUNE			

SUPERVISION SUPPORT LIST – NOTES

CLINIC NAME _____ **SUPERVISOR NAME** _____

MONTH	NOTES	ACTIONS	DONE
JULY			
AUGUST			
SEPTEMBER			
OCTOBER			
NOVEMBER			
DECEMBER			

QUARTERLY SUPERVISORY SUPPORT CHECK LIST

CLINIC		SUPERVISOR			
DISTRICT		CLINIC STAFF		DATE	

MANAGEMENT FUNCTIONS

[✓] Tick appropriate box

PERSONNEL	Action to be taken			Clin	Sup
Vacant posts pending	#				
Disciplinary action pending	#				
Employer folder updated	Y	N			
Staff training plan	Y	N			
Staff meetings weekly	Y	N			

LOGISTICS					
Telephone working	Y	N			
Radio working	Y	N			
Ambulance service functional	Y	N			
Transport plan	Y	N			

SUPERVISION					
Monthly visit schedule	Y	N			
Visits on schedule	Y	N			
Written report of supervision	Y	N			
In-service training of clinic staff	Y	N			

INFORMATION					
Registers used properly	Y	N			
Monthly stats feedback	Y	N			
Data graphed	Y	N			
Catchment map update	Y	N			
Posters up to date / display	Y	N			

EQUIPMENT					
Refridge – temperature record	Y	N			
Polio VVM	Y	N			
Vaccines expiry	Y	N			
BP cuff	Y	N			
Scales	Y	N			
Other requirements (lists)	Y	N			
Repairs not completed/awaited	Y	N			

DRUGS/SUPPLIES					
Review monthly out of stock	Y	N			
Out > 1 full month	Y	N			
Storage conditions/records ok	Y	N			

COMMUNITY	Date		Action to be taken	Clin	Sup
Last meeting					
Last CHW meeting					
Condoms in clinic freely	Y	N			
Condoms in community places	Y	N			

Clin = Clinic
Sup = Supervisor

QUARTERLY SUPERVISORY SUPPORT CHECK LIST

SERVICE PROVISION

[✓] Tick the appropriate box

SERVICES AVAILABLE			Action to be taken if (N) to questions below	Clin	Sup
EPI	#		Days		
Sharps disposal correct	Y	N			
Records correct	Y	N			
Return date indicated	Y	N			
FP	#		Days		
Continuity of cases	Y	N			
All choices available	Y	N			
HIV counsel	Y	N			
ANC	#		Days		
RPR's sent/treated	Y	N			
Fe tabs	Y	N			
Tetanus Toxoid	Y	N			
STD's	#		Days		
Contact tracing	Y	N			
FP	Y	N			
HIV counsel	Y	N			
Mental	#		Days		
Violence counseling	Y	N			
Psychiatric disease	Y	N			
Epilepsy f/u	Y	N			
Chronic	#		Days		
Diabetes managed	Y	N			
Hypertension cases checked	Y	N			
Home cases	Y	N			
Child Curative	#		Days		
IMCI protocol use	Y	N			
EPI checked	Y	N			
Nutrition advise	Y	N			
Nutrition Growth Promotion	#		Days		
WT Chart used for advise	Y	N			
No bottles	Y	N			
Vitamin A	Y	N			
Adult Curative	#		Days		
HIV counselling	Y	N			
BP > age 50	Y	N			
Gloves for blood	Y	N			
All services 5 days	Y	N			

OTHER VISITS TO CLINICS OVER PAST QUARTER

Environmental health officer	Visits	Action to be taken	Clin	Sup
(map, water, toilets)	#			
Dental	#			
Genetic	#			
Eye	#			
Other (doctor, Psych, etc)	#			

Clin = Clinic
Sup = Supervisor

QUARTERLY SUPERVISORY SUPPORT CHECKLIST

[✓] Tick the appropriate box

QUALITY OF SERVICES	No	Action to be taken	Clin	Sup
Of 10 infants reach age 1 # fully immunized				
Of 10 women reach delivery # ANC visit 3/ more				
Of 10 STDs treated # syndromic Rx				
Of 10 diarrhoea # only ORS				
Of 10 TB # regular Rx last month				
Of 10 # nutrition chart used to advise				

Clin = Clinic
Sup = Supervisor

SUPERVISION SUPPORT LIST – NOTES

ACTIONS TO BE TAKEN BY SUPERVISOR

ACTIONS TO BE TAKEN BY CLINIC

Supervisor Signature		Clinic Nurse		Date	

OTHER COMMENTS/NOTES

SECTION 3: SUPERVISORS SUPPORT LISTS

CHECKLIST: CLINIC SUPERVISORS – STAFF RELATIONSHIP

Note: Supervisors need to complete this self-assessment before starting their new supervisory schedule and monthly after clinic visits to help make decisions about changing/improving their supervisory approach. It will help to keep track of one's progress in enhancing their interpersonal relationships with clinic in-chare and other staff.

CLINICS VISITED		DATE	
	1.		
	2.		
	3.		
	4.		

DO YOU NEED TO CHANGE YOUR APPROACH?

Take a few minutes to assess how you approach staff and relate with them

	[✓] Tick appropriate box		Comments if NO
Approach all clinic staff more as supervisor's important partners and team members in ensuring quality PHC services and less as mere subordinates	Y	N	

Having good knowledge about the clinic and staff being supervised/visited

• Review/study clinic file prior to visit to note agreements/issues raised previously	Y	N	
• Note strengths and limitations regarding clinic performance in delivery of integrated package of PHC services and community participation	Y	N	
• Note staffing complement and technical preparation	Y	N	
• Be aware of important community issues already known/reported	Y	N	
• Note any known recent personal experiences of individual staff members that need supervisor's word of comfort, best wishes, or congratulations	Y	N	

Communication before visit

• Make sure clinic sister/staff are aware of intended supervisory visit and date	Y	N	
• Share written agenda for visit with in-charge ahead of visit	Y	N	

Approaching and treating clinic staff and their clients well

• Greet staff and announce arrival politely	Y	N	
• Show warmth, respect and patience when handling in-charge and others throughout the supervisory visit	Y	N	
• Allow time for staff to complete any consultations underway and for any hand over	Y	N	
• Help to create calm atmosphere by waiting for appropriate timing before making comments or asking about staff behaviour/performance or mistakes eg when seated, once there is privacy, when climate is conducive	Y	N	
• Validating that any emergencies have been attended to and in-charge is free to attend to the supervisor	Y	N	
• Explain or review agenda for day's visit with in-charge	Y	N	

CHECKLIST: CLINIC SUPERVISORS – STAFF RELATIONSHIP

	[✓] Tick appropriate box	Comments if NO
Use a team enhancing approach throughout the supervisory activities		
• Practice active listening during discussions and throughout the interactions	Y N	
• Encourage staff to express what they liked about their work in the past month and their wishes for coming weeks	Y N	
• Give in-charge and other staff complements for jobs done well, new initiative and innovations or jobs done well to improve quality of care	Y N	
• Take enough time to understand the issues of clinic staff and problems or opportunities at the facility	Y N	
• Correct errors and wrong practices gently and constructively rather than criticizing or scolding	Y N	
• Assist, involve and encourage clinic in-charge and other staff to identify problems and in problem-solving	Y N	
• Give staff the information they need to do their jobs well (use the relevant sections in the supervisors manual and standard guidelines	Y N	
• Give staff the practical, workable suggestions on how they can obtain the supplies, equipment, and other materials they need to do their jobs well	Y N	
• Maintain open and focused discussions by asking open-ended questions, paraphrasing, and summarizing findings and agreed on solutions from time to time	Y N	
• Speak with other levels of staff and not only the sister in-charge	Y N	
Concluding the visit		
• Summarize with in-charge the specific aspects of care going well and commend them for it	Y N	
• Summarize the specific aspects that need change and discuss/review what needs to be done and how	Y N	
• Share with staff as a group the supervisor's general impressions on what is going well and what needs further improvement based on the supervisor's findings (details to be provided by clinic in-charge later)	Y N	
• When ready to leave, thank clinic in-charge and others where possible	Y N	
• Bid them goodbye till next time	Y N	

SECTION 3: SUPERVISORS SUPPORT LISTS

CHECKLIST: CLINIC SUPERVISORS – STAFF RELATIONSHIP

ACTIONS ON IMPROVING SUPERVISOR – STAFF RELATIONSHIPS AND APPROACH TO SUPERVISION

SECTION 4

ADMINISTRATION AND MANAGEMENT

- Introduction
- Clinic Managers Checklist

Revised date: 3 February 2003

SECTION 4: ADMINISTRATION AND MANAGEMENT

INTRODUCTION

To improve the many administrative and management functions at the clinic level, the NDOH has developed the Clinic Managers Handbook, a concise guide to managers on how to deal with the many issues for which they are responsible, issues largely falling outside of clinical services. A full copy of this handbook in included on the CD Rom and can be downloaded and printed.

The enclosed checklist was derived from the Clinic Manager's Handbook and is a succinct listing of the tasks or activities that should be accomplished. This is a long list and should be viewed as a set of expectations for management to accomplish over a period of time. It is expected that clinic managers and their staff will, each month, identify one or two outstanding issues from this list on which they require further guidance or clarity from their supervisor during the monthly visit. Most of the items on this list once accomplished need not be addressed again at subsequent visits. Thus this checklist is a tool to enable a progressive accomplishment of clinic management tasks over time. The supervisory role is to facilitate and guide these various management tasks, using the full clinic manager's handbook and other resources to assist the process.

Also found on the CD Rom, but not present in this manual for supervisors, is a Primary Health Care Checklist identifying specific activities and services which should be available at each level of primary health care in the community, at mobiles, clinics, CHC and District Hospital. These are organised on the checklist in a life cycle approach and serve not only to identify the agreed functions which should occur at each level of the primary health care system but also serve as a guide to referral to higher levels at which desired services can be obtained. The PHC checklist is a useful tool to keep in the clinic, both to guide referral and to identify expected service levels in each of the stages of life from pregnancy through birth, infancy, school age, adolescence, adulthood and old age. The supervisor will want to be familiar with the contents of this checklist and its use.

CHECKLIST: CLINIC MANAGERS

CLINIC _____ **DATE** _____

[✓] Tick appropriate box

❑ General leadership and planning

• Vision / Mission Statement developed and posted visibly?	N	Y	Date last revised / checked
• Core values for team developed and posted?	N	Y	Date last revised / checked
• Operational plan or business plan for year developed?	N	Y	Date last revised / checked

❑ Staff

• New clinic staff oriented?	N	Y	Date last revised / checked
• Staff establishment for all staff categories known; vacancies discussed with supervisor?	N	Y	Date last revised / checked
• Job descriptions for each staff category in clinic file?	N	Y	Date last revised / checked
• Performance plan / agreement for each staff member available?	N	Y	Date last revised / checked
• On-call roster/calendar posted; is it fair?	N	Y	Date last revised / checked
• Absenteeism/attendance register; used and discussed?	N	Y	Date last revised / checked
• Task list for clinic with appropriate rotation of tasks done?	N	Y	Date last revised / checked
• Services/tasks not carried out due to lack of skills identified?	N	Y	Date last revised / checked
• For each staff member: Record of meetings, workshops, and training attended; is the balance of opportunity reviewed?	N	Y	Date last revised / checked
• Staff meetings held regularly?	N	Y	Date last revised / checked
• In-service training activities taking place?	N	Y	Date last revised / checked
• Discipline problems documented and copied to supervisor?	N	Y	Date last revised / checked

❑ Finance

• Budget for year known for main categories?	N	Y	Date last revised / checked
• Monthly recording of expenditure in each category	N	Y	Date last revised / checked
• Are balances calculated? Action taken, if necessary?	N	Y	Date last revised / checked
• Has transfer of funds between line items been requested, if necessary? (as permitted in your setting)	N	Y	Date last revised / checked

❑ Transport / communication

• Weekly or monthly plan for transport needs	N	Y	Date last revised / checked
• Submitted to supervisor or transport co-ordinator?	N	Y	Date last revised / checked
• Telephone/radio - working (line in clinic, card phone, etc)	N	Y	Date last revised / checked
• Used for official purposes only?	N	Y	Date last revised / checked
• Able to contact ambulance for urgent patient transport?	N	Y	Date last revised / checked
• Supervisor informed of problems?	N	Y	Date last revised / checked

❑ Visits to clinic by unit supervisor

• Visited monthly by supervisor?	N	Y	Date last revised / checked
• Date and time of visit known ahead?	N	Y	Date last revised / checked
• Is clinic prepared for next visit by supervisor?	N	Y	Date last revised / checked
• Written record of visit left with clinic?	N	Y	Date last revised / checked

❑ Community

• Community fully involved in developing clinic priorities and support service programmes actively?	N	Y	Date last revised / checked
• Community health committee in place and met last month? The clinic committee should have a clinic staff member present at the meetings. This staff member should have this link part of his/her job description and should have a structured support programme by providing stats, enlighten the committee on policy changes, problems, etc.	N	Y	Date last revised / checked

CHECKLIST: CLINIC MANAGERS

❑ **Organisation Of Services / Quality / Client Satisfaction** — **[✓] Tick appropriate box**

- Client Consideration
  - – Patient charter posted? In local language? — N | Y | Date last revised / checked
  - – Clear list of services available (with times) posted? — N | Y | Date last revised / checked
  - – Is each client greeted in a friendly manner? — N | Y | Date last revised / checked
  - – Complaint mechanism in place (ie suggestion box)? — N | Y | Date last revised / checked
  - – Waiting times - tracked periodically? — N | Y | Date last revised / checked
  - – Privacy for consultation (auditory privacy); and privacy for examination (visual)? — N | Y | Date last revised / checked
  - – Is facility and service acceptable/accessible to disabled persons? youth? — N | Y | Date last revised / checked

- Service Organisation
  - – Any problem can be seen anytime (eg supermarket approach)? — N | Y | Date last revised / checked
  - – Patients with same conditions encouraged (not required) to come as a group? - Facilitates group education, support groups for clients — N | Y | Date last revised / checked
  - – Efforts made to spread work over entire day (see description)? — N | Y | Date last revised / checked
  - – Information for patients/posters/health education available in waiting area; in local Language? — N | Y | Date last revised / checked
  - – Arrangements for visiting doctors/other specialist services? — N | Y | Date last revised / checked
  - – Referral system
    - ↳ Letter sent with patient to referral level? — N | Y | Date last revised / checked
    - ↳ 'Back-referral' / 'downward referral' coming back? — N | Y | Date last revised / checked
    - ↳ Drugs needed for continued care sent to clinic? — N | Y | Date last revised / checked
  - – Clinic outreach conducted? (see examples) — N | Y | Date last revised / checked

- Clinical Standards
  - – Infection control
    - ↳ Hand washing with disinfectant after each client examination? — N | Y | Date last revised / checked
    - ↳ "Standard precautions" practiced? — N | Y | Date last revised / checked
    - ↳ Needle disposal management — N | Y | Date last revised / checked
  - – Standard Treatment Guidelines (STGs) followed? - especially for: TB, STDs, Diarrhoea (ORS), High Blood Pressure, Diabetes, other local priorities — N | Y | Date last revised / checked
  - – Each drug dispensed to patient properly labelled? — N | Y | Date last revised / checked
  - – Patients provided with verbal and written instructions? — N | Y | Date last revised / checked
  - – Waste disposal procedures followed according to standards? — N | Y | Date last revised / checked
  - – Post-HIV exposure prophylaxis for employees available? — N | Y | Date last revised / checked

❑ **Equipment and facility**

- Essential equipment for PHC in place? (eg oxygen, pelvic exams, BP) — N | Y | Date last revised / checked
- Inventory of clinic equipment up-to-date? — N | Y | Date last revised / checked
- Broken equipment labelled and listed, with problem stated? — N | Y | Date last revised / checked
- Equipment due for routine maintenance identified? — N | Y | Date last revised / checked
- Facility clean, tidy; cleaning carried out daily? — N | Y | Date last revised / checked
- List of facility repairs needed (doors, window, water) — N | Y | Date last revised / checked
- Discussed with supervisor and/or Clinic committee? — N | Y | Date last revised / checked
- Refrigerator - temperature recorded daily? — N | Y | Date last revised / checked

CHECKLIST: CLINIC MANAGERS

❑ **Drugs and supplies**	[✓] Tick appropriate box		
• Secure place for all stocks, under appropriate conditions?	N	Y	Date last revised / checked
• Stock cards used and up-to-date?	N	Y	Date last revised / checked
• Orders placed regularly and on time?	N	Y	Date last revised / checked
• Verify drugs received against order placed	N	Y	Date last revised / checked
• Discrepancies discussed with supervisor?	N	Y	Date last revised / checked
• Monthly stock-outs recorded and discussed with supervisor?	N	Y	Date last revised / checked
• Organisation of stock: orderly, FEFO (first expiry, first out) followed, no expired stock?	N	Y	Date last revised / checked
• Drug ordering to save costs	N	Y	Date last revised / checked
• Following Essential Drug List (EDL)?	N	Y	Date last revised / checked
• Is cost-effectiveness of drugs used analysed?	N	Y	Date last revised / checked
• Number of items per prescription analysed; discussed with supervisor?	N	Y	Date last revised / checked
• Lab test supplies in stock (for sputa, blood, etc)?	N	Y	Date last revised / checked

❑ **Information, documentation**

• References and resources			
– Up-to-date printed material on each national programme available for use by staff (protocols, treatment guidelines)?	N	Y	Date last revised / checked
– Norms / standards for clinical services accessible to providers (see description)?	N	Y	Date last revised / checked
– Resource materials / references available?	N	Y	Date last revised / checked
– Flow charts on wall/desk - (STD, IMCI, TB, ...)?	N	Y	Date last revised / checked
– List of circulars, documents received, with date?	N	Y	Date last revised / checked
• Reporting, recording			
– Patient records	N	Y	Date last revised / checked
– Patient held records used? New cards available?	N	Y	Date last revised / checked
– If clinic held records used: retrieval time, % lost analysed?	N	Y	Date last revised / checked
– Patient visit recorded and services recorded? (using tick register or other method)	N	Y	Date last revised / checked
– Continuity records kept, up-to-date, follow-up done? (eg registers)	N	Y	Date last revised / checked
– FP, EPI, ANC, STD, TB, chronic (DM, HBP, epilepsy)	N	Y	Date last revised / checked
– Lab specimen register kept? Missing results followed up?	N	Y	Date last revised / checked
– Medico-legal forms available (notifications, statutory responsibilities)?	N	Y	Date last revised / checked
– Notifiable diseases			
↳ New cases reported immediately?	N	Y	Date last revised / checked
↳ "Null" reports submitted weekly?	N	Y	Date last revised / checked
– Births, deaths - timely reports on correct form?	N	Y	Date last revised / checked
– Monthly PHC statistics report - accurate, on time, filed/sent?	N	Y	Date last revised / checked
• Managing with information			
– Monthly data checked, <u>discussed,</u> graphed with/by clinic staff - action? Shared with clinic committee?	N	Y	Date last revised / checked
– Data displayed - up to date?	N	Y	Date last revised / checked
– Annual data verified, discussed?	N	Y	Date last revised / checked
– Operational plan (business plan) developed (not a monthly activity, but plans can be reviewed and updated often)?	N	Y	Date last revised / checked
– In line with district plan? National and provincial plans? Informed by statistics?	N	Y	Date last revised / checked
– Catchment area map available? Including location of mobile stops, DOTS supporters, CHWs and other outreach activity	N	Y	Date last revised / checked

CHECKLIST: CLINIC MANAGERS

NOTES

FOLLOW UP ACTIVITIES

ACTIVITY	DONE

SECTION 5

INFORMATION SYSTEM GUIDELINES

- Introduction
- Guide for reviewing the monthly PHC report
- Example of adapted information guide from the Elliot Health District
- Monitoring Forms
- Data Definition
- Information Manual

Revised date: 20 February 2003

INTRODUCTION

The information system provides the "brains" for primary health care, both to track services provided as well as guide managerial decisions. The quality of data provided from the clinics is the most critical factor in assessing the validity of the information system. If the monthly reports from the clinics are incorrect the entire system is mislead. A standard data form for PHC monthly data has been agreed to for each province, although individual districts can add additional information to this form if they desire. It is important that workers in the clinic understand the definitions of each data element and record it correctly. One of the most frequent errors is a misunderstanding of the definition of the data item. It is the supervisor's job to understand the definitions and to scrutinize the monthly report each month to see that the information submitted is correct and valid.

The District Health Information System - DHIS is the computer software that analyses this data. It provides not only for the validation of entry figures (detecting numbers which lie outside of a normal range described as the min and max of each data field and also does validity checks on certain figures to be sure that they are within the range of possibility). The computer automatically produces reports of the data for any desired period and calculates a whole set of indicators, many of which are described in this information section.

It is important for people in the clinic to understand their own data and to use it for self analysis and decision making. For this reason clinic staff are encouraged to graph the data from their monthly reports. Supervisors are expected to assist and oversee in this graphing process. Each month the latest addition to the graphs should be discussed to decide whether or not progress is as expected. Some items such as immunisation coverage and family planning are best graphed in a cumulative graph. This shows the number for the month as well as the total numbers receiving the service since the beginning of the year to show the progress towards an annual objective. Other data is best graphed month by month to show differences according to season, such as cases of diarrhoea or acute respiratory illness. Sometimes data can be shown or traced on a locally drawn map. New cases of STD may cluster in a particular geographic area and will give hints on control. New cases of tuberculosis may show communities in particular need of intensified case finding and control of spread.

The monthly review of the routine statistics is an important supervision activity and contributes to improved quality of both health services and management.

GUIDE FOR REVIEWING THE MONTHLY PHC REPORT

The Clinic Supervisor is responsible for reviewing the monthly report, verifying the data, making suggestions to the clinic and signing the report to signify the data have been checked and found correct, before it is submitted to the district office. This guide provides pointers for the supervisor in this important task.

Notice that there is a space for comments next to each data box. Here is where any observations on the data, especially validating unusual data, should be recorded. Data, which falls substantially out of line from past months should be questioned and if verified as true, a comment should be made explaining why it is outside normal. Any unusual circumstances may also be noted in this space.

1 Management

- Headcount under five and over five record the number of visits made to the clinic throughout the month.

- The number of DOTS visits is recorded to enable subtraction of DOTS patients when calculating workload of nurses other than DOTS (routine DOTS visits take very little time and are a matter of routine. Each DOTS patient is expected to visit twenty times a month.)

- Nursing staff days worked cannot be any higher than the total working days in the month times the number of nursing staff in the clinic. Any personnel providing nursing services regardless of their actual rank or title (staff nurses, nursing assistant) is included in "nursing staff days worked". If absences are high, look into the reasons.

- Supplies or drugs available all month are recorded from the list, which is also appended and sent in. The list of tracer drugs and supplies should be kept in the clinic drug storage area and if any item is found out during the month tick [✓] to indicate that a stockout occurred. It is not necessary to record how many days the item is out but just a single tick is adequate to say at some point it was out of stock. The number of items with a tick is filled in this box and represents the number of items out of those traced(if the clinic has certain items which are never stocked, the number of expected items is less than the full list). Find out <u>why</u> any item has gone out of stock and try to suggest remedial measures.

2 Ante-natal visits

- First antenatal visits - is the number of pregnant women who were newly booked this month. Some provinces record whether this first visit occurred before or after 13 weeks (first trimester) or before or after 20 weeks. Be sure to know what your province requires. Subsequent ante-natal visits is all other ante-natals, which is usually more than the first ante-natals

- Pregnant women receiving tetanus toxoid number two (previously only the third dose was recorded), or a booster if tetanus toxoid was given previously, is recorded here. This will probably occur during a subsequent ante-natal visit. The number who receive tetanus toxoid number 2 should be the same number as first ante-natal visits when summed over the year but will not be the same month to month as two or more doses are required, requiring more visits.

3 Deliveries

- Note that live-borns **who were delivered in this reporting facility** are the only ones that should be recorded. Make sure that only those born in the facility, not outside of the facility are recorded. Those born in the facility weighing less than 2.5 kilograms assumes that all others born in the facility weighed more than 2.5 kilograms.

- Deliveries to women age less than eighteen is women up through age seventeen and provides a measure of what is called teenage pregnancies delivering in this facility.

- Still-borns are those who are not alive at birth, made no breath or cry.

GUIDE FOR REVIEWING THE MONTHLY PHC REPORT

4 Contraceptive protection

- Please note it is not numbers of people but oral pill cycles that are recorded. Injections are usually one per person. IUDs are no longer reported from PHC as they are unusual at this level.

- Condoms dispensed are the number of condoms, which were given out plus those taken from the public dispensing box in the waiting area.

- Number referred for TOP refers to women who asked for counselling and were sent to another institution, whether they actually went or not.

5 Child Health

- Diarrhoea in children is generally defined as greater than three loose stools, although even a massive watery stool is technically diarrhoea. Here one would look for unusual increases in numbers representing a local epidemic. Check that each child received ORS.

- Lower respiratory infection is diagnosed by counting respirations. (Greater than 60/ minute in infants under 2 months old, >50/minute in infants, >40/minute in children over age one according to the IMCI protocol.) Others with cough and cold should **not** be recorded here.

- Children under five years weighed should be recorded in this box. If any child is weighed more than once in a month it may be recorded on the RTH card but is recorded here only once in the month. Note that every child under age five coming to the clinic should be weighed whether he is coming for nutritional services or not. Of those who are weighed how many did not gain weight since the last time they were weighed? This is an important indicator of faltering growth and should be monitored carefully by clinic staff to be sure those not gaining weight have received advice and follow-up. They are not necessary malnourished but simply not growing as expected and some action should be taken, usually advice for more frequent feeding at home. This is not necessarily an indicator to provide nutritional supplements but follow-up of each child is indicated to assure growth recovers.

- Severe malnutrition these are only the cases **newly** diagnosed this month. Any case severely malnourished will surely remain so for several months. These cases should be referred to the hospital for treatment and should not be managed as outpatient treatment in a clinic.

- The number of children in the PEM scheme during the month are those who have received food under the PEM scheme at one or more times during the month. Each child is counted only once in any given month.

6 Immunisations are recorded as they are given. Note that when a child has received all of the primary immunisations before one year he is recorded once and only once in the box “new cases fully immunised before age one year”. It is very unusual for this number to be higher than the number of measles (nine month) or the number of third DPT or third Polio or third HBV. You should check these numbers to be sure they make sense.

Vitamin A supplementation is now provided as part of the immunization program. Newly delivered mothers should receive a dose before their baby reaches 4 weeks of age, preferably given to the mother in the hospital before she is discharged. Check each postpartum mother to be sure that she received this dose – if not give it in the clinic. Only doses given in the clinic should be recorded. A different dose of 100,000 units is given to the child at 6 months (or any time up to 11 months) and a dose of 200,000 is given to older children (at 12, 18, and 24 months in ECape, six monthly in other provinces). Check to see that the doses of vitamin A given are equal to the comparable doses of vaccines at the same ages (eg BCG at birth, 9 month measles and 18 month measles). You may want to graph these together.

GUIDE FOR REVIEWING THE MONTHLY PHC REPORT

7 Tuberculosis

- Suspect TB cases are the number of cases from whom a sputum was taken and sent to the laboratory are counted as suspect TB cases. The clinic should be regularly suspecting TB in any adult with chronic cough. Normally, one would expect at least 1-2% of the adult head count to require a sputum exam. If fewer sputa are sent, the clinic is not adequately seeking new TB patients.
- New TB cases are those diagnosed this reporting month
- All new cases of TB should be urged to have and HIV test. Up to 50% of TB cases also have HIV infection and it is important to treat both conditions.
- TB cases under treatment are those who are carried on the TB register for treatment during the reporting month. This means any case, even if they have been irregular, is recorded here. Do not report those who are cured, died, transferred out or abandoned treatment.

- TB cases under DOTS care was previously recorded, but is no longer collected – all patients with TB should be on DOTS care either in the clinic (desirable) or if not possible, in the community with a DOTS supporter.

8 STDs (also called STIs)

a. New cases treated as STD are any new case treated according to the STD protocol, whether it is truly diagnosed as STD should be recorded here.
b. All new cases of STD should be urged to have an HIV test. HIV is just one form of STI
c. Male urethral discharge is self-evident. These are also included as New Cases above
d. Contact slips should be issued to each patient treated as STD and contact slips issued are probably close to the same number as new cases.
e. Number of contacts treated are any contacts returning with a slip or without a slip who say they are coming back because their partner was treated for STD. Over a period of months the number of contacts treated should equal the contact slips issued.

9 HIV/AIDS – (new data fields in 2003 – these need to be carefully explained and checked more frequently by the supervisor until their definitions and recording are well understood)

- HIV counseling, testing and results are recorded for males and females separately
- Discordant tests (where the two different rapid tests give different results) need to be all checked by a sample being sent to the lab. If many, the test kits need checking by the lab.
- Cotrimoxazole newly started should be the number of new positives who have symptoms – the total receivers is a measure of continuity of care and should be maintained and increasing as new patients are put on prophylactic care.
- PMTCT data fields enable you to track the positive rate in pregnant women, and the proportion of them who accept nevirapene treatment for themselves and their babies. A high rate of acceptance of testing and of nevirapene use by positives is desired.
- Babies of HIV positive mothers should receive either **exclusive** breastfeeding or **exclusive** bottle feeding – mixed feeding is dangerous to these infants
- Infants are tested at one year to see if they are infected – if positive, they should be tested again at 18 months as a few could be false positives at 12 months. When HIV positive mothers have received Nevirapene and given a dose to the baby, then HIV positivity at one year should be less than 10% if bottle fed, less than 15% if breast fed.
- Suspect opportunistic infections are those unusual infections that make one suspicious of underlying immune deficiency – all of these should be counseled to have HIV testing.

10 General patients

Mental health cases are now divided into:

a. Cases of violence against women. Any complaint of violence, physical or mental, would be recorded here.

b. Cases of psychiatric illness are those with psychiatric diagnosis being treated either by a mental health nurse or having been discharged from a psychiatric facility, are coming back for re-treatment of established illness.

c. All other mental health cases are marked, as before, as those cases requiring counselling of some type but are not a psychiatric diagnosis.

Chronic cases are divided into:

- diabetes,
- high blood pressure,
- epilepsy
- all other chronic illnesses (such as arthritis, asthma, etc).

Referred to doctor are **all cases who the nurses refer to the doctor** whether the doctor is in the same establishment, the same building or visiting occasionally, or the patient is sent out of the facility to the doctor. It is assumed that patients see the nurse first and are sent by her to the doctor.

You should discuss any unusual findings, making suggestions to the nurse as how to improve performance or response to any of these reported services.

In cases where numbers look clearly wrong, inspect the register or source of data directly and make concrete suggestions for improvement.

For each facility three to five of these data, or indicators calculated from these data should be monitored in a graphic form on the wall of the clinic. The supervisor can help to set up these graphs and transfer the data to the graphs each month, eventually passing this responsibility on to the clinic staff. Ideas on how to draw graphs, interpret indicators and actions to take are found in the manual for health workers at facility level by EQUITY: *Using Information for Action.*

Feedback on earlier reports from the district office should also be discussed with the clinic staff. And plans made to take action to improve the performance such as immunisation coverage, FP acceptance, STD contact tracing or better TB outcomes. Monitor the results of these actions each month as you review the data returns.

LOCAL ADAPTATION OF GUIDE TO SUPERVISORS OF DHIS MONTHLY STATISTICS

SUPERVISORY CHECKLIST FOR MONTHLY TOTAL SHEET (REGION B)

Check the following:

- Children weighed < 5 years (Block 7) should not be more than total number of children < 5 (Block 4).
- Check that all marasmic children (Block 8) are not automatically recorded as failure to gain weight (Block 10), but only if they are not gaining weight according to the definition in the guidelines. Also make sure that only new cases of marasmus and kwashiorkor are recorded each month and not those that were diagnosed and recorded on total sheets in previous months.
- The total of children fully immunised (Block 62) should not be considerably higher than the measles 9 months (Block 22). There may be some who had DPT3, etc, after having had 9 months measles. If measles 9 months and fully immunised are always the same, please check the clinic records as it is highly unlikely that all children come in the correct sequence for immunisations. If the fully immunised column is much higher than the 9 months measles, check that the person who did the stats understands the definition of "fully immunised". It is common for clinic personnel to tick this column in the tick register when they see that the child has had all immunisations rather than when they administer the last immunisation to the child under 1 year. Block 62 is the sum of blocks 23.1 and 23.2, please check that it has been correctly calculated.
- Check that the Tetanus Toxoid given (sum of blocks 25 – 27) is not higher than the total number of ANC visits (Block 68)
- Block 67 is the sum of blocks 28.1 and 28.2, please check that it has been correctly calculated. Block 68 is the sum of blocks 67 and 29, please check the calculation.
- Check that Wr for ANC's (Block 34) and Rh (Block 33) are more or less the same as the initial ANC visits (Block 67). If they differ greatly, it indicates that the clinic staff are either not taking blood when they should or are leaving this for the second or third visit.
- Wr for STD (Block 35) may be more, but should not be less than the 1st treatment this episode (Block 39). Clients who do not have symptoms of STD'S (eg Some contacts) may have blood drawn and then only be treated when the results come back. All clients who are treated should have blood drawn for STD.
- First treatment this episode (Block 39) should not be more than the sum of blocks 37 and 38. There should also not be considerably more clients in blocks 37 and 38 than in 39 as most STD clients are given complete treatment on their first visit and do not return for follow up. Please ensure that repeat infections are not recorded as follow ups, but as new infections, therefore, should be recorded in block 39. Check the definitions in the guidelines if you are unsure.
- Blocks 69 to 74 are the answers to the figures in blocks 42 to 47 divided or multiplied by the factor to the right. For example: Block 42 is divided by 13 and the answer is recorded in block 69. Block 47 in multiplied by 200 and the answer is recorded in block 73. Block 75 is the sum of blocks 69 to 74. Please check these calculations.
- Total psychiatric cases (Block 50) should only be those that are seen and treated by the clinic staff and not those seen by visiting psychiatric teams such as Komani hospital. Block 76 is the sum of blocks 51 and 52. Please check the calculation.
- Block 77 is the sum of blocks 53.1 to 53.6, check the calculation.
- Block 78 is the sum of 54.1 and 54.2, check the calculation

- If the number of lower respiratory infections in children under 5 (Block 56) is very high in relation to the total number of children under 5 (Block 4) please check that the clinic staff know the correct definition and are only ticking those children whose symptoms comply with the definition.

- Total number of DOTS clients (Block 82) should not be more than the number of TB patients on treatment (Block 79). Make sure that staff are recording the number of clients and not the number of visits in block 80 and 81. The total number of DOTS visits to the facility (Block 83) should look realistic in relation to the DOTS clients seen at the clinic (Block 80). Block 82 is the sum of 80 and 81 – check the calculation.

- If mobile clinic are working according to a schedule then the number of stops planned (Block 84) should remain constant from month to month unless changes are made to the schedule. Ideally, the number of stops planned and the number of stops visited should be the same. If there are major discrepancies, the causes should be checked and corrected.

- Please check that the number of days worked has been correctly calculated according to the definition in the guidelines.

- Block 87 is the sum of blocks 5 and 6, please check the calculation. Block 88 is the sum of blocks 87 and 4. Please check that this has been correctly calculated.

EASTERN CAPE PHC MONITORING FORM

MONTHLY REPORT OF PRIMARY HEALTH CARE ACTIVITIES

		CODE
NAME OF FACILITY		
MAGISTERIAL		
HEALTH DISTRICT		
HEALTH REGION		

MONTH		YEAR	
DATE SUBMITTED			
COMPLETED BY			
CHECKED BY	*(Supervisors Name)*		

1. MANAGEMENT

	COMMENTS
Total headcount – all ages and visits	
Under 5 years	
5 years and older	
DOTS visits to this facility	
Nursing staff days worked	
Supplies/drugs available (append list)	

2. ANTE-NATAL VISITS

First Ante-natal visits	
Subsequent Ante-natal visits	
Pregnant women received tetanus toxoid # 3 or booster	

3. DELIVERIES

Live born in this facility (not outside births)	
Live born in this facility weighing > 2.5 kgs	
Deliveries to women less than age 18	
Stillborn in this facility	

4. CONTRACEPTIVE PROTECTION

Oral pills (cycles)	
Nur-isterate (injections)	
Depo-provera/Petogen (injections)	
IUCDs (insertions)	
Condoms (number dispensed)	
Referred for TOP	

EASTERN CAPE PHC MONITORING FORM

MONTHLY REPORT OF PRIMARY HEALTH CARE ACTIVITIES

		COMMENTS
5. CHILD HEALTH		
Diarrhoea in children < 5 years of age (> 3 loose stools)		
Lower respiratory infection in children (> 50 resp/min)		
Children under 5 years weighed (record only once per month)		
Of those weighed number not gaining weight since last weighed		
Sever malnutrition (> 60% standard weight for age / marasmus / kwashiorkor **newly diagnosed this month**)		
Number of children in PEM scheme during month		
6. IMMUNIZATION		
BCG		
DPT (Hib) [1]		
DPT (Hib) [2]		
DPT (Hib) [3]		
Polio 1		
Polio 2		
Polio 3		
HBV 1		
HBV 2		
HBV 3		
Measles (9 months)		
New cases fully immunised before the age of one year		
Measles 2nd dose		
7. TUBERCULOSIS		
Suspect TB cases (one or more sputa sent)		
TB cases under treatment		
TB cases under clinic DOTS		
TB cases under community DOTS		
8. SEXUALLY TRANSMITTED DISEASES		
New cases treated as STD		
Male urethral discharge		
Contact slips issued		
Number of contacts treated		

EASTERN CAPE PHC MONITORING FORM

MONTHLY REPORT OF PRIMARY HEALTH CARE ACTIVITIES

9. GENERAL PATIENTS

		COMMENTS
Mental Health Cases		
	Cases violence against women	
	Cased psychiatric illness	
	All other mental health cases	
Chronic Cases		
	Diabetes melitus	
	High blood pressure	
	Epilepsy	
	All other chronic cases	
Referred to doctor		
TOTAL HEALTH EDUCATION SESSIONS HELD		

EASTERN CAPE PHC MONITORING FORM

MONTHLY REPORT OF PRIMARY HEALTH CARE

SUPPLIES/DRUGS AVAILABLE

NAME OF FACILITY		**COMPLETED BY**	
HEALTH DISTRICT		**MONTH**	
HEALTH REGION		**DATE SUBMITTED**	

[✓] Tick if an item runs out of stock at any time during the month

No	Description	Out of stock
1	Amoxicillin 125mg/5ml Suspension (75ml)	
2	Test, Glucose in Urine (50 sticks)	
3	Condom	
4	Gloves Disposable, Non-Sterile	
5	IV Giving set (60 drops)	
6	Needle (21G, 22G or 23G) Disposable	
7	Syringe, 5ml, Disposable	
8	Beclomethasone Inhaler	
9	Oral Rehydration Salts	
10	Amoxicillin 250mg	
11	Ciprofloxacin 500mg	
12	Co-trimoxazole 480mg	
13	Doxycycline 100mg	
14	Glibenclamide 5mg	
15	Hydrochlorothiazide 25mg	
16	Mebendazole 100mg	
17	Paracetamol 500mg	
18	Rifampicin/Isoniazid/Pyrazinamide/Ethamabutol 120/80/250mg)	
19	Half Darrows Solution, IV (200ml)	
20	Adrenaline 1/1000 (1ml) Vial	
21	Norethisterone Enanthate or Medroxyprogesterone Injection	
22	DPT/Hib Vaccine (vial)	
23	INH – Rifampicin Tablets	
TOTAL BOXES checked out of stock at any time during the month (record total on PHC monthly form)		

PHC MONITORING FORM

DATA SET DEFINITIONS

Data Field	Data Field Definitions
Total headcount	All individual patients seen during the period (usually month). Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen.
DOTS visit to this facility	The total number of visits to the clinic for DOTS patients that have occurred in the month. These are included in the headcount.
Nursing staff days worked	Number of actual work days by nurses during the period (month). Only days used to handle patients are included. Nursing staff includes professional nurses, clinical nurse practitioners, and enrolled nurses. Nursing assistants, trainees, etc not actually responsible for treating patients are NOT included.
Supplies/drugs out of stock	The number of essential supplies or drugs that were out of stock at least once during the period (month)
First antenatal (booking) visits	The number of first antenatal (booking) visits - only 1 for each pregnancy - during the pregnancy.
Subsequent antenatal visits	All antenatal visits other than first antenatal visits (ie follow-up visits).
Tet Tox 3rd/Booster Dose to Pregnant women	The number of pregnant women with three tetanus immunisations during the pregnancy. Women who have proof of being fully immunised during a previous pregnancy are considered fully immunised after receiving one booster dose of tetanus toxoid during this pregnancy.
Live born in health facility	The total number of live born in the facility. Live born are those babies that cried after birth - all those born and never cried are considered still births. Babies born before arrival (BBAs) or at home are excluded.
Live born in health facility < 2.5 kgs	The number of live born in a health facility weighing less than 2.5 kgs.
Oral Pill cycles	The total number of packets (cycles) of oral contraceptives issued during the period (usually month).
Injectable contraceptives	The total number of Nur isterate injections given. The total number of Depo-provera/Petogen injections given.
IUCDs (loops) inserted	The total number of Intra Uterine Contraceptive Devices (IUCDs) inserted during the period (usually month).
Condoms distributed	The total number of condoms which has been given our or taken from distribution points in facilities or elsewhere (including campaigns in streets, markets, factories, etc). The normal procedure would be to count stock at the beginning of each month. Add the number in stock at the beginning of the reporting month to supplies received during the month, and subtract what was left at the beginning of the next month. The difference is the # Condoms distributed.
Referred for TOP	Any patient who has requested information on TOP and who was referred to a health facility where TOPs can be performed.

PHC MONITORING FORM

DATA SET DEFINITIONS

Data Field	Data Field Definitions
Children < 5 years with diarrhoea	The total number of children seen with diarrhoea. Diarrhoea is formally defined as 3 or more watery stools in 24 hours, but in practice any complaint by the mother that the child is suffering from diarrhoea should be counted as a diarrhoea episode. NB: Only count the first visit for each episode.
Lower respiratory infection in children	Children under age 5 who have appeared at the clinic with a complaint of cough and whose respiratory rate was measured and found to be greater than 50 respirations per minute.
Children < 5 years weighed	All children under five years should be weighed when visiting a clinic, but the child should be recorded only once per month even if they come more frequently (eg for a follow-up visit).
Children < 5 years not gaining weight	Children that have not gained weight compared to the weight recorded at least one month earlier. Only the first visit during an episode of not gaining weight should be counted. Children weighing less than 60% Estimated Weight for Age should NOT be included here, but should be counted under 'Children < 5 years with severe malnutrition'.
Severe malnutrition	Any child diagnosed for the first time with weight less than 60% of the standard or clinical marasmus or kwashiorkor using standard definitions. Each patient so identified should be reported only once in the month of diagnosis.
Number of children in PEM scheme	All children who received food from the PEM scheme one or more times during this month. Each child to be accounted only once during the reporting month.
BCG at birth	All BCG (tuberculosis) vaccines given to newborn babies.
DTP-Hib 1st Dose	All DTP-Hib (Diphtheria/Tetanus/Pertussis-Haemophilus influenzae B) vaccine 1st doses given to children under one year – preferably at around 6 weeks.
DTP-Hib 2nd Dose	All DTP-Hib (Diphtheria/Tetanus/Pertussis-Haemophilus influenzae B) vaccine 2nd doses given to children under one year – preferably at around 6 weeks.
DTP-Hib 3rd Dose	All DTP-Hib (Diphtheria/Tetanus/Pertussis-Haemophilus influenzae B) vaccine 3rd doses given to children under one year – preferably at around 6 weeks.
OPV 1st Dose	All OPV (Poliomyelitis) vaccine 1st doses given to children under one year (previously called TOPV). Trivalent
OPV 2nd Dose	All OPV (Poliomyelitis) vaccine 2nd doses given to children under one year (previously called TOPV). Trivalent
OPV 3rd Dose	All OPV (Poliomyelitis) vaccine 3rd doses given to children under one year (previously called TOPV). Trivalent
HepB 1st Dose	All Hepatitis B vaccine 1st doses given to children under one year (preferably at 6 weeks).
HepB 2nd Dose	All Hepatitis B vaccine 2nd doses given to children under one year (preferably at 10 weeks).

PHC MONITORING FORM

DATA SET DEFINITIONS

Data Field	Data Field Definitions
HepB 3rd Dose	All Hepatitis B vaccine 3rd doses given to children under one year (preferably at 14 weeks).
Measles 1st Dose at 9 months	All measles vaccine 1st doses given to children under one year of age (preferably at 9 months of age). Other doses given to YOUNGER children during an outbreak should NOT be counted here, but 1st doses given to children between 10 and 12 months should be included.
Children fully immunized < 1 year	The total number of children who have completed their primary course of immunisation before the age of one. A Primary Course includes BCG, OPV 1,2 & 3, DTP-Hib 1,2 & 3, HepB 1,2 & 3, and 1st measles dose at 9 months. The child should only be counted as fully immunised when coming for the 9 month measles immunisation AND there is documentary proof of all required previous vaccines.
Measles 2nd Dose at 18 months	All measles vaccine 2nd doses given to children above one year of age (preferably at 18 months).
Suspect TB cases	All cases of TB from whom a sputum, one or more, were sent to the laboratory with a possible diagnosis of tuberculosis. Each patient to be counted only once regardless of the number of sputa sent.
TB cases under treatment	All cases of TB currently active on the TB program of this clinic whether or not they are regular attenders. This excludes patients who have died, been transferred, completed treatment or have been determined to have officially abandoned treatment.
TB cases under clinic DOTS	Cases who have been treated during the month with DOTS in the clinic. Each case so treated to be counted one time in a month.
TB cases under community DOTS	TB cases who have been treated outside of the clinic following a directly observed treatment from any volunteer community member or other person other than within the clinic. Each patient treated under community DOTS to be counted only one time in a month
New cases treated as STD	Any new case presenting as STD or reproductive tract infection that is treated following the STD protocol.
New Male Urethral Discharge	The total number of males presenting with a new Male Urethral Discharge (PUD) - often called "Penile Urethral Discharge".
STD contact slips issued	Number of contact slips issued in relation to new cases treated as an STD.
STD contacts treated	Number of patients with STD symptoms that present as a result of receiving a contact slip.
Cases of violence against women	Any case of complaint by women of violence of any kind, this includes mental as well as physical violence complained of by women.
Cases of psychiatric illness	Any case diagnosed and or treated as a psychiatric disease. Includes follow-up cases discharged from psychiatric facilities as well as cases being followed chronically for diagnosed psychiatric illness.

PHC MONITORING FORM

DATA SET DEFINITIONS

Data Field	Data Field Definitions
All of the mental health cases	Any other case falling under the heading of mental health not included in the two categories above.
All other chronic cases	Any other chronic illness cases seen during the months that require recurring treatment in the health facility not including the three categories mentioned above.
Referred to Doctor	The total number of patients/clients (children and adults) seen by a Professional Nurse or a Clinical Nurse Practitioner for a curative service (diagnosis and treatment) and referred to a doctor. This referral may occur due to diagnostic difficulties or due to the treatment required. The referral might be to a doctor in the same facility or another facility.
Total health education sessions held	Any session provided inside or outside the clinic with an aim of educating the public to issues in health matters.

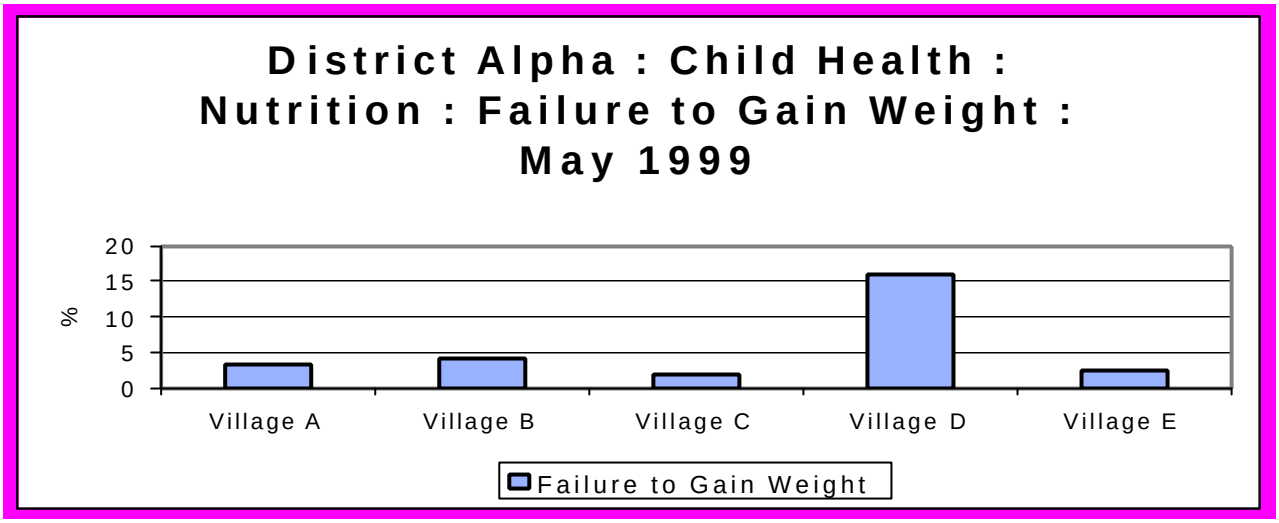
ROUTINE MONTHLY INDICATORS FOR PROGRAM MANAGEMENT

A selected list of indicators are included to support the clinic supervisor and staff in discussing data and determining actions following from the data.

CHILD HEALTH INDICATORS

Name	**Failure to gain weight Rate**
Target	No child should fail to gain weight over the period of one month – continuous growth is a more important sign of good health than attained weight.
Definition	Percentage of children below the age of 5 years who had an episode of growth faltering/failure (failing to gain weight) during the month, or since the last visit if over one month. While each weight may be recorded on the Road to Health Card, a child should NOT be entered more than once in a month for either weighing or failure to gain weight, even if it is weighed more often.
Calculation	Numerator: Number of children < 5 years failing to gain weight
	Denominator: Number of children < 5 years weighed
Rationale	Failure to gain weight, even for one month, indicates early nutritional problem or an acute illness and is the most sensitive indicator of the nutritional well being of individual children or whole communities. This indicator encourages the use of the Road to health (RTH) card and raises awareness of the problem of malnutrition.
Data Source	Each weight is recorded on the Road to Health card, and the register if weight gain is absent. If there is no RTH card available, be very careful. The nutrition register, Tick register, Child health register are less reliable because of potential double counting
Common Mistakes	Children coming back for rehabilitation are often entered more than once in a month. Not all children coming are weighed – if only those who "look malnourished" are weighed, the results will be biased
Actions to consider	Any individual child not gaining weight needs to be put on an "at risk" register and followed closely, with support to the mother both at home and in the clinic. Communities with more than 5 - 7% of children not gaining weight need special nutrition remedial action and nutrition promoting activities in the community.
Graphs	Simple line or bar graph of % children not gaining weight. The village location of those not gaining can be placed on a spot map – if clustered, do outreach to that village or community.
Other possible indicators	Nutrition is classically a field for sample surveys and sentinel site investigation, as routine growth monitoring is seldom accurately done. Yet this is the most sensitive and accurate indicator of child health. % Children under the third centile is a less sensitive indicator of current nutritional situation. This only picks up malnutrition once it is established. If all the weights of the children coming to the clinic are recorded on a large RTH card on the wall, one can easily see how many are MALNOURISHED – that is under the 60% line. Height for age measures stunting (shortness) but this is not a measure of current nutrition – ie the child may have been sick long ago and not grown at that time – thus, this measure is used in surveys to measure long term trends Micro-nutrient deficiency (Vitamin A, Iodine, anaemia) require special surveys to measure. However, mothers of children who are not gaining weight should be reminded to use iodised salt in the home, provide vegetables eggs and meat to assure adequate micronutrients

CHILD HEALTH INDICATORS – continued



Village A, B, C and E have a low rate of children who are failing to gain weight as compared to Village D. Why is Village D's rate so high? Perhaps at present there is a severe food crisis in the area, or mothers need additional support in regards to understanding basic nutritional needs for a family and specifically children. Or perhaps the clinic provided the incorrect data to the district office.

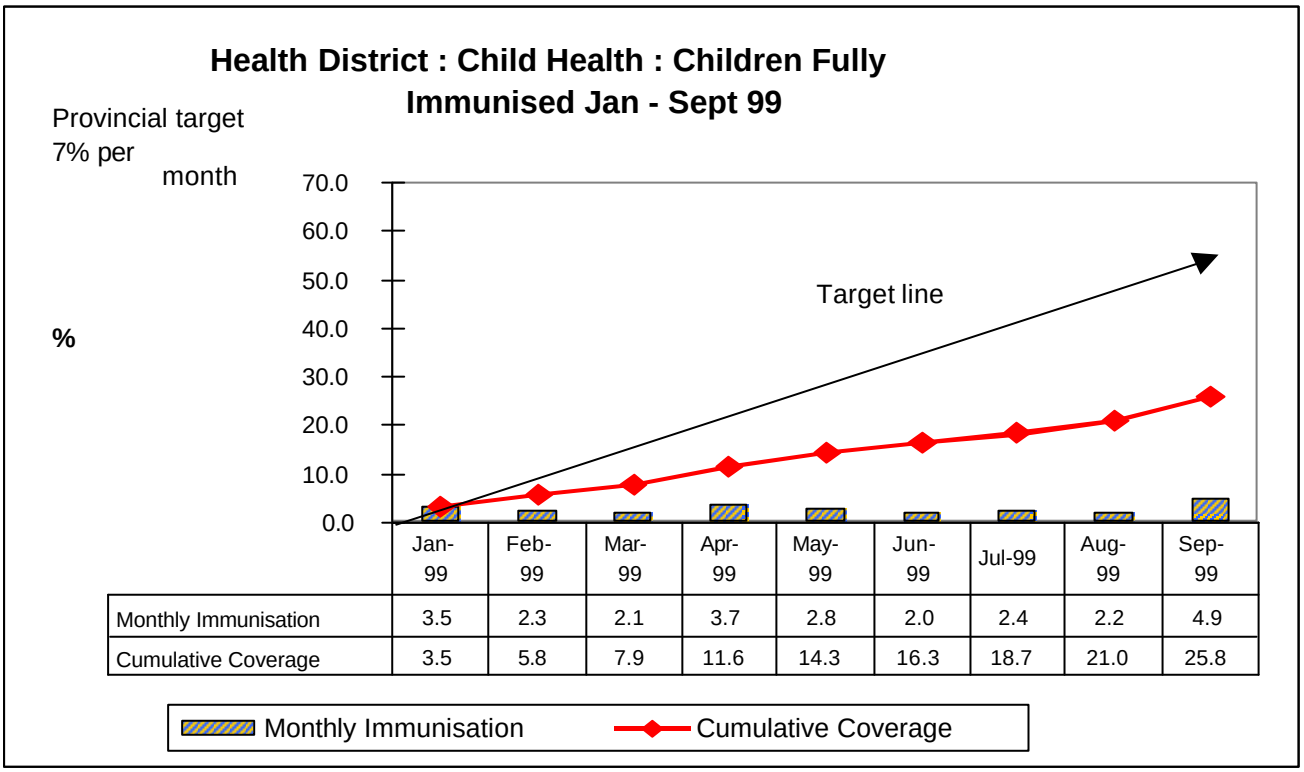
Name	**Severe malnutrition rate (new cases)**
Definition	The proportion of children who are weighed who are newly found to be suffering from Kwashiorkor, Marasmus or have weight under 60% of expected weight for age.
Calculation	Numerator: Number of children < 5 years with new severe malnutrition
	Denominator: Children under Five weighed
Rationale	Severe malnutrition is a failure of preventive services and is the tip of the iceberg representing the larger pool of malnutrition in the community. These children should have been found and nutrition intervention begun earlier.
Normal range	NO children should be severely malnourished. Any severely malnourished child is a danger signal of a big problem.
Common Problems	Most children with severe malnutrition do not come to the health services and die at home Not all children are weighed at clinics
Data Source	Clinic tick register – special register for PEM scheme
Actions to consider	• All children with severe malnutrition should be referred to a hospital • If you find children with severe malnutrition, you should consult community leaders and actively look for other cases in the community
Other possible indicators	Severe malnutrition in the community is measured using the denominator of the total number of children under five, rather than only those weighed Severe malnutrition can be measured by age group to find out which age suffers most from this problem.

CHILD HEALTH INDICATORS – continued

Name	Fully Immunised coverage	
Target	National has set a target of 90% fully immunised children by 1 year of age; the provinces have each set their target and these need to be modified by the district, depending on past performance.	
Definition	The percentage of all children in the target area under one year who have received the full series of primary immunisation prior to reaching age one year. This is usually about the same as measles at coverage at 9 –12 months A full Primary Course of immunisation includes BCG, TOPV 1, 2 & 3, DPT/HIB 1, 2 & 3, HBV 1, 2 & 3, and 9 month measles.	
Calculation	Numerator:	Number of children < 1 year fully immunised – recorded only once for each child on the visit when they received their LAST immunisation shot (usually 1st measles) at the clinic on that day.
	Denominator:	Number of children reaching 1 year of age in the catchment area for the same period of recording as used in the numerator (month, quarter, year to date, calendar year) Use the same period of time for both numerator and denominator
Rationale	Immunisation coverage compares the number of fully immunised children to the number of children under one year old. This indicator is a wide-ranging measure of nursing skills, clinic management skills, transport management, community participation, cold chain and effectiveness of health education.	
Data Source	Register (Tick or immunisation), or immunisation tally sheets Population data children < 1 year	
Common problems	Never count a child twice – only record a child as fully immunised if you yourself have given the final dose on the same day! Counting of children who come back to the clinic after they have previously been fully immunised at your clinic or elsewhere causes incorrect coverage rates. The denominator data may be wrong – be sure you use the denominator period the same as the numerator – also the catchment area of the clinic may not reflect outsiders into the catchment area who use the clinic – check with your supervisor	
Graphs	Cumulative Immunisation coverage graph shows the numbers fully immunised each month, added to the previous months to show the total year to date. Measles and BCG may be graphed on the same graph – This will show achievement of target and dropout rate since BCG starts the series and Measles ends it.	
Actions to consider	A low immunisation coverage needs a review of your immunisation strategy. Communities with low coverage need to be identified and special efforts made to immunise them. Coverage should never be over 100% annually. If your coverage is > 100%, check population figures, make sure children are not being counted twice and investigate outsiders coming into your area.	

CHILD HEALTH INDICATORS – continued

Name	Fully Immunised coverage
Other possible indicators	Monthly immunisation rate is often multiplied by 12 so that the projected picture for the whole year can be estimated. This is the annualised immunisation rate. Measles coverage is a good proxy indicator to compare to fully immunised – normally they are very similar Cold chain performance can be measured by plotting % days the refrigerator is outside the normal range Availability of vaccines is measured using measles stock-outs in the drug list Drop out rate from eg BCG to measles (0-9 months), DPT1 to DPT3 (6 weeks- 14 weeks) and DPT1 – Measles) are useful indicators to assess quality of immunisation. If BCG coverage is much lower than DPT, the hospitals are probably NOT reporting into the DHIS! Measles case incidence is a measure of the impact of your immunisation program



This is an example of a Cumulative Coverage graph which demonstrated the percent of children immunised every month and then adds up the months to show what percentage of children have been immunised after a certain number of months. In order to Fully Immunised at least 80% of Children before they turn one year old, on average some 7% of the children need to be immunised every month. Reasons for poor immunisation levels may include no measles or other vaccine in stock and fridge out of order as examples. Immunisation levels at present in the Eastern Cape just over 60%. Nationally the immunisation level should be 90%. This graph needs to be displayed prominently on clinic walls and updated monthly.

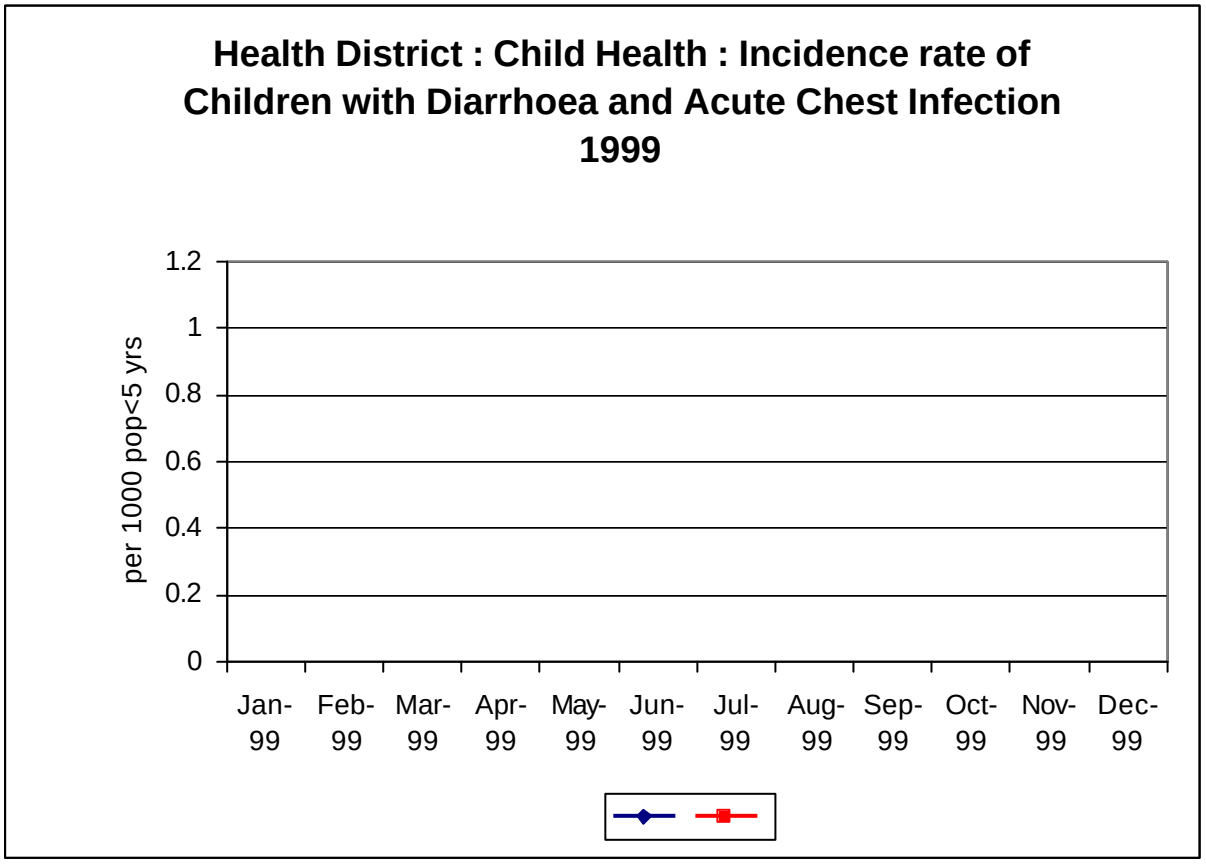
CHILD HEALTH INDICATORS – continued

Name	Incidence of Diarrhoea in children
Target	There are no fixed targets –however, surveys show that you can expect about 3 episodes for each child per year – far fewer come to the facility for treatment. Seasonal variation and intervillage differences are signs of a problem that needs investigation.
Definition	The number of children with new episodes of diarrhoea per 1,000 children under five years in the catchment population. Diarrhoea is formally defined as 3 or more watery stools in 24 hours, but in practice any complaint by the mother that the child is suffering from diarrhoea should be counted
Calculation	Numerator: Number of children < 5 years with diarrhoea Denominator: Number of children < 5 years of age
Rationale	Diarrhoea incidence in children is a sensitive indicator of environmental health and socio-economic conditions. However many cases do not come to the clinic and one has to beware of the "hippopotamus effect" where one sees only the nose of the hippo above water and misses the big animal under water. These children need a special survey to detect them. Need a picture of a Hippopotamus under water
Data Source	Tick register, facility Register, OPD register; Population data - under 5 years
Graphs	Simple bar graph of diarrhoea incidence by month, especially comparing different areas. A spot map is useful to identify outbreaks.
Actions to consider	Treatment with salt and sugar solution in the home will prevent dehydration and death – make sure mothers know this Diarrhoea needs an intersectoral action involving environmental health officers, water affairs and housing ministries as well as fundamental health promotion measures Diarrhoea incidence usually increases in warm months. A rapid increase could indicate an outbreak of dangerous infection such as typhoid, cholera or dysentery. Identify communities with high incidence and investigate the causes with some action research through a community survey – poor water supply, poor personal hygiene or lack of toilets all need health promotion interventions
Other possible indicators	Bloody diarrhoea (Dysentery) is a notifiable disease and should be monitored in all age groups Percentage households with access to potable water or toilets will give a long-term indicator and should be part of Environmental health indicators Community surveys will identify the children with diarrhoea, and the possible causes

Name	Lower Respiratory Tract infection rate (< 5 years)
Definition	The proportion of children presenting who have a respiratory rate of over 50 per minute
Calculation	Numerator: Children presenting with respiratory rate > 50 breaths per minute Denominator: Headcount < 5 years
Rationale	Lower respiratory tract infection is a common killer of children and these deaths can be prevented if the child is given early and appropriate antibiotics.

CHILD HEALTH INDICATORS – continued

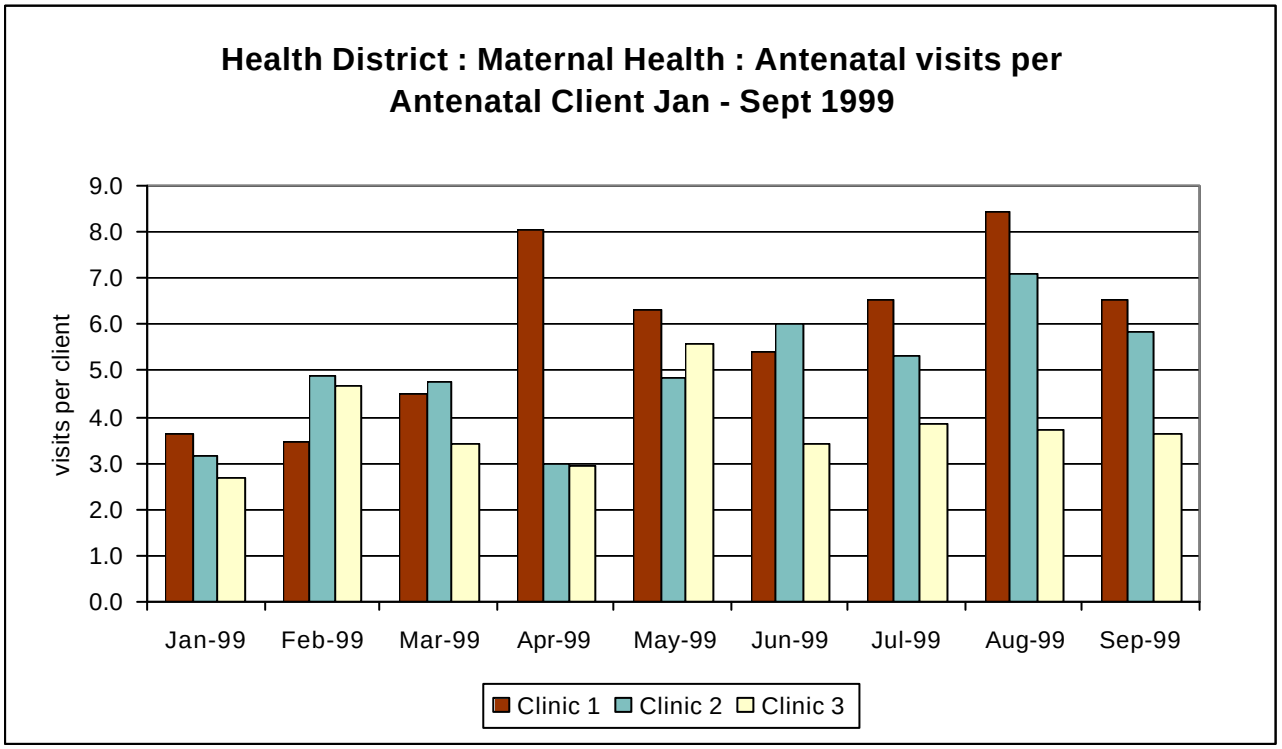
Common Problems	Every child with cough should have her respiratory rate measured to check for rapid respiration. This is the only reliable measure of lower respiratory infection.
Data Source	Clinic register
Graph	Line graph (with other childhood diseases such as Diarrhoea, measles etc)
Actions to consider	High or rising rates of lower respiratory infection mean that there may be some environmental problem affecting the children in their homes. This may be smoke from fires, poor ventilation, rising damp from poor housing or just long, hard and wet winters. Check use of drugs -Number of cases receiving antibiotics for respiratory symptoms should only be these.
Other possible indicators	The incidence of LRTI in the population is obtained if the total population < 5 years is used as a denominator In urban areas, the air pollution index may be linked to increased respiratory infection Make a ratio of number of paediatric cases given antibiotics divided by LRTI. This ratio should not be much over 1.0



Diarrhoea tends to be seasonal with a peak in the summer months with a reduction in winter. Targets can be set that aim at reducing the summer peak to an incidence rate (new cases) of below 20 children per 1000 per month. Lower Respiratory Tract Infection tends to be seasonal with peaks in winter.

MATERNAL HEALTH INDICATORS

Name	Antenatal Care Coverage
Targets	The National target is 90%; the provincial target is 90%
Definition	Percentage of pregnant women attending ANC at least once. This visit should be a 'booking' visits where all initial procedures relating to assessing/preparing a woman for pregnancy and delivery occur
Calculation	Numerator: All first ANC (initial) visits
	Denominator: Total expected deliveries (2.2-3.2% of population) discuss with supervisor.
Rationale	All women should have at least three antenatal visits during a pregnancy. These should start as early in pregnancy as possible.
Data Source	Tally sheets, Registers – either Tick register or maternal health registers Population data – an estimate of the number of pregnant women is close to the number of children born
Common Problems	Women who have started ANC elsewhere, but who come to your facility for follow up should be counted as subsequent ANC and NOT first ANC
Actions to consider	• Low coverage means either the strategy for providing ANC needs to be reviewed to increase access, or the community should be approached to increase awareness • High coverage may mean problems with your choice of denominator.
Other possible indicators	Risk and continuity indicators are important in ANC % Women getting third ANC shows continuity of care WR coverage shows quality of care- this should be taken at first ANC visit ANC referrals shows risk detection (and transport availability) % ANC booking < 20 weeks shows early care



Arthur – this is not a useful graph – better to have cumulative like immunisation for first ANCs

MATERNAL HEALTH INDICATORS - continued

Name	ANC visits per client
Targets	The National target is that 90% of women should have three at least ANC visits
Definition	Average number of antenatal visits by women coming to antenatal care.
Calculation	Numerator: All ANC visits (first and repeat visits all included)
	Denominator: First ANC visits
Rationale	All pregnant women should have at least three visits in each pregnancy. This indicator does NOT measure visits by each woman, but measures the average number of visits.
Data Source	Tally sheets, Registers – either Tick register or maternal health registers
Common Problems	Women who have started ANC elsewhere, but who come to your facility for follow up should be counted as subsequent ANC and NOT first ANC
Actions to consider	Low repeat visits means that there may be problems with the acceptability of the services provided and the attitude of staff needs to be investigated.
Other possible indicators	% Of antenatal clients having three visits (if data is available) % Referred to hospital %WR positive who are treated (important quality measure – should be 100%)

Name	Institutional Delivery coverage
Targets	The National target is 80%; some provincial targets are much lower but some achieve almost 100%. This depends largely on delivery infrastructure, access to transport and customs of the population
Definition	The percentage of deliveries from the catchment population taking place in this reporting health facility under supervision of trained personnel.
Calculation	Numerator: Number of deliveries conducted in this institution in the reporting period
	Denominator: Total expected deliveries in this population for the same time period The number of children under one year is used as a proxy denominator for expected deliveries per year – divide by 12 for monthly estimate.
Rationale	The proportion of deliveries done by the institution is an indicator of accessibility and acceptability of the health services
Data Source	Maternity (delivery) register Expected deliveries is 2.2 –3.4% of population (discuss with supervisor)
Common Problems	Many clinics report deliveries of their clients that occurred in institutions ELSEWHERE. This causes double reporting for they are reported from the place where they actually deliver as well. As most deliveries occur in hospitals, this indicator is really only valid at the district level where all deliveries in all institutions are added together and compared to all expected deliveries in the district population.
Actions to consider	If less than 80% (? 60% in rural areas) of deliveries in the district occur at health facilities, (or with trained assistance), your maternal health services need to be re-examined. The facilities need to be assessed for capacity to provide emergency services

MATERNAL HEALTH INDICATORS – continued

Name	Institutional Delivery coverage
Other possible indicators	Maternal mortality Rate is a district-level indicator which assesses the quality of maternity services – there are so few maternal deaths that each should be thoroughly investigated – MMR in a district is usually meaningless due to tiny numbers Ambulance turnaround time shows how long it takes for a facility to be served by ambulance services and can be monitored and improved % Essential delivery equipment shows how prepared facilities are for doing deliveries

Name	Low Birth Weight rate
Target	Less than 10% of all live births should be under 2,500 grams
Definition	Percentage of live born babies children with a birth weight under 2,500 grams
Calculation	Numerator: Number of babies delivered with a birth weight < 2,500 grams
	Denominator: Total number of live births during the period
Rationale	Live babies with weight of < 2,500 grams may indicate poor nutritional status of mothers, but may be influenced by other factors such as smoking, alcohol abuse, other illness such as TB, HIV or chronic lung or heart disease.
Data Source	Maternity Register
Graphs	Simple line graph of % children with low birth weight. This could be combined with other nutrition indicators eg % children < 3rd centile, children not gaining
Actions to consider	High levels of low birth weight mean poor nutritional status of mothers, which needs comprehensive and integrated nutrition programs and intensive education Each LBW baby needs close follow up at home and weekly weighing till she reaches 5 kgm weight Exclusive breastfeeding is the best diet for LBW babies – help the mother BF
Other possible indicators	Failure to gain weight in < 5 year olds % Children severely malnourished HIV positive rate in ANC mothers

Name	Percentage of pregnant women fully immunised against tetanus
Definition	The percentage of pregnant women fully protected against Tetanus Toxoid, (either through three immunisations or, if immunised during previous pregnancy, a booster dose)
Calculation	Numerator: Number of women fully immunised for tetanus
	Denominator: Total first ANC visits
Rationale	Tetanus is a fatal disease that is easily prevented by sterile delivery practices and by immunisation. It occurs in pockets around the country especially where mothers tend to deliver at home.
Data Source	Tick and Maternity registers. Denominator is from ANC first visits
Actions to consider	The pockets of neonatal tetanus need to be identified, immunisation coverage increased and delivery practices researched and corrected All women coming for first ANC should get a booster or first dose TT

MATERNAL HEALTH INDICATORS – continued

Name	Percentage of pregnant women fully immunised against tetanus
Other possible indicators	% Children born to fully protected mothers is a much better indicator, and easier to collect accurately Neonatal tetanus incidence shows where immunisation and health promotion efforts have failed % Of estimated pregnancies protected by tetanus can be calculated using estimated pregnancies as the denominator

Name	Couple (Women) Year protection rate
Definition	Percentage of women in the community protected by "modern" family planning methods.
Calculation	Numerator: Number of women protected by family planning
	Denominator: Number of fertile age women
Rationale	Each family planning method is effective for different periods – this is a calculated indicator which measures the contribution of each method to protection of the female community
Data Source	The easiest way to calculate this is from the stock cards – note the total outgoing contraceptives for each type. It can also be calculated from the tick register, but this is more work. Fertile women are approximately 20% of total population
Graphs	Cumulative coverage graph of women years protected

Name	Couple (Women) Year protection rate
Actions to consider	Low coverage means that unwanted pregnancies will occur. Increased CYP will occur mainly through health promotion and increases status of women, but will also be increased by Increasing availability of contraceptives to teenagers, working women and other high risk groups Improving the contraceptive mix to include more effective and long-term contraceptives such as injectables, IUDs and sterilisations
Other possible indicators	This indicator is best annualised – ie the months value multiplied by 12 to get a picture of what would happen if this rate continued throughout the year Termination of pregnancy referral rate is an indicator of failed contraception leading to unwanted pregnancies % CYP under 20 years indicates the effectiveness of our coverage of the high risk group of teenagers Method mix is the relative proportion of total CYP provided by each method. It is best visualised as a pie diagram Acceptor rate is a useless indicator which is not much used as it does not measure protection of women

SECTION 5: INFORMATION SYSTEM GUIDELINES

DISEASE INDICATORS

Name	Incidence of Male urethral discharge (New cases)
Definition	The number of **new** cases of Male Urethral Discharge coming for the first treatment of a fresh episode - per 1,000 males over 15 years in the target population. It is also called Penile Urethral Discharge (PUD)
Calculation	Numerator: Number of new male urethral discharge cases
	Denominator: Male population: over 15 years
Rationale	PUD is used as a proxy to estimate all other STDs, as it is a true STD, easily diagnosed, usually has to come for treatment and responds well to syndromic treatment. Many of the other STD symptoms may actually NOT be STDs and to include them overestimates STDs. Changes in PUD are the best measure of changes in new cases of all STDs
Data Source	Tick register and Males (± 20%) in the total Population
Actions to consider	High Penile discharge rates are indicative of unprotected sex and will only be reduced if condom usage is improved and health promotion messages about safe sex are adhered to.
Other possible indicators	Reproductive tract infection rate. The Incidence of all STDs treated syndromically will give a less sensitive indicator of the true incidence of STDs in the community, as not all of these will be true STDs (eg vaginal discharge is most often NOT sexually transmitted) Condom utilisation rate will show how much sexual activity is protected Ratio of PUD to all STDs will show the proportion of "all" STDs that are attributed to PUD

Name	STD Contact tracing rate
Definition	The percentage of STD contacts who are treated at the facility, either coming with contact slips or saying that they were told to come by their partners
Calculation	Numerator: Number of contacts treated
	Denominator: Number of contact slips issued
Rationale	The percentage of STD contacts coming for treatment is a good indicator of the quality of the health promotion component of the STD program
Data Source	The numerator will include the number of contact slips that are returned to a facility AND the contacts who come saying they want to be treated
Problems	Some patients will have their cards issued at your clinic, and their partners will go elsewhere for treatment… and others issued by other clinics will come to you if you are good!
Actions to consider	A low rate (< 80%) means that clients have not had adequate health education about the need to get their partners treated. This needs clear messages to be taken into the community, particularly amongst the high risk groups
Other possible indicators	Condom utilisation rate will show how much sexual activity is protected Incidence of PUD – a dropping PUD rate will show that the contact tracing is working effectively

DISEASE INDICATORS – continued

Name	Mental health case load
Definition	The percentage of total headcount that are presenting with mental health problems.
Calculation	Numerator: Number of clients who have mental health problems
	Denominator: Total headcount
Rationale	This shows the proportion of mental health patients in the facility
Data Source	Registers
Actions to consider	If this is high or low, the definition of "mental health patient" needs to be reviewed and health workers educated accordingly
Other possible indicators	Incidence of new cases shows the incidence Referral rates show how many clients are considered to be beyond the scope of the facility % Patients seen by specialist psychiatric services shows how much of the mental health services have been decentralised to local nurses
Definition	Percentage of clients attending the clinic for chronic conditions

Name	Chronic care case load
Calculation	Numerator: Number of clients with chronic illnesses
	Denominator: Headcount > 5 years (chronic illness in young children is rare)
Rationale	This shows the proportion of chronic care patients in the facility. These may be divided according to category – eg Diabetes, Hypertension, Epilepsy, Arthritis, Chronic Obstructive Airways Disease etc
Data Source	Registers – these need to include detailed disease categories
Actions to consider	Low chronic care caseloads show that the facility is not providing comprehensive care. Staff should be trained and medicines provided. High case loads will need careful assessment of type of medicines used, as chronic care is very expensive, and costs can be reduced by rational prescribing
Other possible indicators	Incidence of new cases put on treatment shows the incidence of new clients coming for treatment Population rates for specific chronic diseases (eg Psychiatric illness, Diabetes, Hypertension, Epilepsy) will show the proportion of chronic diseases coming for treatment Proportion of each chronic disease coming for treatment is clearly shown in a pie diagram. Proportion of facilities stocking chronic medicines will show where chronic diseases can (or can not) be treated Referral rates show how many clients are considered to be beyond the scope of the facility % Chronic patients seen by doctors shows how much of the chronic disease services have been decentralised to local nurses

DISEASE INDICATORS – continued

Name	Percentage of referrals made to the doctor
Definition	The proportion of all the clients coming to the facility who are actually referred to the doctor
Calculation	Numerator: Number of referrals to doctor
	Denominator: Total headcount
Rationale	To assess the proportion of cases seen by doctors. Normally nurses can deal with 90% or more of all cases
Data Source	Tick registers, other registers or tally sheets
Actions to consider	A high referral rate means that nurses are not being used to their full potential, and this is very expensive
Other possible indicators	Ratio of patients seen by doctor and nurse Type of doctor referred to eg Hospital doctor, District surgeon, specialist Referrals to other higher level Internal referrals compared to external referrals

Name	Tuberculosis suspect rate
Definition	Proportion of clients who are suspected of having TB and whose sputum is sent for sputum tests
Calculation	Numerator: TB suspects with sputum sent
	Denominator: Headcount over five years
Rationale	TB is an epidemic in south Africa and needs to be actively looked for in the community by sending sputum for testing. All patients with a cough for over a month or weight loss need to be tested
Normal range	0.5% of all adults in the community have TB, at least 1-2% of those coming to the clinic should be tested – this indicator should be at least 2% of the headcount > 5 years
Common Problems	Suspect TB cases are not sent for TB sputum examination When sputa are sent, results do not come back
Data Source	TB register, or some tick registers
Actions to consider	Low rates of suspect tracing shows that staff are not looking for TB, and need to be encouraged
Other possible indicators	Population suspect TB rate is the proportion of the adult population who is sent for TB sputum examination

DISEASE INDICATORS – continued

Name	DOTS treatment rate
Definition	Proportion of TB patients who are treated using DOTS
Calculation	Numerator: TB cases under DOTS (community and facility based)
	Denominator: Total TB cases under treatment
Rationale	This shows the proportion of TB cases who are on first-line pulmonary TB treatment in the community and at the clinic
Normal range	At least?? 75%? Of your TB patients should be on DOTS, and the majority of these should be on community DOTs
Common Problems	Community DOTS patients are often not counted
Data Source	TB register
Actions to consider	A facility with low DOTS treatment rate < 60% needs to review its TB strategy and try to increase DOTS usage
Other possible indicators	Proportion of community based DOTS patients compared to clinic- based DOTS…. The higher this is, the better your TB control program TB case finding – if this reaches 0.5% op population you will have a heavy burden of TB treatment that can best be handled by DOTS

Name	Health Education session rate
Definition	Proportion of population served by health education messages
Calculation	Numerator: Number of health education sessions
	Denominator: Total population served
Rationale	This is a crude indicator of intensity of health education efforts
Normal range	Every person in the population should be reached every time they come for services at the facility – ie Health education sessions should = headcount plus community based health promotion
Common Problems	Definition of a "health education session" is almost impossible – any formal effort to gather listeners and discuss or demonstrate issues in health can be considered health education session. An individual patient interaction is not considered a health education session for this purpose.
Data Source	Health education register
Actions to consider	Look for a better indicator for health promoting activities
Other possible indicators	Proportion of target groups who are actually doing what they have been "educated to do – eg providing ORS to children with Diarrhoea, using condoms, reducing weight etc

MANAGEMENT INDICATORS

Name	Essential supplies/drugs out of stock
Definition	Percentage stock out of items on the drug list approved for the facility that were out of stock at least once during the month.
Calculation	Numerator: Number of items ever out of stock during the month
	Denominator Total items on drug list for this facility (may be individualised)
Rationale	This is an indicator of the overall effectiveness of the essential Drugs program, using the chosen drugs as a proxy indicator of all the drugs in the EDL
Data Source	The list of indicator drugs is placed on the door of the pharmacy/store room and any drug out of stock is ticked whenever it is not available –it is not necessary to record the number of days out of stock – once is enough to show the stores of this drug were inadequate
Common problems	Facilities that do not stock the full range of PHC drugs – eg local authorities who do not have chronic drugs, facilities that do not do immunisations need to reduce their denominator to the number of indicator drugs that they stock regularly
Actions to consider	The drug procurement cycle needs to be assessed – is the problem with ordering, supply, distribution, storage, prescription or dispensing?
Other possible indicators	The length of time the various drugs have been out of stock (eg < 1 week, > 1 week) Proportion of facilities who do NOT stock the full range of 30 drugs shows where comprehensive services are NOT provided

Name	Nurse workload
Definition	The number of patients seen per nurse per working day. Nurse is any nurse providing clinical services to clients, regardless of rank
Calculation	Numerator: Total headcount
	Denominator: Nursing staff days worked
Rationale	This indicator is a useful way of calculating how hard staff in a facility, program or district are working. Nurses are expected to see a certain number of patients each day. This number varies according to the type of job the nurse is doing, but should be from 25-40
Common Problems	The concept of nursing days can cause confusion at first …. The simplest way is to include ALL nurses, regardless of category who work an 8-hour daytime shift. Confusion arises With facilities providing 24 hour or 7 days a week shifts – only the day shifts during the weeks should be counted With nurses doing administrative duties or attending courses and meetings – only the time actually spent with patients should be counted With hospital OPDs – only nurses working the DAY shifts and doing PHC duties should be counted – the rest are counted in OPD duties
Data Source	Attendance register and headcount
Actions to consider	If workload at the facility is high, managers should consider transferring staff from facilities with workload to that facility

MANAGEMENT INDICATORS – continued

Name	Nurse workload
Other possible indicators	Nurse workload can be broken into different categories eg Enrolled nurse / nursing assistant, clinical nurse practitioner etc. Other non-nursing staff can be included in workload eg clients per doctor, physiotherapist, social worker or any other health worker category – Adjusted workload for DOTS. This adjusted workload counts 4 DOTS patients coming to the clinic as one regular patient, on the assumption that daily DOTS visits should take little time. The headcount has the number of DOTS patients divided by four, as these are a special type of headcount Workload by service – if the number of working days and headcount are known for any particular service, workload can be compared across facilities

Name	Utilisation rate	
Definition	The number of people coming for services out of the total population	
Calculation	Numerator:	Headcount (may separate under five or over five)
	Denominator:	Population (under five or over five years)
Rationale	This indicator shows the degree to which the population is using the services provided – monthly rate multiplied by 12 gives the annualised rate – number of visits per person per year. This is expected to average about 3 visits per person in the population each year	
Normal range	This varies considerably, but on average children under five need approximately four visits per year, and adults less – about two per year	

Name	Utilisation rate
Common Problems	Population estimates of catchment may heavily influence this indicator – very low or high values should lead to reassessment of effective catchment population
Data Source	Headcount is obtained from the clinic register; Population from the census
Actions to consider	A low utilisation rate shows that the population is not using the services offered, and the cause of this non-use must be identified A high utilisation rate also needs to be investigated. Does the community have a poor health status and need frequent health service support, or are they perhaps being over-serviced?
Other possible indicators	Consultation rate can be calculated for any group of people which you know the size of both numerator and denominator – for example women, teenagers

Name	Violence against women rate
Target	NO person should have violent acts committed against them – sadly this is not the case in South Africa today
Definition	Proportion of women who have violent acts of any kind perpetrated on them

MANAGEMENT INDICATORS - continued

Name	Violence against women rate
Calculation	Numerator: Number of reported cases of violence against women
	Denominator: Total female population over 15 years
Rationale	Violence against women is a serious problem in South Africa and needs to be exposed and monitored – cases should be reported to the police
Common Problems	Most violent acts against women never get to health facilities Health workers do not look for these problems and regard it as "normal"
Data Source	Facility registers
Actions to consider	Any act of violence, particularly against women, is unacceptable and should involve community health fora, security services and community based organisations designed to help prevent violence and to protect women
Other possible indicators	Interpersonal violence rate shows rate of violence on people of any gender Proportion of women referred for violence Rape rate – a particularly viscious form of violence – special procedures required

SECTION 6

REFERRAL SYSTEM GUIDELINES

Revised date: 3 February 2003

SECTION 6: REFERRAL SYSTEM GUIDELINES

INTRODUCTION

A fundamental principle of Primary Health Care (PHC) is the close relationship between all levels of the health care system, starting at the community extending upward to clinic, health center and district hospital and beyond. Each patient is therefore connected through a seamless continuum of services and should arrive at the appropriate level capable of giving optimal health care for any given problem. This assures that the most common and often important measures are available nearest to home and convenient to each citizen. Through a smoothly functioning referral system, the patient can arrive at higher levels where more specialized medical professionals as well as diagnostic and therapeutic tools are available. Thus the referral system is an integral part of PHC.

Effective referral requires clear communication to assure that the patient receives optimal care at each level of the system. Because the patient is moving between facilities it is the role of the supervisor to assure that this movement is facilitated and that proper communication accompanies it in both directions: upward, describing the problem as seen at the lower level facility and requesting specific help and, importantly, information back to the lower level facility describing the findings, the actions to be taken and the follow up needed.

The referral form is designed to facilitate communication in both directions although effective referral can occur with written communication on the patient held record or any other convenient paper. Every patient referred upwards should be accompanied by a written record of the findings, the questions asked, any treatment given and specific reasons for referral and expectations from the lower level facility. Such communication should accompany the patient (usually carried by the patient) and a clear designation of to which, facility the patient is being sent. Once the patient is seen and receives the attention at the higher level facility, back referral to the original facility is of vital importance. This communication contains answers to the questions posed with specific findings, special investigations, diagnosis, treatment offered and follow up expected from the lower level facility. The back referral may be written in the patient held record, but is most usually on a separate piece of paper, which should be delivered by the patient to the clinic, but may also be sent by fax or mail to the clinic.

The weakest part of this communication is generally back referral from the higher level facility. This communication not only assures proper patient care and follow up, but importantly provides continuing education to the lower level facility and their staff. The supervisor should assure that such communication occurs and in its absence actually pursue the medical officer at the higher level facility to seek proper back referral information.

The supervisor should review all referrals made from the clinic upwards each month for the appropriateness of the decision to refer. Usually between 5 and 10% of patients seen in the clinic will be referred to a higher level for either diagnostic or more specialized care. The supervisor should discuss referred cases:

- Identifying those which should have been properly treated at the clinic itself without referral
- But also identifying cases which should have been referred but were handled locally.
- An important role of the supervisor is to discuss the back referrals received to determine whether the information is adequate and being acted upon by the clinic.

This form of continuing education can be stimulated and reinforced by discussion with the supervisor to enable the clinic to progressively take over the greater responsibility for many of the cases. Continuing treatment of chronic cases such as diabetes, hypertension, epilepsy and psychiatric illness is particularly important and assures not only high quality of care for the patient, but also greater convenience and less burden on the higher levels of the system.

A monthly review of referrals upward and back referrals received is an important supervisory function. Additionally the supervisor should follow up cases that have been referred with no feedback received to assure that they arrive at the higher level and to determine what actions were taken and follow up needed at the clinic.

REFERRAL FORM

From										
Address of health facility										
Tel arrangements made	Y	N	Tel No		Fax No					
To					Date					
Patients Name										
Identity No				Age		Sex	M	F		
Address										
History										
Findings										
Treatment given										
Reason for referral										
Name					Signed					
On completion of management of patient please fill in and detach the referral back slip below and send with patient or fax or post										

Tear off ✂ ----------

From Facility			Tel No		Fax No					
Reply from (name)					Date					
To referring person										
Address of health facility										
Patients Name										
Identity No				Age		Sex	M	F		
Address										
This patient was seen by				on						
Patients History										
Physical Findings										
Special Investigations										
Diagnosis										
Treatment / Operation										
Medicines prescribed										
Please continue with (meds, Rx, f/u, care)										
Refer back to				on						

SECTION 7

GUIDE TO USE OF STG'S

Revised date: 3 February 2003

SECTION 7: GUIDE TO USE OF STG'S

INTRODUCTION

The correct application of standard treatment guidelines is of great importance to ensure high quality care. The National Department of Health has provided service providers with a number of STG's to support them in their work. There are specific programme STG's – management of STD's, management of pulmonary TB. Additionally, staff have been provided with a booklet to support the clinical management of patients; **PHC Standard Treatment Guidelines and Essential Drug List, 1998 (Green Book).**

CS's have an important role to play by ensuring that clinic staff follow STG's for conditions treated at the clinic level. By ensuring the use of STG's we know that our clinic staff will;

- Diagnose correctly
- Treat their patients with the correct drugs.
- Give correct non-drug treatment of many conditions
- Refer patients in an appropriate and timely way for higher level care when necessary.

HOW DO WE GET STAFF TO USE THE STG'S?

1. By ensuring that each clinic nurse and doctor who prescribes treatment have a "**Green Book**" on their desk.

2. By ensuring that staff use the "**Green Book**" – does the book look new or does it look as if it is being used (well paged)

3. By supporting staff in the use of the "**Green Book**". It is proposed that during a supervisory visit, the CS will select five interesting cases from the clinic register and through using the "**Green Book**" assess the appropriateness of management of each of the five conditions. The CS will be able to support the STG review with"Clinical Tips" where they are available for the specific condition reviewed.

   By getting staff to use the "**Green Book**" we can make a great difference to the quality of care we provide at the clinic.

SECTION 8

COMMUNITY PARTICIPATION GUIDELINES

Revised date: 3 February 2003

SUPERVISORY SUPPORT FOR COMMUNITY PARTICIPATION IN PRIMARY HEALTH CARE

Supervisors realise that community involvement in health is an essential element of primary health care and that the interaction between a community health committee and a clinic must be stimulated and monitored. The Eastern Cape Supervisory Checklist, developed in collaboration with the EQUITY Project, encourages supervisors to review clinic-community interaction each month. The following section is an extract from an EQUITY publication, **Strengthening Community Participation in Health** and includes the tools used by Community Health Clinics (CHC's) to evaluate their own functioning.

After EQUITY Project facilitators held focus group discussions with supervisors in Elliot and Umtata Health Districts, supervisors were asked to write down what they thought to be the ten most important aspects to supervise in each programme area. One of the areas noted was community health work.

Elliot District supervisors listed the following areas related to CHC activities to be covered in supervisory visits:

- Are health committees established and meeting regularly with staff? Are relevant stakeholders involved? Are records kept of meetings?
- Are community health workers (CHW) used appropriately and do they receive in-service training?
- Is the community aware of the availability of health services?
- Support and encourage projects involving communities and clinic staff. Are clinic staff involved in these?
- Is the community involved in the organisation of, preparation for and participation in Health Days, eg, preparing community dramas on AIDS?
- Ensure that there are open lines of communication between clinic staff and communities, eg by attending community-based meetings and ensuring the clinic has a complaints box.
- Is there a response to problems identified from the community with regards to health services in general and the clinic services in particular?
- Ensure that notices of important events are appropriately advertised.
- Invite participation in the mapping process.
- Encourage the involvement of youth groups in HIV/AIDS awareness creating campaigns.
- Ensure that communities develop insights into new health issues (eg HIV/AIDS). Do these committees have a chance to learn about the conditions, discuss them openly, and do they influence health messages?

SUPERVISORY PROCESSES FOR COMMUNITY PARTICIPATION IN PRIMARY HEALTH CARE

In Umtata Health Districts, there was a similar process of discussion with supervisors and it became clear that linkages of clinic with community differ between urban and rural areas. In urban Umtata there is a clear link between health services and the community through the clinic committee or the community health committee, - as they are called in some areas. All communication passes through the clinic committees to the community and vice versa. This committee has extensive powers, and will even veto new staff appointments. In rural areas these committees exist and clinic staff take part in community meetings arranged through the village headmen. Community matrons will often join these meetings to provide input. Health staff in rural clinic areas have links to their communities via two mechanisms: through the clinic committee and through participation in community meetings.

The items which supervisors check on in relation to community participation were similar to those in Elliot District but they added a few new facets:

- Are the objectives of the committee feasible and relevant and does the committee need support?
- Is there a system for the CHW to report to clinic nurses? What is the relationship between CHWs and the committee and do they cooperate?
- Are there community development projects in which nurses are involved and have the nurses arranged training for those involved and is this training done locally?
- Is the community aware of other disciplines and departments involved in health, such as Departments of Water Affairs and Forestry, Social Welfare, and Housing.
- Are support services provided by communities to clinics, such as the supply of water, assistance with transport, or providing watchmen for clinics?
- Are changes in clinic services or new policies shared and explained to the community?
- Are new staff introduced to the community?

THREE TOOLS FOR INCREASING COMMUNITY HEALTH COMMITTEE CONTRIBUTION TO IMPROVE PHC

CHECKLIST 1

Roles and Activities of Community Health Committees

In meetings held with existing community health committee, committee members expressed a desire for guidance on their role and so a checklist for this was designed by the EQUITY Project. The checklist includes the following key points: the committee should discuss each point with the clinic as a partner; then indicate which roles they accepted, which they could not or would not accept, and which ones should be considered for the future. Comments should also be included for future reference. After completing the exercise, the committee should inform the community members of the roles they have accepted. The tool is shown in the Annex.

CHECKLIST 2

Rapid Situation Assessment by Community Health Committee

This checklist is intended for use in discussions between the community and the clinic staff leading to community action to address identified problems. The checklist answers should form the basis for further discussion. These discussions should include an analysis of what was found, the reasons for the finding followed by the development of a plan of action to improve matters. (This is the "Triple A Cycle" of assessment, analysis, and action). Periodic review of the key issues identified will also serve to document progress and identify further action for joint work and improvement.

CHECKLIST 3

Community Health Committee Assessment of Community-Based Health Care for different Life Stages

At each stage of life, critical expects of health determine present and future well being. This checklist identifies important aspects of health in the community at each life stage:- pregnancy, delivery, infancy, preschool, school, adolescent, adult and elderly. This tool is long. Committees using it need to understand the importance of life stages and how each can strengthen or weaken an individual for subsequent stages. For example, it is easy to understand that what happens in utero during pregnancy and what happens during delivery are two critical stages that can lead to a healthy or a damaged infant. Discussion of the stages of life can establish connections. For example, unsafe sex in adolescence can lead to infection with HIV and death from AIDS as an adult, or passing the infection to the next question during childbirth. As the checklist is so long, it is suggested that one or two stages be covered in each meeting. Also it is suggested that in each life stage only one or two items be prioritised for community health committee action. Prioritisation should be based on urgency of problem, number of people affected, the serious consequences for health if the problem is not addressed, the committee's ability to tackle problem with existing resources, and sustainability of action.

CHECKLIST 1

THE ROLE AND ACTIVITIES OF THE COMMUNITY HEALTH COMMITTEE

HEALTH COMMITTEE			
DISTRICT		**DATE**	

[✓] Tick if already included if not or if it could be included and add comments as appropriate

1.	To facilitate working together of existing community based health activities (eg NGO, CBO, Health, other Sectors such as Education, and private enterprises) **Comments**	Yes	No	Could be
2.	To identify felt needs for more health/work such as recruiting volunteers for DOTS **Comments**	Yes	No	Could be
3.	Guiding the clinic on how to be more accessible and meet more of community felt needs, for example, possible changes in clinic hours. **Comments**	Yes	No	Could be
4.	Initiate health and environment related projects and activities with community participation eg, periodic collection of rubbish and plastic bags, or water/sanitation project **Comments**	Yes	No	Could be
5.	Attend periodic meetings with health staff to discuss mutual concerns **Comments**	Yes	No	Could be
6.	Initiate and support nutrition projects (eg for schools and old people) **Comments**	Yes	No	Could be
7.	To provide a channel for a flow of health information from the clinic to the community **Comments**	Yes	No	Could be
8.	Assist by providing "grassroots" information on needs for planning the health services for the community. **Comments**	Yes	No	Could be

CHECKLIST 1

THE ROLE AND ACTIVITIES OF THE COMMUNITY HEALTH COMMITTEE

[✓] Tick if already included if not or if it could be included and add comments as appropriate

		Yes	No	Could be
9.	To be advocates for positive behaviour change to improve health in the community – even on sensitive issues eg, not drinking alcohol during pregnancy, giving up smoking, safe sex and use of condoms.			
	Comments			
10.	Identify under served groups in the community and areas, which have difficult access to the clinic services.			
	Comments			
11.	Identify high risk families in the community e.g, unemployed widows with small children			
	Life types			
12.	Organize health days relevant for community and participate in them (eg AIDS day)			
	Comments			
13.	Keep register of disabled children or people needing periodic home visits by community health workers (Nompilo) or nurses			
	Comments			
14.	Liase with health groups, NGO and other committees, eg District council, Hospital board, District health forum			
	Comments			
15.	Notify outbreaks of disease or unusual conditions (eg Dysentery)			
	Comments			
16.	Work with other government sectors to improve environment eg Department of Water and Forestry, Agriculture			
	Comments			

CHECKLIST 1

THE ROLE AND ACTIVITIES OF THE COMMUNITY HEALTH COMMITTEE

[✓] Tick if already included if not or if it could be included and add comments as appropriate

17. Provide certain types of non-professional support to local clinics eg

Cleaning service	Yes	No	Could be
Guard service	Yes	No	Could be
Ground improvement eg garden	Yes	No	Could be

Comments

18.

Manage minor repairs and maintenance	Yes	No	Could be
Manage or supervise CHW (administrative supervision)	Yes	No	Could be
Contribute to directly observed treatment of TB, follow-up of chronic cases	Yes	No	Could be

Comments

19. Other: does the committee know about the National Patients Rights Charter and does it help to see that it is observed? (There should be a poster and pamphlet about this charter in every clinic).

Yes	No	Could be

Comments

CHECKLIST 2

FOR RAPID SITUATION ANALYSIS BY COMMUNITY HEALTH COMMITTEE

Note: This rapid situation analysis should be participatory with all members of the committee taking on active part assisted where necessary by the clinic staff. This checklist is only an indication of the possible questions and investigations and it should be altered and expanded as necessary by the committee.

COMMUNITY NAME		**DISTRICT**	
CLINIC NAME		**DATE**	

Number and names of villages served by clinic: *(add distance in Km and/or minutes walking and also population estimate)*

Committee helped clinic construct map YES ? NO ?
Usual opening time of clinic
Usual closing time of clinic
Variations within week on times open
Problems in reaching clinic

THE CLINIC PROVIDES DAILY		
Health education	Yes	No
Child prevention and promotive care (immunization, nutrition)	Yes	No
Child curative care	Yes	No
Adult curative care	Yes	No
Antenatal care	Yes	No
Maternity care delivery	Yes	No
Family planning	Yes	No
Mental health	Yes	No
Chronic disease care	Yes	No
A good supply of health information pamphlets and posters in Xhosa is always available	Yes	No
Other (specify)	Yes	No

Attitude of clinic staff (*give example*)

Attitude of community members to health care facility and the staff *(give examples)*

Comment on cleanliness of clinic

Can condoms be easily obtained without embarrassment at this clinic? Yes ? No ?
The committee is always informed about staff changes at the clinic Yes ? No ?

CHECKLIST 2

FOR RAPID SITUATION ANALYSIS BY COMMUNITY HEALTH COMMITTEE

Are nurses always there during clinic hours?	Yes ?	No ?
Are nurses always there after clinic hours?	Yes ?	No ?
Is staff quarters available?	Yes ?	No ?
Can a patient see the same nurse each visit?	Yes ?	No ?

Waiting time before being attended to: _____

Total time usually spent on one visit: _____

Time taken for ambulance to be called in an emergency: _____

Services needed but not offered at clinic:

_____

_____

_____

The clinic is practising Batho Pele:	Yes ?	No ?
There is a complaints box at the clinic:	Yes ?	No ?
Complaints are dealt with promptly:	Yes ?	No ?
Is there a poster or are pamphlets available on the National Patients Rights Charter	Yes ?	No ?
Does the clinic provide a healthy and safe environment?	Yes ?	No ?
Are the health care providers known by their names?	Yes ?	No ?
Are patient-held records in use?	Yes ?	No ?
Is counselling available on reproductive health and HIV/AIDS?	Yes ?	No ?
Are patients treated with dignity and respect?	Yes ?	No ?

Clinic Health Committee

Complete table

AGE	WOMEN	MEN
16 - 25		
26 - 45		
46- 65		
66 +		
Chairperson		

Community structures represented

_____

_____

Frequency of meetings _____

Do clinic staff attend meetings _____

Major community-based activities in which committee participates:

ACTIVITY		
Work with clinic staff on measles/polio campaigns	Yes	No
AIDS/STD/Sexuality Education	Yes	No
Community mobilization for DOTS	Yes	No
Dealing with conflict/violence/rape/child abuse/substance abuse	Yes	No
Community initiated water and sanitation projects	Yes	No
Child weighing and feeding	Yes	No
Community Gardens	Yes	No
Environmental cleaning	Yes	No
Poultry	Yes	No
Drainage and tree planting	Yes	No
Pig keeping	Yes	No
Youth health projects	Yes	No

CHECKLIST 2

FOR RAPID SITUATION ANALYSIS BY COMMUNITY HEALTH COMMITTEE

IF THERE ARE COMMUNITY HEALTH WORKERS (NOMPILO) COMPLETE FOLLOWING SECTION

Community health workers (CHW) (Nompilo) Yes ? No ?
Name each village and give number of CHWs in each

Trained by

Selected by community: Yes ? No ?

Acceptance by community, describe:

Consultation with CHW after hours possible: Yes ? No ?
Remuneration through community: Yes ? No ?
Details of remuneration or incentives:

Clinic staff regularly support to CHW includes following:

Major activities and achievements of CHW:

CHECKLIST 3

FOR COMMUNITY HEALTH COMMITTEE TO ASSESS *COMMUNITY BASED* HEALTH CARE FOR DIFFERENT LIFE STAGES IN THE COMMUNITY

COMMUNITY NAME		**DISTRICT**	
CLINIC NAME		**DATE**	

[✓] Tick relevant column

PREGNANT WOMEN	**Yes**	**No**	**Could be**
Are pregnant women provided with information on warning signs of serious complication (headache, bleeding)?			
Are they provided with education on breast feeding and foods needed in pregnancy?			
Do community Health Workers (CHW) refer pregnant women to clinic and keep a list of expected births?			
Do traditional healers and traditional birth attendants refer pregnant women to clinic for blood test and injections (Tetanus Toxoid)?			
Does the community have arrangements for emergency transport of women in labour and about to deliver?			
DELIVERY	**Yes**	**No**	**Could be**
Do traditional leaders, traditional healers, CHW and mothers report home deliveries to nearest clinic?			
Are women who delivered at home visited by health workers?			
Are traditional birth attendants able to get training at clinic if they have been delivering many babies?			
Is there a breast feeding support group in the community?			
Are still births or deaths of baby shortly after delivery reported to the clinic?			
If any abnormal babies are born are they recognised quickly and referred to clinic?			
INFANCY	**Yes**	**No**	**Could be**
Are immunization campaigns done with community involvement and well publicised?			
Have Health Surveys on Nutrition or other health matters been done with community involvement?			
Do the health committee or CHW checks immunization cards of infants in village\area and refers those not up to date to clinic?			
Has the community been educated about polio, measles and neonatal tetanus and need for reporting and immunization?			
Does a nurse from clinic visit homes of mothers with newly born twins or very small newborn babies?			
Is there some system for care of orphans of fostering children from families where parents died?			
Has the clinic arranged some training for mothers with disabled children?			
Does a team from the clinic, health centre or hospital visit the families with disabled children?			
Does the community collect mother and infants under 2 every month for weighing and promoting good growth?			

CHECKLIST 3

FOR COMMUNITY HEALTH COMMITTEE TO ASSESS *COMMUNITY BASED* HEALTH CARE FOR DIFFERENT LIFE STAGES IN THE COMMUNITY

[✓] Tick relevant column

PRESCHOOL AGE	Yes	No	Could be
Do the health committee and environmental health officer or clinic nurse inspect preschools?			
Are homes where orphans live visited periodically?			
Are there community feeding projects in preschools and for preschool age children?			
In the last year has there been a round of immunization for measles and polio?			
Are all disabled children referred periodically to the clinic for review?			
Do all preschools have community parents committee that consider health aspects?			
SCHOOL AGE	**Yes**	**No**	**Could be**
Does the community or some group encourage packed lunches for schools in order to improve nutrition and school performance or are there school feeding programmes?			
Are school inspections of environment (eg toilets, water) done by community committee with nurse and environmental health officer?			
Do school nurses screen school children and discuss with parents?			
Do the teachers in this community attend health workshops?			
Do the environmental health officers check buildings and grounds of schools and reports to committee?			
Are there adequate sports facilities and coaching for both boys and girls of school age to decrease sports injuries?			
Does the committee discuss the problems of children in the street and living in the street?			
Has life skills teaching been introduced in all schools?			
Are there community feeding projects in preschools and for preschool age children?			
In the last year has there been a round of immunization for measles and polio?			
Are all disabled children referred periodically to the clinic for review?			
Do all preschools have community parents committee that consider health aspects?			
ADOLESCENT	**Yes**	**No**	**Could be**
Has the community arranged for mature approachable women or women teachers to act as someone to whom sexually harassed school girls can go for help and support?			
Are there peer group health educators for schools and out of school youth?			
Can contraceptives and condoms be obtained by adolescents in the community easily at the clinic?			
Are there youth group activities for recreation and health for male and female youth?			
Is there available to youth: health education on smoking, drugs, alcohol and safe sex and dangers of STD\HIV\AIDS			
Do adolescents (girls and boys) receive nutritional guidance from nutrition works?			
Does the environmental health officer check on sport and play facilities to ensure safety?			
Is there a community based mental health programme?			
Has circumcision been made a safe procedure in the community?			

CHECKLIST 3

FOR COMMUNITY HEALTH COMMITTEE TO ASSESS *COMMUNITY BASED* HEALTH CARE FOR DIFFERENT LIFE STAGES IN THE COMMUNITY

[✓] Tick relevant column

ADULTS	Yes	No	Could be
Has there been health worker participation in community-based planning, eg for water points, toilets, sitting of clinics, telephones?			
Does the community have members trained in early TB diagnosis and daily Direct Observed Treatment (DOTS)?			
Does the community have group work for men and women related to health?			
Are there Non-government or Community-based Organisation activities for health and welfare in the community?			
Do nurses help with the reintegration of mentally ill into their families after discharge from mental hospitals?			
Have the committee and community members done their own health surveys?			
Has the committee participated with health staff investigating outbreaks of disease (eg dysentery)?			
Is there a committee concerned with violence\dispute\conflict resolution?			
Is the health in occupational situations eg factories, plantations, workshops, bus\taxi ranks, bars\hotels monitored?			
Has there been community education for adults on TB, HIV, AIDS, STD and condom use?			
Are the mentally ill returning from hospital visited by health staff (and committee members if relevant)?			
Does the community arrange for rapid emergency transport in cases of accidents, violence or for maternity emergencies?			
Does the environmental health officer (EHO) check new buildings, rubbish collection and toilets in the villages?			
Does EHO also advise on keeping pigs and on inspection of home slaughtered animals?			
Can an adult who is HIV positive get confidential counselling from the clinic or lay counsellor?			
Has the committee has taken steps to decrease the stigma of mental Illness, epilepsy, AIDS and TB?			
EDERLY	**Yes**	**No**	**Could be**
Does the committee or the CHW “nompilo” keep a register of chronic disease (high blood pressure, diabetes, asthma, mental illness)?			
Does the committee arrange for home visits of the chronically ill?			
Has the community some arrangements for care of the elderly?			
Are old people or disabled people in the community assisted in getting pensions or grants processed?			
Are some arrangements made with community workers or nurses to help with terminal care of the extremely ill?			
Are there community volunteers who help with the aged and bedridden			

Having gone through the checklist first, list those activities, which can be started now. Then by consensus agree on a prioritised small number which

- affect most people
- have the most serious health consequences if not done
- can be tackled with existing resources
- are activities which can be sustained

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

Revised date: 3 February 2003

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 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 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).

CORE NORMS AND STANDARDS FOR HEALTH CLINICS

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.

CORE NORMS AND STANDARDS FOR HEALTH CLINICS

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.

CORE NORMS AND STANDARDS FOR HEALTH CLINICS

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 task list 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 co-ordinator.
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.

CORE NORMS AND STANDARDS FOR HEALTH CLINICS

9.6 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 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.

WOMEN'S REPRODUCTIVE HEALTH

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.

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).

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.

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) *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.

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 outbreaks 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 mopping 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.

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.

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.

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 dildo (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.

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 clinics 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 forms 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.

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

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.

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.

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.

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.

SECTION 10

IN-DEPTH PROGRAMME REVIEWS

- TB
- STD's
- EPI
- Child Health
- Maternal Health
- Contraceptive Services
- Chronic Care
- HIV/AIDS
- Drug Management
- Information Systems

Revised date: 3 February 2003

CHECKLIST: TUBERCULOSIS

CLINIC _____ **DATE** _____

[✓] Tick appropriate box

	Daily	Special days
❑ **Availability of services**		
❑ **Fast Line service available for TB patients currently on treatment**		Y N
❑ **Protocols and policies available**		
• The SA TB Control Practical Guidelines 2000		Y N
• Provincial Circular 22/1999 on "EDL: Implementation of new Tuberculosis Treatment Regimes"		Y N
• A Training Manual for DOTS supporters		Y N
• Flow charts on TB diagnosis		Y N
• The latest EDL manual on TB management		Y N
• TB posters on walls, leaflets and pamphlets in local languages for distribution		Y N
❑ **Is there a single person responsible for TB management in the clinic**		Y N
❑ **Are TB patients notified and notification forms submitted to the appropriate office**		Y N

CLINICAL MANAGEMENT OF ADULTS WITH TB

❑ **Are clinic staff doing the following**	
• Identifying TB suspects	Y N
• Requesting appropriate sputum investigations for specific categories of patients	
– Sputum direct for new TB suspects/patients currently on treatment	Y N
– Sputum culture and MCS for TB retreatments/patients who fail to convert on treatment	Y N
• Requesting sputum investigations at the correct times	Y N
– After 2 months on treatment	Y N
– After 5 months (new patients) / 7 months (retreatment patients) on treatment	Y N
• Initiating the correct treatment protocols for	
– Newly diagnosed patients	Y N
– Retreatment patients	Y N
• Providing the following information to new TB patients	
– The importance of treatment compliance	Y N
– The need for a treatment supporter	Y N
– What to do if side-effects occur, they run out of drugs, need to leave for another area beyond the clinics catchment area	Y N
• Reviewing the clinical progress of each TB patient at least once during the treatment period	Y N
• Referring TB patients for appropriate care when necessary	Y N
• Managing contacts according to TB Programme guidelines	Y N
• Offering VCT and HIV testing to all newly diagnosed TB clients	Y N

CLINICAL MANAGEMENT OF CHILDREN WITH TB

❑ **Are clinic staff doing the following:**	
• Identifying children with suspect TB	Y N
• Actively searching for the child contacts of all TB patients	Y N
• Using PPD testing in children under five	Y N
• Correctly reading PPD tests	Y N
• Initiating the correct treatment for children	
– Contacts	Y N
– Children with active diseases	Y N
• Referring suspect children with TB when necessary	Y N

CHECKLIST: TUBERCULOSIS

EQUIPMENT AVAILABILITY

[✓] Tick appropriate box

		Y	N
❑	**Weighing scales**		

SPUTUM MANAGEMENT

		Y	N
❑	**Are sputum jars/request forms available**		
❑	**Are stock outs of sputum jars ever experienced**		
❑	**Is the sputum collection correctly done**		
❑	**Are laboratory request forms completed correctly**		
❑	**Does sputum transportation to laboratory occur regularly**		
❑	**Are the result of all sputum investigations returned to the clinic**		
❑	**Does this occur within one week of the sputum being sent off**		

DRUGS

		Y	N
❑	**Do TB drug stock outs ever occur**		

TREATMENT SUPPORT SYSTEMS

❑ **How does the clinic provide treatment to TB patients**

•	Daily clinic based dots	Y	N
–	Number of TB patients currently on daily clinic based DOTS	#	
–	How many of these patients have missed more than three consecutive days of treatment during the last month	#	
–	What has been done to improve the compliance of patients who are not regular - explain		

_____

_____

•	Through a network of community based treatment supporters (community based DOTS)		
–	Number of patients currently supported by treatment supporters	#	
–	Does the clinic keep a record of the performance of the treatment supporters	Y	N
–	Do clinic staff meet regularly with treatment supporters	Y	N
–	Are clinic staff able to visit treatment supporters in the field for supervision and support	Y	N

•	Patients own responsibility to take treatment				
–	How regularly does the patient collect treatment	Weekly	2 weekly	Monthly	
–	Does the clinic monitor the regularity at which the patient should collect treatment			Y	N
❑	**Does the clinic have any form of outreach service for TB patients**			Y	N
•	To provide drugs to patients who have a difficulty in reaching the clinic			Y	N
•	To trace patients who have apparently defaulted			Y	N

TB RECORDING

		Y	N
❑	**Is the TB register correctly completed and up to date**		
•	Proper recording of sputum request and results	Y	N
•	Proper recording of patient outcomes	Y	N
❑	**Are the blue clinic retained patient records fully completed and up to date**	Y	N
❑	**Are the green patient retained cards of TB patients correctly completed and up to date**	Y	N
❑	**Is the PHC monthly report for TB cases filled correctly**	Y	N
❑	**Are results/problems discussed at least monthly**	Y	N
❑	**Do clinic staff experience problems with the preparation of quarterly statistics**	Y	N
❑	**Are stock outs of TB stationery ever experienced**	Y	N

CHECKLIST: TUBERCULOSIS

PATIENT TRANSFERS

[✓] Tick appropriate box

❑ **Does the clinic have a mechanism to ensure that patients who transfer out have reached their intended destination**	Y	N
❑ **Does the clinic report to the referring institution that a patient who has been transferred in has reached her/his destination**	Y	N
❑ **Does the clinic complete the referral documentation (transfer out forms) correctly and completely when referring a TB patient**	Y	N

CHECKLIST: TUBERCULOSIS

NOTES

FOLLOW UP ACTIVITIES

ACTIVITY	DONE

GUIDELINES FOR USING CLINIC SUPERVISOR'S TB CHECKLIST

GENERAL (A clinic needs a few important things in place to facilitate the provision of a good TB service)

	Intent/Purpose	Information source
❑ **Availability of services**	To check on regular TB service availability	• Clinic staff provide information
❑ **Fast Line service available for TB patients currently on treatment[2]**	To ensure that TB patients do not have to spend long periods in queues when fetching drugs/seeking care	• Clinic staff provide information
❑ **Protocols and policies available**		
• The SA TB Control Practical Guidelines 2000	Check availability of prime TB reference document for clinic staff.	• Supervisor to observe
• The latest TB training manual for health workers - 1998	Check availability of supportive materials for clinic staff	• Supervisor to observe
• Provincial Circular 22/1999 on "EDL: Implementation of new Tuberculosis Treatment Regimes"	Check availability of Provincial Circular, which provides the latest information on treatment guidelines.	• Supervisor to observe
• A Training Manual for DOTS supporters	Check availability of supportive materials for clinic staff	• Supervisor to observe
• Wall flow charts on TB diagnosis	Display simplifies management of TB	• Supervisor to observe
• The latest EDL manual on TB management	Availability simplifies/ensures correct TB management	• Supervisor to observe
• TB posters on walls, leaflets and pamphlets in local languages for distribution	Check availability of appropriate health promotion material	• Supervisor to observe
❑ **Does one person take responsibility for day to day TB management in the clinic**	Generally, if one person is responsible for day to day management in the clinic then there is less confusion	• Clinic staff
❑ **Are notification of TB patients done and submitted to the appropriate office**	Check that key activity is carried out.	• Request to see notification book and observe if adequately completed.

CLINICAL MANAGEMENT OF ADULTS WITH TB (You want to ensure that the clinic is providing the following set of activities)

	Intent/Purpose	Information source
❑ **Are clinic staff doing the following**		
• Identifying TB suspects	Verify that case-finding is taking place – a vital component of the TBCP	• Questioning of staff • Check amount of suspects identified on monthly PHC return form.
• Requesting appropriate sputum investigations for specific categories of patients	Clinic staff often have difficulties in requesting appropriate investigations for new and retreatment patients. It is necessary to verify the correctness of sputum requests	• TB register – sputum results • See "Sputum Results" - Blue card
• Requesting sputum investigations at the correct times[3]	Efficient TB programme management requires that sputum investigations are done timeously and for all patients with PTB	• TB register – sputum results • Blue card – Sputum results

[2] Fast line – a mechanism which ensures that TB patients can rapidly access care without waiting in a queue for extended periods.
[3] Duration of treatment calculated from the point in time when patients started treatment.

Revised date: 3 February 2003

GUIDELINES FOR USING CLINIC SUPERVISOR'S TB CHECKLIST

CLINICAL MANAGEMENT OF ADULTS WITH TB - continued

❑ Are clinic staff doing the following	Intent/Purpose	Information source
• Initiating the correct treatment protocols for newly diagnosed and retreatment patients	Clinic staff often have difficulties in initiating appropriate treatment for new and retreatment patients. It is necessary to verify the correctness of patient treatment.	• TB register – see column – regimens • Blue card – Regimen and Dosages
• Providing information to new TB patients	Patients need appropriate information to allow them to complete treatment. The information which is passed on to patients should be assessed.	• Observe a patient/ nurse interaction • Question TB patient on information received • Role play and check what information the staff provide
• Offering VCT and HIV testing	The HIV testing of all TB patients needs to be promoted.	• Noted on Blue Card.
• Reviewing the clinical progress of each TB patient at least once during the treatment period	Reviewing the patient's clinical progress is useful as it indicates improvement/problems of the patient. It also serves to enhance the relationship between the clinic staff and the patient.	• Clinic staff • Notes in patient Blue card
• Managing contacts according to TB Programme guidelines	Contact management is not always optimal. It is necessary to ensure that staff know who the contacts are and that they are taking steps to trace contacts.	• Clinic staff • Contact list on Blue Card completed

CLINICAL MANAGEMENT OF CHILDREN WITH TB

❑ Are clinic staff doing the following	Intent/Purpose	Information source
• Actively searching for the child contacts of all TB patients	It is important to ensure that clinic staff are taking steps to trace and initiate contact treatment for children under five.	• Clinic staff • Ask to be provided with the Blue card of each contact and check details on card.
• Using PPD testing in children under five	It is important to ensure that only children under five years are diagnosed with TB using PPD testing as the only diagnostic method. It is important to ensure that PPD testing is used appropriately in children.	• TB register (look at disease coding column and compare with patient age and diagnostic criteria used).

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GUIDELINES FOR USING CLINIC SUPERVISOR'S TB CHECKLIST

CLINICAL MANAGEMENT OF CHILDREN WITH TB – continued

❑ Are clinic staff doing the following	Intent/Purpose	Information source
• Correctly reading PPD tests	PPD tests need to be interpreted properly before deciding whether they are positive or not. Staff should record the size of induration (Mantoux) or the grade of the reaction (Tine) and it is necessary to ensure that the diagnosis is based on guidelines (especially patient age) determined by the TBCP.	• Knowledge of clinic staff • Blue Cards of patients diagnosed in this manner
• Initiating the correct treatment for children	Ensure that children receive the appropriate treatment regimes according to contact or disease status.	• Register • Blue Cards

CHECKLIST: TUBERCULOSIS

SPUTUM MANAGEMENT (The diagnosis of TB based on sputum results is one of the key activities of the TBCP. The correct management of issues related to sputum are therefore critical)

	Intent/Purpose	Information source
❑ **Are laboratory request forms completed correctly**	Useful TBCP monitoring information can be obtained from the laboratory providing that clinic staff complete request forms properly. The correct completion of these forms need to be verified.	• Ask the staff to complete a form for an imaginary patient. • Ask laboratory staff how request forms are being completed
❑ **Are sputum jars/request forms available**	It is important to verify the availability of sputum request forms and jars.	• Ask to see jars and forms
❑ **Are stock outs ever experienced**	This allows the opportunity to explore the reasons for stock outs if they do occur and to make plans to prevent such occurrences.	• Clinic staff • Laboratory staff
❑ **Are the results of all sputum specimens sent to the laboratory returned to the clinic**	Late or non-return of sputum results affects the ability of the clinic nurse to manage TB patients optimally.	• Clinic staff • Specimen register
❑ **Does sputum transportation to laboratory occur regularly**	The regularity of transport to the clinic should be assessed. Irregular transport affects the confidence of both clinic staff and patients.	• Clinic staff
❑ **Is the sputum collection correctly done**	The laboratory requires a good quality sputum specimen. It is important to verify that the laboratory is provided with good specimens.	• Observe a patient providing sputum/ check the way that the specimen is labeled and sealed • Ask the clinic staff to role play the process

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GUIDELINES FOR USING CLINIC SUPERVISOR'S TB CHECKLIST

DRUGS

	Intent/Purpose	Information source
❑ **Do TB drug stock outs ever occur**	This allows the opportunity to explore the reasons for stock outs if they do occur and to make plans to prevent such occurrences.	• Clinic staff • Drug stock cards

TREATMENT SUPPORT SYSTEMS (A variety of treatment support systems exist at clinic level – these include clinic-based DOTS, community based DOTS and self-supervision by patients. It is important to understand what treatment support system each clinic provides and how the clinic is performing in providing treatment. A clinic may provide one or more forms of treatment support, therefore you need to enquire about the presence or not of each form of support.

❑ **How does the clinic provide treatment to TB patients**		
• Daily clinic based dots	To determine whether this form of treatment is provided from the clinic	• Clinic Staff
– Number of TB patients currently on daily clinic based DOTS	To determine how many patients are on clinic based DOTS.	• TB register • Blue Cards
– How many of these patients have missed more than three consecutive days of treatment during the last month	One needs to get an idea of how well the clinic is performing in ensuring that these patients take their TB drugs	• Blue cards of patients on clinic-based DOTS
– What has been done to improve the compliance of patients who are not regular	If the clinic is experiencing problems with clinic-based DOTS clients it is important to determine what is being done to solve these problems	• Clinic staff
• Through a network of community based treatment supporters (community based DOTS)	To determine whether this form of treatment is provided from the clinic	• Clinic Staff
– Number of patients currently supported by treatment supporters	To determine how many patients are on community- based DOTS.	• TB register • Blue Cards
– Does the clinic keep a record of the performance of the treatment supporters	Clinic staff should be aware of how treatment supporters are performing.	• ? Clinic record to be created
– Do clinic staff meet regularly with treatment supporters	There should be some form of interaction between treatment supporters and clinic staff. It is important to enquire whether interaction does take place.	• Clinic staff • Treatment supporters • ? Clinic record of such meetings
• Patients own responsibility to take treatment	To determine whether this form of treatment is provided from the clinic	• Clinic Staff

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GUIDELINES FOR USING CLINIC SUPERVISOR'S TB CHECKLIST

TREATMENT SUPPORT SYSTEMS – continued

	Intent/Purpose	Information source
❑ **How does the clinic provide treatment to TB patients** – How regularly does the patient collect treatment	Knowing the regularity at which a patient collects treatment is important as it does give an indication of the compliance of the patient. A patient who collects treatment weekly and is regular in that is probably taking the drugs whilst this may not necessarily be the case for persons collecting drugs monthly. It is also easier to detect compliance problems in patients who collect their drugs weekly than it is for those who collect drugs monthly.	• Blue card
– Does the clinic monitor the regularity at which the patient should collect treatment	It is important to know whether clinic staff have a system whereby they can detect patients who do not come back for treatment.	• Blue Card • ? Other form of attendance register.
❑ **Does the clinic have any form of outreach service for TB patients**	It is important to determine what efforts the clinic is making to deal with TB patients who have either problems in obtaining TB drugs or who have compliance problems. Outreach services might be in the form of sending messages to the patient, linkages with community health workers and clinic committees/traditional leaders and sending clinic staff out to support patients.	• Clinic staff

TB RECORDING (Proper TB recording supports the proper management of the TBCP)

	Intent/Purpose	Information Source
❑ **Is the TB register correctly completed and up to date**	The recording of sputum results and patient outcomes are often inadequately done. It is therefore worthwhile to verify that this is done.	• Take the register and look at a couple of pages to assess whether it is fully completed or not
❑ **Are the blue clinic retained patient records fully completed and up to date**	It is necessary to ensure that the Blue Card is adequately completed and kept up to date	• Take a few Blue Cards and look through them
❑ **Are the green patient retained cards correctly completed and up to date**	It is necessary to ensure that the Green Card is adequately completed and kept up to date	• If possible, find a few Green Cards and look through them

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GUIDELINES FOR USING CLINIC SUPERVISOR'S TB CHECKLIST

TB RECORDING - continued

	Intent/Purpose	Information Source
❑ **Is the TB section of the monthly PHC monthly report correctly filled correctly**	It is important to verify that TB data entered into the PHC monthly returns are correct. Staff often have difficulties in understanding what is meant by certain terms such as a treatment supporter. We should try to ensure that data entered onto the monthly report form is accurate	• See section on the HIS in Supervisors Manual for definition of terms used in the PHC monthly report form • Cross-check that number of patients currently on treatment in register corresponds to figure inserted into monthly PHC monthly report form
❑ **Do clinic staff experience problems with the preparation of quarterly statistics**	Clinic staff do experience problems in completing quarterly statistical reports. It is necessary to ensure that clinic staff feel competent to do this and to the extent that it is possible to verify the correctness of reports.	• Clinic staff • Verify correctness of statistical returns
❑ **Are stock outs of TB stationery ever experienced**	This allows the opportunity to explore the reasons for stock outs if they do occur and to make plans to prevent such occurrences.	• Clinic staff

PATIENT TRANSFERS (Large numbers of patients are lost to follow up during transfer from hospital to clinic, clinic to hospital and clinic to clinic. It is important to ensure that clinics are doing all they can to minimise this loss of patients during transfers).

	Intent/Purpose	Information
❑ **Does the clinic have a mechanism to ensure that patients who transfer out have reached their intended destination**	It is important to ensure that referring institutions are sure that TB patients reach their intended destinations.	• ? Referral register
❑ **Does the clinic report to the referring institution that a referred patient has arrived at her/his supposed destination**	It is important that institutions to which patients are referred report the arrival of that patient to the referring institution.	• ? Referral register
❑ **Does the clinic complete the referral documentation (transfer out forms) correctly and completely when referring a TB patient**	Poorly completed referral documentation is a great source of frustration to staff who receive a referred patient. Clinic staff should complete the TB referral form (No) properly and this should be verified.	• Review of referral forms where possible.

Revised date: 3 February 2003

District STD Quality of Care Assessment
DISCA

INSTRUCTIONS

Please fill out this evaluation by

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

ACCESSIBILITY

[✓] Tick appropriate box

- ❑ Does this facility offer STD treatment at all times between 8 am and 4 pm on all weekdays — Y / N
- ❑ Does this facility offer STD treatment as part of after clinic hours services — Y / N
- ❑ How many adult consultation rooms are there in this facility
  - Does this facility use all adult consultation rooms to treat patients with STD — Y / N
  - If no, how many consultation rooms are used for STD care
- ❑ Please observe whether this facility offers consultation in private for all STD patients ie consultations cannot be observed by other patients and providers — Y / N
- ❑ Please request a caseload book or register
  - What is the total number of adult patient attendances last month — #
  - What is the total number of STD attendances last month — #

SAFE EXAMINATION

- ❑ Are the following pieces of equipment available in all adult consultation rooms
  - Examination couch — Y / N — Total number in this facility
  - Examination light — Y / N — Total number in this facility
  - Sterile speculums — Y / N

PROVISION OF SAFE TREATMENT

- ❑ Are there STD syndromic management guidelines at this facility — Y / N
- ❑ Are there STD syndromic management guidelines in all adult consultation rooms — Y / N
- ❑ Are there individual patient education materials about: STD/HIV prevention and treatment available in this facility — Y / N
- ❑ Are these educational materials written in a local language — Y / N
- ❑ Is syphilis RPR testing available in this health facility — Y / N
- ❑ What is the **turn around time** for the RPR test results (*the time elapsed between taking blood (for RPR) from the patient and getting the results back from the laboratory — Days
- ❑ Have there been any occasions over the last month that the male **condoms** ran out — Y / N
- ❑ Are STD patients **shown** how to use condoms in this facility — Y / N
- ❑ Is there a **dildo** available for condom demonstrations in this facility - If no, how do you make sure that the patient knows how to us condoms in this facility — Y / N

_____

_____

- ❑ Does this facility have a **referral policy** specifically for STDs in case where patients do not respond to treatment or have complications — Y / N
- ❑ Partner notification – **observe**
  - Are partner Notification cards/letters available in all adult examination rooms — Y / N
  - Are the cards written in a local language — Y / N
- ❑ Ask for the Laboratory Specimen Book or Register
  - How many STD client had **blood taken** for RPR (syphilis) test last month

District STD Quality of Care Assessment
DISCA

ANTENATAL SCREENING AND STD TREATMENT

[✓] Tick appropriate box

❑ Does this facility provide **antenatal care**	Y	N
❑ If yes, is **syphilis screening** done on all pregnant clients who attend antenatal care for the first time	Y	N
❑ Do you **examine and treat pregnant** clients for STDs other than syphilis	Y	N

STAFF TRAINING

❑ How many clinicians (doctors or nurses who examine and treat patients) are working today	
❑ How many clinicians who are working have been on a formal training course in STD syndromic management	
❑ How many clinicians working today have been on a formal HIV/AIDS counselling course	
❑ Is there a nurse or doctor with responsibility to supervise STD care in this facility	Y N

STD DRUGS AND TREATMENT

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

Drugs	Is it currently in stock		Over the last month has drug run out		State the reasons for drugs running out
Ciprofloxacin 250mg tabs	Y	N	Y	N	
Flagyl 2g tabs	Y	N	Y	N	
Erythromycin 250mg tabs	Y	N	Y	N	
Doxycycline 100mg tabs	Y	N	Y	N	
Benzathine Penicillin 2.4 mu	Y	N	Y	N	

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

STD Patient folders	Was the patient diagnosed according to syndromes below		Specify the syndrome See codes below	What type of drugs did the patient receive? State the type, dose and duration	Is the drug prescription correct		Was the RPR or VDRL test requested	
1	Y	N			Y	N	Y	N
2	Y	N			Y	N	Y	N
3	Y	N			Y	N	Y	N
4	Y	N			Y	N	Y	N
5	Y	N			Y	N	Y	N
6	Y	N			Y	N	Y	N
7	Y	N			Y	N	Y	N
8	Y	N			Y	N	Y	N
9	Y	N			Y	N	Y	N
10	Y	N			Y	N	Y	N

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

1 – Penile discharge
2 – Vaginal discharge
3 – Pelvic inflammatory disease (PID)
4 – Genital Ulcers
5 – Genital warts
6 – Other STD (specify)

District STD Quality of Care Assessment
DISCA

NOTES

FOLLOW UP ACTIVITIES

ACTIVITY	DONE

CHECKLIST: EPI, VITAMIN A, DISEASE SURVEILLANCE

CLINIC _____ **DATE** _____

[✓] Tick appropriate box

	Y	N
❑ **Is the immunisation service available daily, 5 days a week**	Y	N
❑ **Is there a record system to ensure continuity of care**	Y	N
❑ **Do staff record and trace children who do not come for their routine immunisations**	Y	N
❑ **Are posters on immunisation and Vitamin A on the walls in appropriate language**	Y	N
❑ **Are pamphlets on immunisation and Vitamin A for patients available in the local language**	Y	N
❑ **Is the AFP toll free telephone number displayed so notification of a suspected case can be made telephonically**	Y	N
❑ **In cases of measles and suspect polio do staff know which laboratory specimens to collect and do they follow referral procedures**	Y	N

❑ **Vaccine stock**

• Are stock cards kept for each vaccine and Vitamin A capsules	Y	N
• Do stock levels correlate with stock in refrigerator	Y	N
• Are vaccines and Vitamin A received regularly and according to amounts ordered	Y	N
• Is the cold chain maintained when vaccines are removed from refrigerator	Y	N
• Has the immunisation programme at your clinic been stopped since the last supervisory visit	Y	N
• How many days was it stopped	#	

- What was the cause of the stoppage

_____

_____

- How was the problem solved

_____

_____

❑ **Refrigerator**

• Is the refrigerator in working order	Y	N
• How many times since the last supervisory visit has it failed	#	

- What did you do to maintain the cold chain

_____

_____

• Is the refrigerator defrosted and cleaned regularly	Y	N
• Is the cold chain maintained during defrosting	Y	N
• Are vaccines correctly stored and packed in refrigerator	Y	N
• Are there any expired vaccines	Y	N
• Is the thermometer in working order	Y	N
• Is the thermometer correctly placed	Y	N
• Are refrigerator temperatures recorded daily	Y	N
• In the last month, has the temperature dropped below 0ºC or above 8ºC. If yes, discuss the reason for this break in cold chain and remedial action to be taken with staff	Y	N

_____

_____

• Is there anything else in the refrigerator besides vaccines	Y	N
• Is there a standby gas supply if your refrigerator uses gas	Y	N
• Has any of the DPT or TT vaccine in the refrigerator been frozen (to check this, use the shake test on randomly selected vials)	Y	N
• Has any of the vaccine in stock expired	Y	N
• Are there any open vials of vaccine in the refrigerator	Y	N
• VVM available	Y	N

CHECKLIST: EPI, VITAMIN A, DISEASE SURVEILLANCE

[✓] Tick appropriate box

❑ **Is the cold chain maintained in mobiles and consulting rooms**	Y	N
• Large cold boxes available, clean and in working order	Y	N
• Small cold boxes available, clean and in working order	Y	N
• Ice packs available	Y	N
❑ **Is the open vial policy followed**	Y	N
• Date of opening recorded	Y	N
• Needles not left in vial	Y	N
❑ **RTH card check**		
• Are vaccinations appropriate for age	Y	N
• Are signatures and return dates entered	Y	N
• Are Vitamin A doses recorded correctly	Y	N
❑ **Vaccination technique**		
• Are vaccines withdrawn correctly from vial	Y	N
• Are the correct needles and syringes used	Y	N
• Is the injection site correct	Y	N
• Are Vitamin A capsules opened and administered properly	Y	N
❑ **Information given to caregiver**		
• Is the return date indicated	Y	N
• Is the caregiver aware of side effects	Y	N
❑ **Emergency tray**		
• Is the emergency tray properly equipped	Y	N
• Is the nurse aware of emergency procedure	Y	N
❑ **Are EPI and Vitamin A guidelines available in clinic**	Y	N
• Are EPI statistics and graphs kept up to date	Y	N
• Is the tick register completed properly	Y	N
• Is the coverage/graph correct and up to date	Y	N
• Are vaccine batch numbers recorded	Y	N
• Are Vitamin A coverage levels equal to the vaccine coverage	Y	N
❑ **Since the last supervisory visit have you had any reports of severe adverse reactions** (such as injection site abscesses severe local reaction spreading further than 5 cm from injection site, anaphylaxis, convulsions, high fever) after immunisation – discuss each.	Y	N
❑ **Notification**		
• Is the notification book available	Y	N
• Is the list of notifiable diseases available	Y	N
• Are disease surveillance forms available/are staff aware of protocols to follow in case of an outbreak	Y	N
❑ **Is there a need for in-service on EPI**	Y	N
❑ **Is sharps disposal adequate**	Y	N

CHECKLIST: EPI, VITAMIN A, DISEASE SURVEILLANCE

NOTES

FOLLOW UP ACTIVITIES

ACTIVITY	DONE

CHECKLIST: CHILD HEALTH

CLINIC _____ **DATE** _____

[✓] Tick appropriate box

	Daily	Special days	
❑ **Availability of services**			
❑ **Is there a system to ensure continuity of care**		Y	N
❑ **Is there a system in place to trace children who do not attend regularly**		Y	N
❑ **Do staff assess and promote child development**		Y	N
• Check on milestones		Y	N
• Instruct mother about the importance of child stimulation		Y	N
• Utilise the RTH card			
– Is the weight plotted correctly		Y	N
– Does nurse interpret findings to mother		Y	N
– Are immunisations up to date		Y	N
– Is the feeding status recorded - exclusive breast feeding, introduction to solids, etc		Y	N
– Is the nutritional status recorded		Y	N
– Is there a service response to failure to thrive		Y	N
❑ **Childhood Illnesses**			
• Are Staff able to correctly examine and assess child for		Y	N
– Dehydration		Y	N
– Respiratory rate		Y	N
– Distress		Y	N
– Ear infections		Y	N
– Neck stiffness		Y	N
• IMCI			
– Are protocols posted and followed		Y	N
– Correct management of important conditions		Y	N
↳ ARI - Is respiratory rate counted and documented		Y	N
↳ ARI - Are antibiotics used when indicated		Y	N
↳ Diarrhoea – use of ORS		Y	N
↳ Fever – rule out meningitis and otitis media		Y	N
❑ **Equipment available and working**			
• Weighing scales		Y	N
• Otoscope		Y	N
❑ **Availability of protocols/policies/guidelines related to child health**			
• When to refer - illnesses, social problems, emergencies - paraffin, burns, foreign bodies, nutritional problems		Y	N
• Protocols - management of diarrhoea/asthma/ARI		Y	N
• Management of RPR positive children		Y	N
• Guidelines for breastfeeding and the HIV positive mother		Y	N
• Deworming guidelines		Y	N
❑ **Provision of health education**			
• Are mothers/care givers aware of use of ORS for GE		Y	N
• Is nutritional information provided to mother/care givers		Y	N
• Appropriate care of the baby by mother/care giver		Y	N
• Are mothers/care-givers aware of where services are available after hours		Y	N
• Are home visits done		Y	N

CHECKLIST: CHILD HEALTH

[✓] Tick appropriate box

❑ **HIV and children**

• Are all infants of HIV+ mothers receiving cotrimoxazole (till age 1)	Y	N
• Are all HIV positive children receiving cotrimoxazole (lifelong)	Y	N

CHECKLIST: CHILD HEALTH

NOTES

FOLLOW UP ACTIVITIES

ACTIVITY	DONE

CHECKLIST: ANC/PNC

CLINIC _____ **DATE** _____

[✓] Tick appropriate box

❑ **Service availability**	Daily	Special days
❑ **Does the clinic have a system to keep a record of pregnant women**	Y	N
❑ **Does the clinic have a system to trace pregnant women who don't attend the clinic regularly**	Y	N
❑ **Clinical management of pregnant women**	Y	N
• ANC first visit		
– Full physical exam - palpation correct, symphysis-fundal height measurements correctly done	Y	N
– Weight/BP/Urine/HB done	Y	N
– Bloods taken - VDRL/Grouping/HB	Y	N
– Previous immunisation records checked and tetanus toxoid given	Y	N
– Health Education - BF promoted/Breast preparation, FP, delivery, nutrition/personal hygiene, exercise. Warning signs and symptoms of pregnancy related problems explained to mother. Mother told when to request medical care.	Y	N
– How done	Individually	Groups
• All other visits		
– Examination, outstanding tetanus toxoid immunisation provided	Y	N
– Weight, BP, urine checked	Y	N
– Blood results checked and entered/appropriate treatment given/syphilis treated according to protocol	Y	N
– Ferrous/folic supplements given	Y	N
– Health Education - care of baby/maternal care	Y	N
• Is VCT offered to all pregnant women at the 1st visit.	Y	N
❑ **Maternal Health Administration**		
• Correct recording of each pregnant woman - tick register, patient card, graphs, laboratory register	Y	N
• ANC coverage indicated on graph	Y	N
• Clients booked at hospital for delivery	Y	N
❑ **Protocols followed**		
• Managing STD's in pregnancy	Y	N
• Exclusive breast feeding promoted	Y	N
• Pregnancy induces hypertension management	Y	N
• Tetanus prevention protocol	Y	N
• Referral protocols - who and when to refer	Y	N
• At risk cases – primiparous women, previous C/sections, abnormal presentations, twins/multiple pregnancies	Y	N
• Complications of pregnancy – Pregnancy induced hypertension, haemorrhage, intra-uterine growth retardation	Y	N
• Follow up visit schedule followed/ completion of cards for return dates	Y	N
• Infection control - gloves used for venesection	Y	N
• Essential equipment available and in working order	Y	N
• PMTCT guidelines	Y	N

DELIVERY AND LABOUR

❑ **Important equipment/supplies available and working**		
• Delivery packs	Y	N
• Suction	Y	N
• Supply availability – IV fluids available, suturing materials, local anaesthetic	Y	N
• Oxygen	Y	N
• Drugs – syntometrine, ATT, Nevirapine	Y	N

CHECKLIST: ANC/PNC

DELIVERY AND LABOUR - continued

[✓] Tick appropriate box

❑ **Delivery protocols followed**	Y	N
• Universal precautions followed	Y	N
• Correct practises followed – first, second, third stages of labour	Y	N
❑ **Staff able to use and interpret partogram**	Y	N
❑ **Correct disposal of placenta/ materials used during delivery**	Y	N

POST NATAL CARE

❑ **Full physical exam of mother and child done**	Y	N
❑ **Immediately after delivery (clinic delivery)**	Y	N
❑ **Home delivery - soon as feasible**	Y	N
❑ **6 week repeat visit**	Y	N
❑ **Do follow up visits occur within seven days after delivery**	Y	N
❑ **Does the mother receive FP advice**	Y	N
❑ **Check that first immunisations given**	Y	N
❑ **Are BCG and polio vaccines given**	Y	N
❑ **Is the Road to Health card completed**	Y	N
❑ **Is the birth notified**	Y	N
❑ **Ensure the promotion of breast feeding - check physically that mothers are breast feeding properly (well baby clinics)**	Y	N

CHECKLIST: ANC/PNC

NOTES

FOLLOW UP ACTIVITIES

ACTIVITY	DONE

CHECKLIST: CONTRACEPTIVE SERVICES

CLINIC _____ **DATE** _____

❑ Service availability at clinic

[✓] Tick appropriate box

	Daily	Special Days	
• When are services available			
• If special days, can clients obtain contraceptive services on other days as well		Y	N
• Are PN's adequately trained?		Y	N
• Does clinic offer the following range of methods			
– Injectables (Depo Provera, Nur Isterate)		Y	N
– Intra-Uterine Device (IUD)		Y	N
– Oral contraceptives (COCs eg Triphasil, Nordette, Ovral 28)		Y	N
(POP eg Microval)		Y	N
– Condoms		Y	N
– Female and male voluntary surgical contraception (sterilisation)		Y	N
• If NO – is there a facility to refer clients		Y	N
• Is referral system effective ie clients get services they need promptly?		Y	N
• Is there a fast line service available for re-supply		Y	N

❑ Service quality

• Do consulting or counselling rooms provide adequate privacy?	Y	N
• Are adolescents helped in a supportive, friendly manner?	Y	N
• Are they provided with methods if requested?	Y	N
• Does the clinic experience contraceptive method stock outs?	Y	N
• Do nurses have a good knowledge of drug interactions, which may influence the contraceptive method effectiveness -TB drugs (rifampicin) and anti-epileptic drugs?	Y	N
• Is there a quick reference available in each consulting and treatment room?	Y	N
• Is there a pap smear register?	Y	N

❑ Counselling

• Are there guidelines on information staff are to cover during counselling sessions	Y	N
• Are methods explained to new clients before giving	Y	N
• Does each client have a choice of methods that are safe and suitable for her/him	Y	N
• Are clients aware of side-effects	Y	N
• Where appropriate, is the partner encouraged and involved in making a choice about the method	Y	N
• Do clients have knowledge of HIV and STD's and how to prevent STD's	Y	N
• Do clients have adequate information about emergency oral contraception	Y	N
• Does the clinic routinely provide counselling and education on TOP	Y	N
• Are medical eligibility criteria guidelines easily available for reference to providers?	Y	N
• If available, are they adhered to?	Y	N
• Is dual protection and its role in preventing HIV infection discussed?	Y	N

❑ History and clinical examination of contraceptive service clients

• Initial visit		
– History examination according to programme guidelines and client record	Y	N
– Physical examination according to programme guidelines	Y	N
– Pelvic examination according to programme guidelines	Y	N
– PAP smear according to age and intervals stipulated in the CA Cervix Policy guidelines	Y	N
– Breast examination	Y	N
• Follow up visits	Y	N
– Weight	Y	N
– Blood Pressure	Y	N

CHECKLIST: CONTRACEPTIVE SERVICES

[✓] Tick appropriate box

• Are abnormal findings managed accordingly (eg vaginal bleeding, vaginal discharge, lower abdominal pain and fever, follow up on positive RPR and HIV tests)	Y	N

❑ **Equipment available and working**

• Scales, sphygmomanometer	Y	N
• Vaginal speculae, light source, gloves, all what is required to decontaminate/disinfect	Y	N
• Aryre's spatulae, cervical brushes, slides and fixative	Y	N
• IUD insertion kit	Y	N
• Counselling kit (samples of methods, charts/pictures)	Y	N

❑ **Is there a continuous, regular and adequate supply of methods**

• Injectables	Y	N
– Medroxyprogesterone acetate (Depo Provera)	Y	N
– Norethisterone enanthate (Nur Isterate)	Y	N
• Oral contraceptives	Y	N
– Microval	Y	N
– Nordette	Y	N
– Ovral	Y	N
– Biphasil		
– Triphasil	Y	N
• Are IUD's available at the referral facility	Y	N
• Condoms	Y	N
• Drugs for STD's	Y	N

❑ **Does the clinic offer facilities for clients/community to give feedback about the service they receive**	Y	N
• Has the clinic committee included contraceptive services program in discussions within last 6 months	Y	N
• Have the clinic staff sought or received any information about how to improve the services from the community recently?	Y	N
• Is there a suggestion box?	Y	N

❑ **Records and register**

• Is the tick register correctly completed	Y	N
• Is there adequate written information on clients card	Y	N
• Are graphs correctly completed and kept up to date	Y	N
• Is the graphed information appropriate for decision making	Y	N

CHECKLIST: CONTRACEPTIVE SERVICES

NOTES

FOLLOW UP ACTIVITIES

ACTIVITY	DONE

CHECKLIST: CHRONIC CARE

CLINIC _____ **DATE** _____

❑ General

[✓] Tick appropriate box

• Does the clinic have a system to detect defaulting patients	Y	N
• Does the clinic have a system to follow up defaulting patients	Y	N
• Does the clinic arrange special times for the follow up of chronic patients	Y	N
• Do staff provide health education to groups of patients with chronic diseases	Y	N
• Does the clinic provide chronic care type health promotion activities in the community	Y	N

❑ Hypertension

• Appropriate disease management		
– Do nurses have knowledge of lifestyle modification in HT	Y	N
– Are STG's followed	Y	N
• Referral / Dr interaction		
– Are patients referred to doctor six monthly for review	Y	N
– Are checks done for end organ damage	Y	N
↳ Urinanalysis	Y	N
↳ Opthalmoscopy	Y	N
↳ Cardiac enlargement	Y	N
• Equipment		
– Baumenometer in working order	Y	N
– Appropriate baumerometer cuffs available (small, adult and wide)		

❑ Cardiac Failure

• Appropriate drug use		
– Are STG's followed	Y	N
• Referral / Dr interaction		
– Are patients referred to doctor six monthly for review	Y	N

❑ Diabetes Mellitus

• Appropriate patient management		
– Are STG's followed	Y	N
– Are nurses knowledgeable on managing diet in diabetics and the care of the diabetic foot	Y	N
• Referral / Dr interaction		
– Are patients referred to doctor six monthly for review	Y	N
– Are checks done for target organ damage	Y	N
↳ Urinanalysis	Y	N
↳ Opthalmoscopy	Y	N
↳ Cardiac enlargement	Y	N
• Equipment		
– Glucometer in working order	Y	N
– Are nurses competent in their use of the glucometer	Y	N

❑ Epilepsy

• Appropriate disease management		
– Are STG's followed	Y	N
• Referral / Dr interaction		
– Are patients referred to doctor six monthly for review	Y	N

CHECKLIST: CHRONIC CARE

❑ **COAD/ASTHMA** **[✓] Tick appropriate box**

- Appropriate disease management
  - Are STG's followed | Y | N |
- Referral / Dr Interaction
  - Are patients referred to doctor six monthly for review | Y | N |

CHECKLIST: CHRONIC CARE

NOTES

FOLLOW UP ACTIVITIES

ACTIVITY	DONE

CHECKLIST: HIV/AIDS

CLINIC _____ **DATE** _____

[✓] Tick appropriate box

	Daily	Special days	
• Availability of HIV services			
• Protocols and policies available?		Y	N
• Ten National Guidelines for HIV/AIDS			
▪ Ethical considerations for HIV/AIDS clinical and epidemiological research		Y	N
▪ Feeding of infants of HIV positive mothers		Y	N
▪ Management of occupational exposure to HIV		Y	N
▪ Managing HIV in children		Y	N
▪ Prevention and treatment of opportunistic and HIV related diseases in adults		Y	N
▪ Prevention of mother-to-child HIV transmission and management of HIV positive pregnant women		Y	N
▪ Rapid HIV testing		Y	N
▪ Testing For HIV		Y	N
▪ Tuberculosis (TB) and HIV/AIDS		Y	N
▪ National guideline on home-based care and community based care		Y	N
• Protocol for PMTCT		Y	N
• Protocol for needle stick injury		Y	N
• PEP protocol for rape victims		Y	N
• Color charts of skin and mouth conditions		Y	N
• IEC activities			
o Are there HIV related posters on walls, pamphlets and leaflets?		Y	N
o Are these available in local languages?		Y	N
o Are clinic visitors exposed to HIV related information whilst waiting in the clinic – talks, video shows, role plays, etc?		Y	N
o Does the facility host and organize special HIV events – plays, talks at schools, provision of food parcels, etc		Y	N

Comments: _____

• Do all staff categories regularly receive training aimed at updating them to new developments in HIV/AIDS	Y	N

Comments: _____

❑ SUPPORT GROUPS

• Are there HIV Support groups in your area (eg. Post-test clubs)?	Y	N

• Name them: _____

_____

• What is the facilities role in maintaining these support groups? _____

Notes: _____

_____

❑ VOLUNTARY COUNSELLING AND TESTING

• Is HIV testing and counseling available/offered in this facility?	Y	N
– Are all persons newly diagnosed with TB, all STI clients and all clinically suspect HIV positive persons offered testing?	Y	N
• Are "lay" counselors used in this clinic?	Y	N
– How many counselors are available at this Facility?		
– How many persons counseled in the last month?		
– Is there mentorship programme for counselors?	Y	N

CHECKLIST: HIV/AIDS

[✓] Tick appropriate box

- Is counseling done in an area that ensures privacy? Y N
- Is HIV Rapid Testing available at this clinic (both rapid tests as per policy)? Y N
  - Number of staff trained in HIV Rapid Testing? Y N
  - Is testing done in an area that ensures privacy? Y N
  - Is the result given to the client by the same counselor who did the pre-test counseling? Y N
  - Is the quality assurance procedure followed? Y N
- If rapid testing not available – what is the turn around time for specimens sent to laboratories?
  - Is this acceptable? Y N

❑ PMTCT

- Are all pregnant women counseled and tested for HIV during routine ANC Y N
- Are women appropriately counseled on taking Nevirapine at the appropriate times, where to deliver, the provision of Nevirapine to the baby and appropriate infant nutrition? Y N
- Is exclusive feeding of infants born to HIV positive mothers emphasized? Y N
- Where is the nearest "Mother to Child Transmission" treatment site? _____
- Does the referral hospital refer clients who have received Nevirapine during delivery back to the clinic? Y N

❑ HOME-BASED CARE

- Is this facility linked to home based care services? Y N
  How? _____
- Does the facility provide and re-stock home care kits for Care Givers? Y N
- Are problems experienced with replenishing care kits Y N
  Comments: _____
- Are there Volunteer Care Givers in catchment area of the facility? Y N
- Do facility staff supervise and support these Care Givers? Y N
  Comments: _____

❑ MANAGING THE HIV POSITIVE PERSON

- Is contraception for HIV positive women promoted? Y N
- Is dual protection for contraception emphasized Y N
- Does the clinic provide information on "wellness management" Y N
- Cotrimoxazole prophylaxis
  - Is Cotrimoxazole prophylaxis provided Y N
  - Are the indications for Cotrimoxazole prophylaxis followed Y N
  - Is there a register to track compliance Y N
- TB and HIV
  - Are all TB patients offered VCT Y N
- Do staff feel confident to deal with the range of opportunistic infections? Y N
- Is there update training required for managing opportunistic infections? Y N
  Comment: _____
- Do appropriate mechanisms exist to refer HIV positives for further medical care or social support? Is it functional? Y N
  Comment: _____

CHECKLIST: HIV/AIDS

[✓] Tick appropriate box

❑ HIV OCCUPATIONAL HEALTH

• Is this health facility practicing Universal precautions?	Y	N
– Are gloves routinely used for venesection and other invasive procedures	Y	N
– Are needles correctly removed from syringes and correctly disposed	Y	N
• Are staff members offered confidential counseling on STD and AIDS related issues?	Y	N
• Is there sufficient protective clothing available for maternity care, dressings, injections, etc?	Y	N
• Are clear guidelines available indicating the management of occupational injuries (needle stick injuries, contact with HIV positive bodily fluids)	Y	N
• Where is the nearest supply of prophylactic treatment available for personnel? _____ Site: _____		
• Is it possible to access these anti-retroviral in the time prescribed by PEP guidelines	Y	N

❑ DRUGS, EQUIPMENT AND SUPPLIES

• Do stock outs of HIV related drugs occur (how often in last three months)?	Y	N
• Rapid Tests		
– Do stock outs of Rapid Tests or reagents occur (how often in last three months)?	Y	N
– Is the stock control procedure being followed?	Y	N
– Are there bin cards for test kits?	Y	N
– Are the bin cards correctly filled?	Y	N
– Are test kits stored properly	Y	N
– Are test kits being used before expiry dates?	Y	N

❑ CONDOMS

• Are condoms available at the clinic today?	Y	N
• Are condoms available in areas easily accessible to all persons visiting the clinic and in consulting rooms?	Y	N
• Are condoms stored in a cool and dry place?	Y	N
• Are there expired condoms in stock?	Y	N
• Are condoms supplied to community depots from this clinic?	Y	N

❑ RECORDING

• Are all HIV Registers correctly completed and kept up to date	Y	N
• Are clinic retained patient records correctly completed	Y	N
• Are clinic retained patient records stored in a safe and confidential manner?	Y	N
• Is the PHC monthly report for HIV/AIDS correctly completed	Y	N
• Are HIV/AIDS graphs correctly graphed and up to date	Y	N
• Are there sufficient stocks of stationary for the HIV/AIDS programme	Y	N

CHECKLIST: HIV/AIDS

NOTES

FOLLOW UP ACTIVITIES

ACTIVITY	DONE

CHECKLIST: DRUG MANAGEMENT

CLINIC _____ **DATE** _____

INFRASTRUCTURE CONDITIONS

[✓] Tick if statement is TRUE

❑ **How does your store match up to the ideal store**

- The store is separate from the dispensary
- Drugs are dispensed only from the dispensing area
- The store is large enough to keep all supplies
- The store is kept locked at all times when not in use
- There are no cracks, holes or sign of water damage in the store
- There is a ceiling in the store which is in good condition
- Air moves freely in the store; fans and screens in good condition
- The windows are painted in white (or have curtains) and are secured with grills
- There are no signs of pest infestations in the store (ie cockroaches, rats,…)
- The store is tidy; shelves are dusted, the floor is swept, and walls are clean
- Supplies are stored neatly on shelves or in boxes
- Shelves and boxes are raised off the floor, on pallets or on boards and bricks
- There are no supplies in direct contact with the floor

STORAGE PROCEDURES

❑ **How well is your store organised**

- Supplies are systematically classified on the shelves (ie. by dosage forms or therapeutic class)
- Supplies are arranged on the shelves in alphabetical order by generic name within each category
- Tablets and other dry medicines (eg ORS) are stored in airtight containers
- Liquids, ointments and injectables are stored on the middle shelves
- Supplies, like surgical items, condoms and bandages are stored in the bottom shelves
- Items are grouped in amounts that are easy to count
- There are no expired drugs in the store
- Drugs with shorter expiry dates are placed in front of those with later expiry dates (FEFO)
- Supplies with no expiry or manufacture date are stored in the order received (FIFO)
- Supplies with a manufacture date only are stored in chronological order
- There are no damaged containers or packages on the shelves
- There are no overstocked, or obsolete items on the shelves
- The disposal of drugs is recorded in a separate register and includes the date, time, witness, value, quantities and reason(s)
- Narcotics and psychotropic drugs are in a separate double-locked storage space
- Are items checked regularly for potential deterioration (ie. bad odour or discoloured tablets)
- Temperature sensitive items are stored in a refrigerator
- The refrigerator is in working condition
- There is no staff food in the refrigerator
- A temperature record is available and up-to-date

CHECKLIST: DRUG MANAGEMENT

STOCK CARD **[✓] Tick if statement is TRUE**

❑ **How are the stock cards used in your facility**

• Is there a stock card for each item in the store	Y	N
• Is the stock card kept on the same shelf as the item		
• Is all information on the stock card up-to-date	Y	N
• Is information recorded on the stock card at the time of movement	Y	N
• Is there an accurate running tally kept in the **balance** column	Y	N
• Is a physical count made at regular intervals, such as once a month	Y	N

ORDERING SUPPLIES

❑ **If delivery schedules changes**

• How often do you place an order		
• What is your average lead time		
• What is your facility's reorder factor		
• Do you know how to calculate the Average Monthly Consumption (AMC) – Ask/Check Formula	Y	N
• Do you take into consideration stock out period when calculating the AMC	Y	N
• Do you calculate the Maximum Stock by multiplying the AMC by the Maximum Stock Factor	Y	N
• Has the Maximum Stock been calculated for each item in the store	Y	N
• Is the Maximum Stock recorded on each item's stock card (in pencil)	Y	N
• When was the last time that the Maximum Stock was reviewed		
• When you order, do you use the Quantity to Order formula – Ask/Check Formula	Y	N
• Is a standard requisition form used	Y	N
• Are all orders placed in writing using the prescribed forms	Y	N
• Is the requisition book kept at the facility	Y	N
• Is all information on the requisition form accurate and clearly written	Y	N

RECEIVING SUPPLIES

❑ **How are supplies received at your store**

• Are deliveries received by a health worker in person	Y	N
• Are deliveries inspected by a health worker before acceptance	Y	N
• Are supplies received against the items listed on the packing slip/delivery form checked	Y	N
• Are deliveries acknowledged and recorded on the prescribed forms	Y	N
• Does the delivery person sign the form before he leaves the facility	Y	N
• Have you ever sent back items to the supplier - as for the Reason		
• Are the expiry dates of all items checked before final acceptance	Y	N
• The health worker checks for poor quality items, such as		
– poorly packaged refrigerated items	Y	N
– discolouration of drugs, vaccines and suspicious product settlement	Y	N
– broken containers and supplies spoiled by leakage	Y	N
– unsealed and unlabelled items	Y	N
• As soon as the supplies are checked; are all receipts recorded on the stock cards	Y	N

CHECKLIST: DRUG MANAGEMENT

[✓] Tick if statement is TRUE

• If poor quality products are suspected, does the health worker check for		
– unusual odours of tablets and capsules	Y	N
– damaged containers	Y	N
– injectables with small particles that reflect light	Y	N
• Suspension with broken glass	Y	N
• Do you accept expired or poor quality items	Y	N
• Are all discrepancies documented	Y	N

CHECKLIST: DRUG MANAGEMENT

NOTES

FOLLOW UP ACTIVITIES

ACTIVITY	DONE	DATE

CHECKLIST: INFORMATION SYSTEM

CLINIC _____ **DATE** _____

Tick appropriate box [✓]

❑ Data Collection

• Is the clinic using a Tick register /Tally sheet for recording clients	Y	N
• Are the ages of clients ticked	Y	N
• Are all children under five weighed	Y	N
• Are children not gaining weight recorded	Y	N
• Are the immunizations recorded		
• Are those fully immunized recorded	Y	N
• Have pregnant women been give Tetanus Toxoid	Y	N
• Have contact slips been issued	Y	N
• Are condoms issued recorded	Y	N
• Have the running totals been done	Y	N

❑ Monthly PHC Report

• Are the Monthly Reports submitted on time at the end of the month	Y	N
• Are copies kept in the clinic	Y	N
• Are the any gaps/unfilled spaces in the forms	Y	N
• Have comments been made against the gaps	Y	N
• Does the staff discuss the report	Y	N

❑ Data Analysis/Interpretation

• Do they have a map of the catchment area	Y	N
• Are indicators calculated	Y	N
• Do they have graphs displayed on the wall	Y	N
• Are the graphs up to date	Y	N
• Child Health Graphs - Immunization Coverage	Y	N
- Children Not Gaining Weight	Y	N
- Diarrhoeal Incidence	Y	N
- Lower Respiratory Tract Infection	Y	N
• Maternal Health Indicators	Y	N
• Communicable Diseases Indicators	Y	N
• Any other, additional graphs displayed	Y	n
• Are there any trends and variation noted on the graphs	Y	N
• Is there any action taken - based on the information	Y	N
• Are the graphs discusses with the clinic supervisor	Y	N

❑ Feedback

• Do they receive written feedback from the supervisor	Y	N
• Is the information shared with the community through the Clinic Committee	Y	N

CHECKLIST: INFORMATION SYSTEM

NOTES

FOLLOW UP ACTIVITIES

ACTIVITY	DONE

SECTION 11

CLINICAL TIPS

- Introduction
- Counselling
- Tuberculosis
- Asthma
- Diarrhoea
- Vitamin A use
- HIV/AIDS
- Contraceptive Services
- Drug Management

Revised date: 3 February 2003

SECTION 11: CLINICAL TIPS

INTRODUCTION

Continuing education is an important responsibility of the supervisor in clinics. Staff cannot be expected to leave the clinic and attend outside workshops on a regular basis, it is simply too costly and disruptive. However, every month new information should be shared and staff should have the feeling that the supervisor always brings new insights and education keeping them up to date and progressing their knowledge and skills. This section on clinical tips provides examples of 1 - 2 page educational aids that can be copied and provided to clinic staff to facilitate discussions and lead to new knowledge and improve quality of services. These are purposely kept brief and are designed to encourage discussion and self analysis in the clinic. The enclosed clinical tips may prove useful, but these should be supplemented by others drawn up locally to meet local need. A continuing inclusion of 1 - 2 page information sheets provided by provincial program managers will facilitate the supervisors task of providing continuing education.

The organisers of this manual hope that as you find useful tips to include in this section that you will send them to up for inclusion in future versions of this manual.

Fact Sheet

TUBERCULOSIS

A thin and ill-looking John comes to your clinic: "I have been coughing for the last month. I have chest pains. I feel weak and tired. I have come to the clinic twice but your treatment did not work. Can you help me? Sister! What do you think is the problem?" **Answer: PTB**

Why is TB so important?

- TB is a major health problem effecting many persons in SA
- It is a treatable disease
- The AIDS epidemic will lead to a great increase in TB patients

What is the most important objective of the TB Control Programme

The most critical area of the TBCP is to treat new sputum positive TB cases (infectious cases). New cases are those who develop pulmonary TB for the first time. The government has given us the target to cure 85% of these new cases. By effectively treating these cases the epidemic will be slowed and controlled and the problem of MDR TB cases will be diminished. "**What is MDR TB? What can we do to prevent MDR TB?**" (see pg 59-61 of TUBERCULOSIS. A Training Manual for Health Workers).

What tools do we have to assist us in dealing with our TB patients?

We have a number of tools to help us to deal with TB patients. You listen to your patient's complaints and you listen to his chest and you use one of the tools you have at hand to help John. What is the first tool you have to use?

The sputum examination (diagnosis) - When a patient comes in for the first time and we suspect TB we can request a sputum specimen from our patient, which is then sent for a direct smear. **"What is a direct sputum smear? When do we request a direct sputum smear? How many specimens do we request"? What about the use of chest-x rays?** (See chapter 5 – How to diagnose Pulmonary TB. TUBERCULOSIS. A Training Manual for Health Workers)

The results come back positive – John has TB. What is your second tool you have?

Good drugs - TB drugs work and are able to cure most patients. You look in the TBCP guidelines and decide which drugs and then –oops! **What do you do? What is the third tool you have to use?**

DOTS - DOTS is a tool you have in your hands to ensure that John receives all his treatment in a supervised fashion. **Why do we use DOTS?** You have now diagnosed John's TB, you have started his treatment and you have arranged for DOTS – **what is the next tool you have available to support you?**

TB Register - Your TB register can support you in helping John. The TB register tells you where John lives, who his treatment supporter is, his response to treatment and eventually serves as a source of information when you have to submit John's statistics to the district office. **When do you enter the patients name into the register? How do you know that the register is correctly completed? When are statistics compiled? How do you know when they are correct?**

The last tool you have is the documentation provided by the NDOH.

SECTION 11: CLINICAL TIPS

TB documentation - The NDoH have provided us with very useful resource materials to consult when we have a query about a patient with TB or the TBCP. These documents are very useful sources of information and should be readily available. They include the following:

- **The South African TB Control Programme.** Practical Guidelines 2000 - This documents you and other health workers to do the same thing when managing TB (it provides for uniformity in TBCP which is essential when you develop a national TBCP)

- **TUBERCULOSIS -** A Training Manual for Health Workers. This document gives a lot of background information on TB – clinical and non-clinical.

- **EDL/STG Guidelines**

- **Manual** – completing the register

TB programme dilemmas:

Most of your TB patients will present with pulmonary TB – at times problems will crop up.

- There are however patients who will present like John but you won't get a positive sputum result back for them. What do you do then? (See flow diagram Page 7. Practical Guidelines. 2000)
- At other times John will tell you that he has a child of four at home. What do you do? Oh yes and what about the rest of John's family (see p 20 Practical Guidelines. 2000)?
- John comes back after he has been on treatment for two months and tells you that he feels nauseous when he takes his treatment. What do you do? (See Page 13 Practical Guidelines. 2000)
- John's 2 month sputum comes back and it is still positive. What do you do? (Refer flow diagrams – page 12 Practical Guidelines 2000)
- The worst possible thing happens! John comes to your clinic for treatment and you don't have TB drugs! You've got a problem! What do you do?
- Then one day, John's treatment supporter comes to you and tells you that John has gone to look for work in Johannesburg. What do you do?

How do you know that you are dealing effectively with the problem of TB in your clinic?

Eventually John is cured. He is one of a number of TB cases you are responsible for in your community. How well are you doing with your TB patients as individuals and are you lessening the impact of the TB epidemic?

You are doing really well when:

- You are curing 85% of your PTB patients.
- Less than 10% of your PTB patients are interrupting treatment.
- The sputum of 85% of new cases (at 2 months) and 80% for retreatment cases (3 months) converts from positive to negative .
- You are really looking for new TB suspects and sending their sputum off for investigation.

Fact Sheet

ASTHMA

What do I need to know about asthma?

- Asthma is a chronic condition – there are recurrent episodes and it needs long term management.
- Asthma is due to a combination of reversible spasm of the bronchi and inflammatory oedema of the bronchi for example from a virus infection.
- The bronchi react to a variety of substances to which the patient is allergic for example cats fur or nuts or house dust.
- Because there can be both inflammation in the bronchi and spasm two drugs are most used – anti-inflammatory (steroids such as beclometasone) and antispasm (Beta agonists such as salbutamol).
- The drugs are most quickly effective when given by inhalation but can also be given by mouth.
- There is a strong genetic tendency with asthma being common in some families.
- Any child with asthma can have a severe or life-threatening attack at any time.

What does a chronic illness mean in childhood?

Asthma is one such illness and it will affect a child more if parents do not understand the disease and how to avoid recurrences and know how to manage it while allowing the child a normal life.

Clinics must manage a child quickly, efficiently and with love so the visits to the clinic do not become something for the child to fear. Parents will spend money repeatedly on travel if episodes are not managed properly by the clinic and by the parents who have been given the right information.

What is needed in the clinic?

- Posters and pamphlets on asthma in the correct language for patients or their carers.
- A chronic disease register
- The green standard treatment guidelines and the drugs mentioned for asthma (inhalation and oral)
- Nebulizers
- Spacers made from 500ml plastic juice bottles
- A peak expiratory flow rate (PEFR) meter
- Oxygen and nasal catheters for child or masks for adult and child

How will I recognize asthma and its likely triggers?

It is shown by wheezing, shortness of breath and cough.

The wheezing which is the most important symptom is most marked during breathing out which is prolonged. When airways are severely obstructed more effort is needed as shown by intercostals retraction.

During an attack the wheezing sounds can be heard with or without a stethoscope. In children wheezing is most probably due to asthma triggered by an allergy or viral infection, vigorous exercise or emotion. In early childhood, respiratory infections are the most important trigger and as the child gets older other triggers become more important.

ASTHMA

What factors can cause an attack?

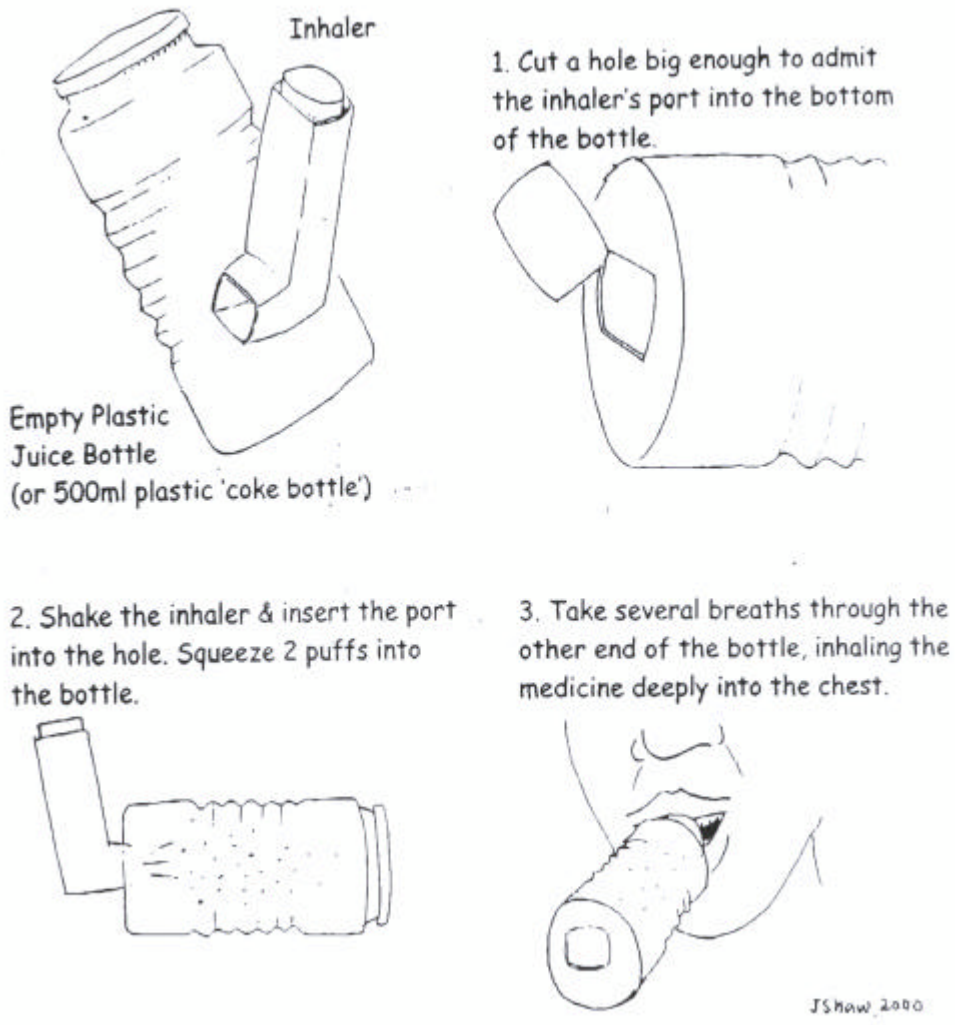
- Inhalation of cigarette smoke
- Dusts in the air which come from cat fur mites in house dust, problems from flowering plants
- Smoke from indoor fires
- Foods and soft drinks containing preservatives or colouring agents

Watch the childs diet and try to find which things have been taken to trigger an attack

What is a spacer?

Inhaled drugs work best with a metered dose inhaler but small children have difficulty breathing to coordinate with the dose. A spacer reduces the risk of side effects and one puff into the spacer can then be inhaled by five breaths. The spacer should be washed once a week and left to dry.

The illustration shows a 500ml plastic juice bottle, which has been adapted to take the nebuliser.



ASTHMA

Do I have the skills to use all of these?

Can I

- Explain the disease to the patient or carer and instruct them on continued management and prevention of attacks
- Understand (and review periodically) the chapter on asthma – chronic asthma, mild asthma moderate to severs asthma, acute severe emergency bronchospasm
- Show a patient how to use an inhaler and spacer
- Make a cheap spacer out of a plastic bottle
- Use a spacer and mask
- Use a PEFR meter
- Give oxygen using a mask

NOW HERE ARE TWO PATIENTS

Mr A Nurse I've "wheeze, wheeze" got asthma “wheeze” again

Nurse Take two puffs from your inhaler and tell me all about it

Mr A My puffer is empty

Nurse Okay, here's a refill now tell me what has happened in the last two weeks. Good you've written it down as I suggested. Night attacks and having to use your inhaler four times a day. Visiting a neighbour’s house with lots of animals. Well Mr A what are we going to do about it – lets hear your suggestions …… and now I suggest also ……

Now fill in the rest of the scenario.

MRS B AND CHILD AGE 5

Mrs B "Little Sipho is coughing and having a fever and making such wheezing noises. In fact we've all been sick with coughs and colds in the last two weeks".

Nurse Is this the first time he has wheezed so much?

Mrs B No, you will see in the notes it first started when he was, was it 2 or 3?

Now complete your management and check your reply with the guidelines

Did you think of the inflammation/oedema and bronchospasm elements in the cause of asthma? Did you elicit how recurrent the problem is, what are related trigger factors and what the response to treatment has been?

Grade the type of asthma

- 80% are mild with very few attacks months apart and they respond to the bronchodilators (Salbutamol).
- 15% are moderate – every few weeks and inhaled bronchodilators has to be used intermittently while inhaled beclomethasone is used more regularly.
- 5% are severs with daily wheezing and the child waking with a tight chest or coughing.

These need referral and will need oral steroids.

SECTION 11: CLINICAL TIPS

ASTHMA

Correct use of drugs

1 Beta 2 agonist (Salbutamol) for mild asthma. When not more than one episode cough/wheeze per week, no night coughing or wheezing, and not recent admission to hospital and PEFR more than 80% predicted. Salbutamol child – 100 – 200 micrograms (1 - 2 puffs) 4 - 6 hourly adult - 200 micrograms (2 puffs) not continually.

2 Inhaled corticosteroid therapy – beclomethasone when
- More than one attack per week
- Severe attacks
- Frequent night time couth / wheeze
- Have to use salbutamol more than twice a day
- PEFR less than 60% predicted

Beclomethasone children 100 micrograms day. Adults maximum 400 micrograms preferably 200 microgram per day. Can start with higher dose till controlled, then reduce to minimum.

3 Other drugs ipratropium bromide inhaler and theophyline are initiated by doctors and are used more for adults and smokers.

4 Severs acute emergency bronchospasm with asthma and chronic obstructive bronchitis needs oxygen and nebulized salbutamol and oral prednisone or hydrocortisone sodium succinate intravenously. Do not sedate. Refer to hospital.

Education of carers

Carers can reduce exposure to trigger factors only if these are explained to them. The carer must know about the recurrent nature of asthma and must understand the use of the two common drugs and the way to deliver them by inhalation.

The signs of worsening or severe asthma must be explained.

Referral

1 How many cases have been referred in the lat 3 months?
2 Were they all entered in a referral register and noted in the chronic disease register?
3 Were the cases referred because:
- There was failure to control frequency and severity of attacks
- The diagnosis was not clear
- Oral prednisone was being used to frequently and for too long
- Life-threatening attack
- Pregnancy with moderate asthma
- Patient arrived in severe attack late in afternoon and not sure if would improve

Follow-up

There should be regular follow-up to assess improvement – including measuring childs or adults PEFR. If asthma is under control for more than 3 months reduce the dose of steroids to the lowest possible.

Job aid for giving Vitamin A with routine immunizations

WHY Lack of vitamin A reduces the ability to fight infections and causes blindness
WHAT At each immunization contact with mothers and children, check and complete the following:

Possible immunization contact	Age Group/Timing	Amount of Vitamin A	
		If using 100,000 IU capsules	If using 200,000 IU capsules
BCG contact (up to 8 weeks postpartum)	For mothers up to 8 weeks postpartum if breastfeeding (up to 6 weeks postpartum if not breastfeeding)	2 capsules	1 capsule
Any immunization contact from about 6 months	Infants 6 - 11 months	Drops 1 capsule	½ drops in a capsule
	Children 12 months or older	Drops in 2 capsules	Drops in 1 capsule
Measles vaccination contacts	Infants 9 - 11 months	Drops in 1 capsule	½ drops in a capsule
	Children 12 months or older	Drops in 2 capsules	Drops in 1 capsule
Booster doses, special campaigns, delayed primary immunization doses, immunization strategies for high-risk areas or groups	Infants 6 - 11 months	Drops in 1 capsule (every 4 - 6 months until 59 months of age)	Drops in 1 capsule (every 4 - 6 months until 59 months of age)
	Children 12 months or older	Drops in 2 capsules (every 4 - 6 months until 59 months of age)	Drops in 1 capsule (every 4 - 6 months until 59 months of age)

Do not give the child vitamin A if he/she has taken drops in the past 30 days.

HOW

1. Check the dose in the capsules, the child's age (for mothers, the date of delivery), and when the last dose of vitamin A was received.
2. Cut the narrow end of each capsule with scissors or a nail cutter and squeeze the drops into the child's mouth. Ask mothers to swallow the capsule in your presence. Do **not** ask a child to swallow the capsule. Do **not** give the capsule to the mother to take away.
3. To give less than 1 capsule to a child, count the number of drops in a sample capsule when a new batch of capsules is first opened. Give one-half or one-quarter the number of drops from capsules in that batch.
4. Record the date of the dose of the child's card and the mother's dose on the mother's card.
5. On the tally sheet/register, place a mark for each mother dosed and another mark for each child dosed. Make a monthly/quarterly/annual chart of vitamin A coverage the same way as immunization coverage is charted. Report coverage of mothers' dose, first dose for infants, and second dose for infants routinely with immunization coverage.
6. Advise the mother when to return for the next doses of vitamin A and encourage completion of the immunization schedule, in addition to vitamin A protocols.

Fact Sheet

DRUG MANAGEMENT

What is meant by "Rational" prescribing and drug medicine use?

- The sick person (client) receives the correct drug/medication.
- The prescribed drug is appropriately indicated for client's current clinical condition or need.
- The drug is appropriate in terms of efficacy, safety and suitability to the client (eg no contraindications)
- The dosage and course of treatment are correct in that they meet individual's requirements for cure or relieve of symptoms or correction of physiological abnormality.
- The cost of drug is the lowest for the person and the community.
- The drug is correctly dispensed and client has received information about both his/her illness and the drug.
- The drug is packed and issued in a way that promotes adherence and continuity.

What can the PHC nurse do to promote rational use of drugs?

You can promote rational prescribing and use of drugs by routinely observing the following steps:

- Start with diagnosing the sick person's health problem ie define or name the clinical problem that requires therapeutic drug intervention.
- Use the relevant sections of Standard Treatment Guidelines/EDL at every step.
- Define the therapeutic management objective related to the diagnosis ie decide if the objective is to cure infection, prevent complications, prevent dehydration or correct it, relieve symptoms such as pain etc.
- Select which treatment (drug or non-drug) is required to achieve the desired objective for each individual sick person.
- If a decision is made in favour of drug treatment, determine which is the best drug based on efficacy, safety, suitability to individual and cost. Be guided by the Standard Treatment Guidelines/EDL.
- Identify the dose, route of administration and duration. Be guided by the condition of patient.
- Give accurate and adequate information to the client and his family about his health condition and the drugs.
- Give client a follow-up appointment and information on what to expect. These enable you to monitor both therapeutic and any adverse effects of the treatment.
- Dispense the drugs in safe hygienic manner.
- Make sure the client or guardian understands clearly about the dosage, course of therapy and how/when to take the drugs.
- Encourage adherence to instructions and completion of the course.

DRUG MANAGEMENT

What to avoid when prescribing or dispensing drugs

Use of drugs where no drugs or non drug treatment is indicated. For example, some prescribes may continue to use antibiotics to treat diarrhoea in situations where only ORS its indicated.

- Use of wrong drugs for example, use of a tetracycline – a broad spectrum antibiotic rather than a narrow spectrum penicillin – as prophylaxis if rheumatic fever.
- Use of ineffective drugs and drugs with doubtful efficacy eg excessive and unnecessary use of multivitamin preparations and tonics.
- Use of unsafe drugs eg continue retention and use of banned drugs or long expired preparations.
- Under-use of available effective drugs/treatment preparations eg ORS prescribed in only a few children with diarrhoea dehydration.
- Incorrect use of drugs eg
  - giving 1 or 2 days supply of antibiotics instead of full course
  - over using injections to please clients/community
- Over-prescribing – giving too many medicines at once or always prescribing a drug for everyone who turns up
- Over-prescribing implies to sick people that need drugs for every aliment. This makes people to inappropriately rely on drugs.

Challenge

- Use the fact sheet information to review and strengthen your own practices on prescribing drugs.
- Use the fact sheet to assist other clinical staff observe correct practices when giving/dispensing medicines.
- Share the progress with supervisor.

SECTION 12

PROBLEM SOLVING AND PRACTICAL SOLUTIONS TO COMMON PROBLEMS

- Increasing EPI Coverage
- Managing Drug Stock Outs

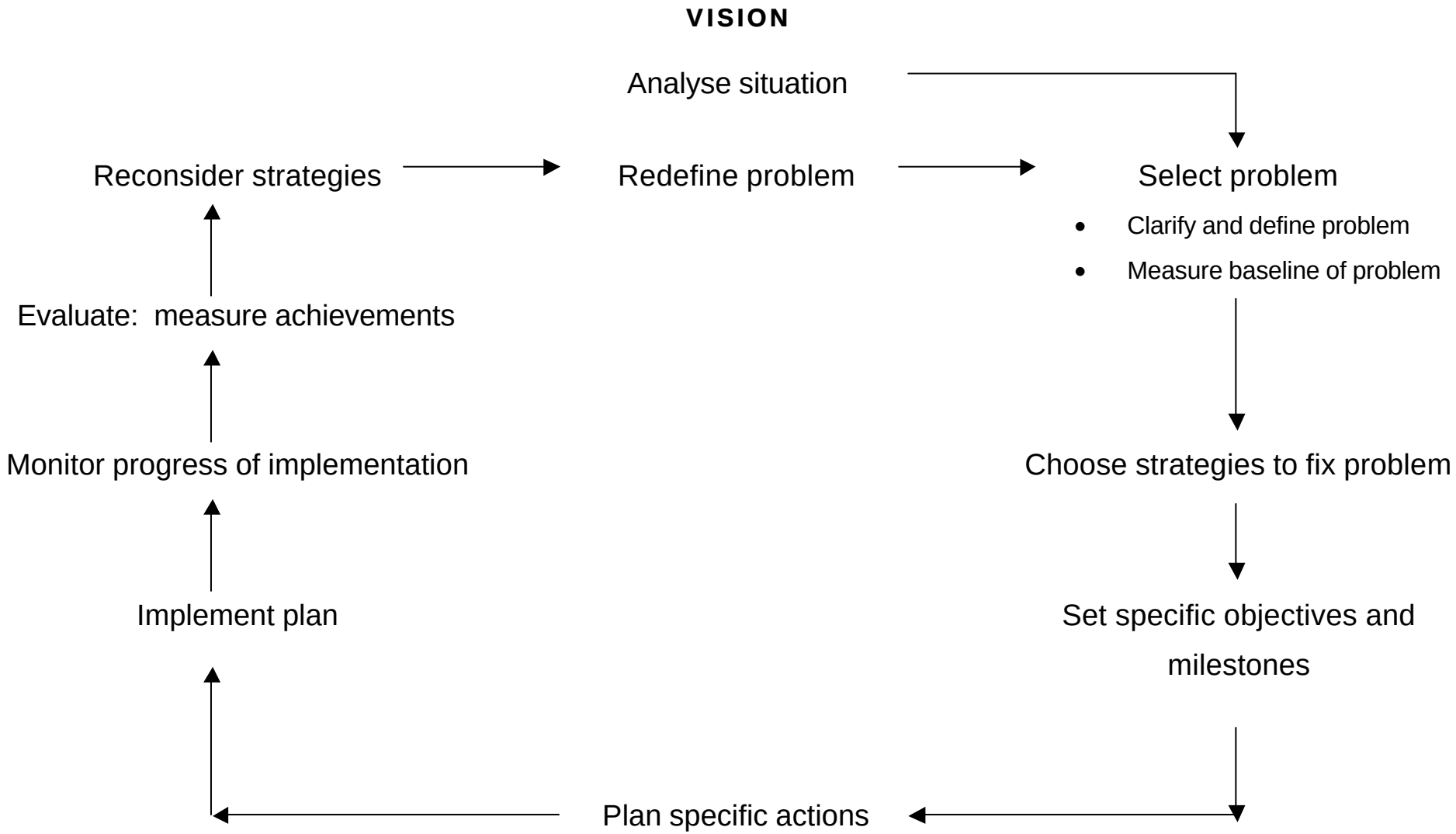
Revised date: 3 February 2003

SECTION 12: PROBLEM SOLVING AND PRACTICAL SOLUTIONS TO COMMON PROBLEMS

INTRODUCTION

The clinic supervisor and clinic staff are regularly faced with problems which need to be solved. This section includes the strategic action cycle and some practical solutions to common problems within the district. As commonly occurring problems are solved in clinics they should be written up and included into this section. As an example, it would be possible to write a page on how to organise an efficient patient flow system through the clinic.

STRATEGIC ACTION CYCLE



Revised date: 3 February 2003

STRATEGIC ACTION CYCLE

The following steps will be helpful in clarifying areas that need attention, breaking issues or problems into manageable pieces and addressing them in a systematic way.

1	Vision	Using a vision as starting point maintains focus on direction and values that are important to the team. Use an overall vision for the clinic as a whole, but use a more specific vision when planning or problem solving for a service or programme.
2	Analyse situation	Carry out a "contextual analysis" or "situation analysis" using a tool or approach that provides a consistent and organised picture of the kinds of issues you are investigating.
3	Select problem	From the situation analysis, identify areas that need attention. From them, determine what most seriously needs attention, what is feasible to work on with the available skills and financial resources. Often a good choice is an area that the team is motivated and enthusiastic about addressing.
4	Clarify and define problem	Using a systematic approach, identify various components and roots of the problem. Try not to define the problem as the absence of an assumed solution (eg transport, separating staff from hospitals), but rather in terms of what is needed or what ought to be. This allows for more creativity in identifying optional strategies.
5	Measure baseline of problem	Once the problem is more clearly defined, establish the starting point, or baseline. The more objectively the starting point can be expressed, the more effectively progress can be measured.
6	Choose strategy to fix problem	Explore different approaches to dealing with the problem. Also explore who should be involved as a resource or who must be co-opted in order to ensure successful implementation. Choose an approach that seems effective, feasible and appropriate in your setting.
7	Set specific objectives and milestones	For each strategy, specific objectives that describe what will be accomplished should be established. Where possible, objectives or milestones should be expressed in terms of numbers of an accomplishment (eg 3 nurses trained, or a manual written) and describe the phases of progress to be made. Time frames are essential.
8	Plan specific actions	To reach each milestone, describe the specific steps that will be followed. Include who will be responsible for ensuring that each step is taken.
9	Implement plans	Get busy to carry out the above plan!
10	Monitor progress of implementation	Follow the progress in carrying out the actions described. If constraints or obstacles impede progress, make and implement a plan to deal with the obstacle, or modify the strategy to be more realistic. Ensure that all responsible parties are fulfilling their obligations.
11	Evaluate: measure achievements	Using the same technique as when establishing the baseline, assess progress made. Is there an improvement in the situation? In not, why not? If yes, is progress sufficient? What other related gains were made?
12	Reconsider strategies	If more progress is needed, what is needed next? Is a change in strategy needed to make more progress?
13	Redefine problem	Follow the steps above to again clarify and define the problem as it is now, establish new baselines, etc. Follow the cycle through again.

INCREASING EPI COVERAGE

REACHING ONE HUNDRED PERCENT IMMUNISATION COVERAGE

Suggestions for Clinics

INTRODUCTION

The following is a series of suggestions, which emerge from experience in clinics, which have been successful in achieving full coverage of primary immunisation of all infants before they reach one year of age. As a priority programme this is one of the most important public health activities that a clinic can undertake. Clinic staff should discuss these ideas together and carry out these and other efforts to assure that every child born in the catchment area of the clinic is fully immunised before reaching his/her first birthday.

Register each pregnant women by name in a pregnancy register (ANC) and follow up to be sure that her child comes for immunisation on a regular basis, even if she delivers in a different institution. Many registers are incorrectly used, writing the name on a new line each time the mother or child comes to the clinic. A single line on the register is adequate to identify the mother and then the newborn child and follow that child, recording each immunisation recorded until fully immunised with the nine months dose of measles having completed BCG, polio, DPT, HiB, HBV series. A large box at the right-hand end of the line can indicate full immunisation and the date.

Wall chart - a wall chart can be maintained listing the names of children in the month in which they will reach their first birthday. Each child, as they come to be immunised, is entered once on that chart in the month of their first birthday. When the child completes full primary immunisation his name is ticked off or a star is placed next to the name. Each month, any child in that month's box who does not already have a star next to the name will be actively sought out and brought to the clinic to complete full immunisation if the 'Road to Health' card does not indicate that it was already done elsewhere. This provides an easy to monitor tool for clinic staff to see who has been missed out and they may take early action.

A cumulative coverage graph for fully immunised children to be kept on the wall of each clinic. Your supervisor can show you how to prepare and maintain this graph showing progress each month.

A missed opportunity contest can be held between nurses to see who can detect children coming to clinic for other complaints who need to be immunised before they leave the clinic. Nurses are recognised for having found and immunised the most children. Ask the village elders to help celebrate a special immunisation day, perhaps a particularly convenient time for mothers and children on a given afternoon or a Saturday morning when the clinic will celebrate immunisation and all children will come. Drums, traditional dancing, music and a festive occasion can involve everyone in the village.

Mobilise the schools to have each child go home and check their own sibling's immunisation cards and bring their siblings to the clinic if immunisation is missing. This is a school health and education activity, which teaches school children the importance of immunisation and uses them to reach into every home, their own and neighbours, to find un-immunised children.

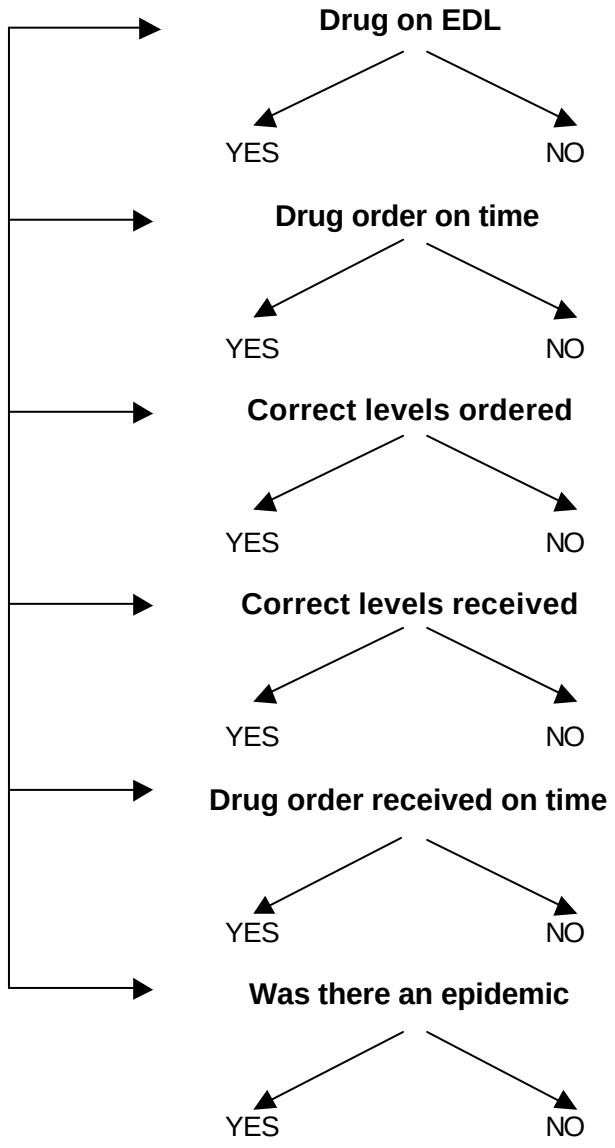
Ask the district office for transport for a **special village outreach** on an announced day to enable clinic staff to provide an immunisation service in the more distant villages of your catchment area making it more convenient. Adequate advance announcement to that village through its leaders and key informants is very important. This may be done with a special visit of your clinic supervisor who can help you organise and will of course arrange for your transport.

EPI INCREASING COVERAGE

Ask the village elders or responsible women volunteers in the village to **collect all immunisation cards** of children under two years of age and bring those cards to the clinic. Look at each card and determine whether the child is either fully immunised, or if further doses are needed, dividing them into two piles. Return the cards to the women volunteer showing her which pile of cards belong to children who must return to the clinic as soon as possible to complete their immunisation while the other pile of cards will be returned to children who are fully immunised and are not required to come to the clinic (until later boosters are required). Cards can be collected and returned on the same day as this takes very little time to sort in the clinic. A list can be kept of the names of the cards returned that are requiring further shots. If the wall chart and register are being used, check that these names also appear there.

HOW TO SOLVE DRUG STOCK OUT PROBLEMS

There are a limited number of causes for drug stock outs at the clinic. The flow chart below can help you figure out why your clinic does not have drugs from time to time and how you can address the problem.



Correct the expectation of drug being on EDL by referring to EDL Book

Review and reinforce ordering schedule

Review bin cards to determine whether correct ordering levels are calculated

Determine whether dispensaries are supplying adequate amount of drugs to clinic.

Review drug distribution mechanism

Review appropriateness of drug use by staff prescribing drugs