

*Esau*

**FINAL DRAFT**

**POLICY FRAMEWORK  
FOR NON-  
COMMUNICABLE  
CHRONIC CONDITIONS  
IN CHILDREN**

**OCTOBER 2002**

## NON-COMMUNICABLE CHRONIC CONDITIONS IN CHILDREN

### Definition of chronic conditions of childhood

A chronic condition is any physical condition that has lasted or is virtually certain to last for longer than one year and which requires comprehensive and coordinated long-term health care.

Non-communicable means it cannot be contracted from another person or, animal and cannot be transmitted in that way either.

## A POLICY FRAMEWORK FOR MANAGEMENT OF NON-COMMUNICABLE CHRONIC CONDITIONS OF CHILDHOOD.

### 1 INTRODUCTION

Contrary to popular belief, non-communicable chronic diseases are highly prevalent in developing countries, not only in adults or older persons, but also in children. This framework will cover diseases like cancers, asthma, diabetes mellitus, genetic conditions that will need long term management etc. and not HIV/AIDS, Tuberculosis or disabilities. The latter are addressed in other documents.

***Please can I be provided with figures of related chronic diseases/conditions if available.***

The different policies and guidelines related to childhood diseases/conditions will be coordinated within provinces by the programme coordinators of Child, Youth and Adolescent Health.

It is of utmost importance that a clear distinction is made and understood between the concepts of acute vs. chronic and communicable (infectious) vs. non-communicable diseases in order to effectively understand the type of care each one needs. Children with chronic conditions and their carers need to make lifestyle adjustments. Lifestyles are not changed by medication under normal circumstances.

Ongoing reliance on acute models has delayed the reforms in the health delivery system that are necessary to address long-term interventions for chronic non-communicable conditions.

For outcomes to be improved, health policy and health system changes are essential. Effective treatment of chronic conditions requires the transformation of health care towards a system that is pro-active and emphasises health across a lifespan, with the focus on the patient's/carer's roles and responsibilities in health care.

An integrated approach to care for chronic diseases is required. With this in mind, this policy framework has been developed to address the special needs of children with non-communicable chronic conditions within the framework of the existing health system, allowing children/carers to be active participants in their health care and not only passive recipients.

This policy framework will hopefully take health care beyond the doorway of the clinic into childrens' living and educational environments and to other responsible role players.

There are certain key issues applicable to long term chronic care:

- It is long term / life long and often incurable
- It should enhance quality of life
- Will require multi-drug regimens and self care
- Lifestyle changes / adjustments will be required
- Disease / condition can be controlled, and therefore should be controlled
- The child is the most important person in the case management

Refer to Annexure A

This policy framework will be accompanied by a set of implementation guidelines. These guidelines would provide the implementers of this policy with a clear idea of how the different services and management levels need to reconfigure in order to bridge the gap between the current service and management infrastructure and what is set out in the policy.

## **2. LEGAL CONTEXT FOR THE IMPLEMENTATION OF THIS POLICY FRAMEWORK**

The rights of children to "basic health care services" and non-discrimination is enshrined in the South Africa Constitution' (Chapter 2: Bill of Rights) and in the Convention on the Rights of the Child', adopted by SA in 1990.

2.1 The Bill of Rights (Section 9) protects everyone from unfair discrimination, on grounds of race, gender, age and disability, amongst others.

Section 27 of the Bill of Rights refers to the rights of everyone to health care services, and emergency medical care. Section 28 specifically focuses on children, and states *inter alia* that every child has a right to:

- nutrition and... basic health care services,
- be protected from maltreatment, neglect, abuse or degradation, and that the child's best interests are of paramount importance.....

<sup>1</sup> The Constitution of the Republic of South Africa, Act 108 of 1996

<sup>2</sup> The Convention on the Rights of the Child: Adopted by the general assembly of the United Nations of 20 November 1989

## 2.2 By adopting the Convention on the Rights of the Child, SA has committed to:

- protect children against all forms of discrimination (Article 2)
- act in the best interests of the Child (Article 3)
- protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment and maltreatment or exploitation..... (Article 19)
- ensure that children enjoy the highest attainable standard of health, and access to facilities for treatment of illness and rehabilitation of health (Articles 24 and 28).
- recognise the right of every child to a standard of living adequate for the child's spiritual, mental, physical, moral and social development .. (Article 27)

The term "basic health services" is generally understood to refer to a package of essential primary health care services, including preventive, promotive, basic curative and limited chronic care services. The aim of such services is to allow children to grow and develop optimally.

Children with non-communicable chronic conditions are usually at an increased risk of acute episodes of illnesses and complications thereof. These children often need additional health care and support to ensure appropriate and complete well-being, growth and development. Hence, the package of "basic health care", and the "highest attainable standard of health" for children with non-communicable chronic conditions, as enshrined in the Constitution (and Bill of Rights) and the Convention on the Rights of the Child, need to be re-defined for children with non-communicable chronic conditions. The package should include services that aim to minimise pain and discomfort attributed to the condition, that limit secondary disability, and which aim to optimise the quality of life for these children.

## 2.3 The National Health Bill

The National Health Bill specifies in Chapter 2 the Rights and Duties of Users and Health Care Providers. This section is mainly to set out the rights of users and health care providers and to respect, protect and promote the people of South Africa's constitutional right to health services.

Hence, as enshrined in the South African Constitution, the Convention on the Rights of the Child, and the Health Bill, children with a non-communicable chronic condition have a right to basic health services that ensure:

- Continuity of health care
- Greater access to appropriate specialised services
- Access to appropriate care, and monitoring at primary level
- Home treatment and community services appropriate to chronic care, and
- Standard appropriate, evidence-based treatment for the condition (at whatever level of the health services this treatment needs to be given)

This has implications for children with non-communicable chronic conditions, who are often in need of specialised medical care at tertiary level, and continued care at primary level.

It is within this context that this document outlines a policy framework for children with non-communicable chronic conditions.

### 3 GOAL

To encourage a health care system that responds to the needs of children with non-communicable chronic health conditions.

#### 3.1 OVERALL OBJECTIVE OF THE POLICY FRAMEWORK

Health services should meet the needs of children with chronic conditions

##### 3.1.1 Specific Objectives

- To apply the Convention of the Rights of the Child to the health care of children with chronic conditions
- To describe the service philosophy required to meet the needs of children with chronic conditions
- To define basic health services required at each level of the health service
- To define the responsibilities at each level
- To define the relationships between these levels to ensure coordination and continuity of services
- To delineate the support services required to sustain the programme

## 4. PHILOSOPHY UNDERLYING THE PROVISION OF HEALTH SERVICES FOR CHILDREN WITH NON-COMMUNICABLE CHRONIC CONDITIONS

### 4.1 Comprehensive integrated services

- Health services should be accessible to children and their carers at all appropriate levels
- **All** children should receive integrated care at all health facilities.
- Promotion of child development should be an essential part of care at all levels.
- Care of children with chronic conditions, at community level needs to occur within the framework of the community-based component of the Integrated Management of Childhood Illnesses (IMCI) Strategy.
- Children with chronic conditions require a dedicated professional health care provider who will provide support to children, carers and their families, as well as to staff at primary care level.

#### 4.2 Communication

- A written communication plan to be available and known to care providers and consumers.
- Communication between primary, secondary and tertiary level facilities is essential. Particular attention should be paid to communication when children are referred between levels, and when medication, not part of the primary care essential drugs list, is needed for a child who has been referred to primary level.
- Communication to the patient and carer is even of more importance – support talks, support groups, correct methods of communication, inter active education.
- Share decision-making. The carer should share the responsibility for the outcome and the treatment decisions.

#### 4.3 Continuity

- Referral systems should be closely linked with transport and communication
- All patients should have a patient carried card or a Road to Health Chart for children less than 5 years and a case management plan.
- A life course approach in prevention, promotion and treatment to be followed.

#### 4.4 Coordination

- The approach should be multi-sectoral, multi-disciplinary and multi-skilled.

#### 4.5 Community linkages

- Care of children with chronic conditions, at community level needs to occur within the framework of the community component of the Integrated Management of Childhood Illnesses (IMCI) Strategy.
- Families and carers of children with chronic conditions, and the children themselves, should be empowered to manage the condition with the assistance of health care staff.
- Locus of control should be with the carer and the patient.

#### 4.6 Caring ethos

- Client/patient centred and oriented care
- Health professional is the facilitator of the disease management process
- Improve quality of care
- Patient centred education

#### 4.7 Responsibilities and services

- Services must facilitate care of teenagers and their transfer, if appropriate, to adult – oriented health care services.

## 5. RESPONSIBILITIES AND SERVICES

### Management Responsibilities

#### A. Primary Level Clinics

##### Responsibilities

- Identification of at-risk children / keep "at risk register
- Identification of children with common chronic conditions of childhood and keep a register.
- Preventive and promotive services
- Case management:
  - Therapeutic education
  - Emergency care
  - Management of referrals from and to other level of care
  - Triaging of children according to needs (NB some children / conditions may need direct referral to specialist care levels)
  - Where resources allow, conditions can be diagnosed and treated according to specific management guidelines
  - Basic individual monitoring equipment should be provided, as per disease management guidelines
- Liaise with local community-based **organisations/services** dealing with childhood chronic conditions and palliative care.
- Ongoing care and support for the child and carers
- **Service/quality of care audits**

##### Support services

- Pharmaceutical services: Supply of **specialised drugs as** arranged with higher level of care and primary EDL drugs for common chronic conditions of childhood
- Basic rehabilitation services as mandated in the Primary Health Care Package
- Transport (see referral section)
- Community Based Organisations
- **Support groups/clubs** for carers and/or affected children
- Training and education of care providers
- School health services
- Palliative care. Refer to the Paediatric Palliative Care Guideline

## B. Community Health Centres (CHC)

### Responsibilities

- Preventive and promotive services to prevent onset of these conditions or prevent complications
- Case management of children with chronic conditions
  - Therapeutic education
  - Emergency care
  - Management of referrals from and to other level of care
  - Basic individual monitoring equipment should be provided, as per disease management guideline
  - Where resources allow conditions can be diagnosed and treated according to specific management guidelines.
- Refer where appropriate
- Liaise with / refer children to home/community based care services. (Refer Home-based Care Guideline)
- Register of children with chronic conditions
- Service/quality of care audits

### Support services

- Pharmaceutical services: supply of specialised drugs as arranged with higher level of care and primary EDL drugs for common chronic conditions of childhood
- Basic rehabilitation services as mandated in Primary Health Care Package
- Transport (see Referral section)
- Support groups/clubs
- Counselling services (psychosocial rehabilitation)
- Training and education of care providers
- School health services
- Integrate the primary level responsibilities as far as possible into the Integrated Management of Childhood Illnesses (IMCI) Strategy
  - Palliative Care. Refer to the Paediatric Palliative Care Guideline

## C. District Hospital

### Responsibilities

- Services as for CHC where no CHC is available
- Support for primary care clinics and CHCs
- Inpatient facilities for step down care
- Acute and emergency care for children with chronic conditions
- Paediatric clinics including
  - Follow-up of common chronic conditions
  - Diagnostic service for children referred from primary care services



- Therapeutic education services for children and their carers
- Training and education to health care providers
- Basic laboratory services, radiography services and other basic diagnostic support services
- Basic monitoring services
- Referrals
- Outreach paediatric services by paediatrician / medical officer to primary level
- Service/quality of care audits
- Liaison with special and mainstream schools in the region
- Liaison with NGOs, home/community-based care services and other role players

#### Support services

- Pharmaceutical services: supply of specialised drugs as arranged with higher care level and paediatric hospital EDL drugs for common chronic conditions/diseases of childhood
- Rehabilitation services as mandated in Hospital Norms and Standards
- Transport (see Referral section)
- Support groups/clubs
- Counselling (psychosocial rehabilitation)
- School health services support

#### D. Regional Hospital

##### Responsibilities

- Specialist paediatric services
  - Inpatient (diagnostic, therapeutic)
  - Outpatient (referral, continuity and condition specific clinics)
- Care of certain children with complex or rare conditions shared with tertiary centre
- Laboratory services, radiography services and other diagnostic support services
- School health services support
- Support for district hospitals
- Referral to specialist care
- Research
- Training, education and therapeutic education
- Service audits

### Support services

- Pharmaceutical services: supply of specialised drugs as arranged with tertiary centre and EDL drugs for chronic conditions/diseases of childhood
- Rehabilitation services, including psycho-social services
- Transport (see Referral section)

### E. Tertiary Hospital

#### Responsibilities

- Full range of specialised, medical, surgical, psychiatric diagnostic, therapeutic and rehabilitation services
- Multidisciplinary services, including social services
- Specialist, multidisciplinary care for children with complex and multiple chronic conditions/diseases
- Support for regional paediatrician and other relevant care provider
- Generate detailed reports on children's treatment for other levels of service
- Liaison with parent support groups and other relevant role players (less common conditions, highly specialised services)
- Specialised support to school health services
- Generate information and management guidelines on less common conditions
- Research and quality of care audits
- Training, education and therapeutic education

#### Support services

- Specialised support services
- Transport
- Specialist / pharmaceutical services

Note, Quaternary and highly specialised services would have a similar role and responsibilities as tertiary services.

## 6. REFERRAL SYSTEM

An effective referral system is fundamental for the success of the continuum of optimal care for children with non-communicable chronic conditions. The key components for such a system are:

- 1 A case management plan
- 2 Devolution of care to lowest possible level
- 3 A relationship between levels of health care
- 4 An efficient transport system

## 6.1 INTEGRATED CASE MANAGEMENT PLAN

A case management plan for each child, irrespective of diagnosis, should be available. The onus is on the health personnel to communicate (hard copy / email / phone) the management plan to the referral facility/service and care givers. The parents/carer should be active participants in the drawing up of the management plan. The management plan should:

- comply with the specific management guidelines (where available)
  - be drawn up at the level of health care responsible for full assessment
  - be drawn up with the division of responsibilities between health care levels in mind
  - be drawn up in consultation with the child and family/carer
  - identify a "case co-ordinator" from the health team caring for children with complex and/or multiple conditions
  - be in written format
  - contain contact details for key health workers
  - be summarised on the Road to Health Chart or patient-carried card
- A patient carried card is an efficient way of maintaining contact and ensuring continuity of care.

## 6.2 DEVOLUTION OF CARE TO LOWEST POSSIBLE LEVEL

Care can only be devolved to centres where adequate drugs and other resources allow.

Once the child has been diagnosed with a specific condition and a management plan worked out, care of this child should be devolved to the lowest possible level. In planning such devolution, the following needs to be considered:

- Medicines, assistive devices etc. need to be available, or accessible to the lower level of care
- Ensure that appropriate services exist before referral
- A plan for emergency care needs to be in place

## 6.3 RELATIONSHIP BETWEEN LEVELS OF HEALTH CARE

- Continuity of care and ongoing collaboration, cooperation and support between levels of care are crucial.
- Communication (written, telephonic, electronic) between levels of health care is essential and should occur with every review or emergency visit
- The Road to Health Chart/Patient carried card is the ideal means of written communication.
- The case management plan should be communicated to pharmacies and suppliers of assistive devices or other equipment.
- Mutual respect should be fostered between professionals at different levels and within treatment relationships

## 6.4 EFFICIENT TRANSPORT SYSTEM

Currently children with chronic conditions do not have appropriate access to transport between levels of health care. Travelling to secondary or tertiary health facilities is essential for optimal health care.

- Innovative actions e.g. transport vouchers, to ensure transport at all times, on time and to be reliable
- Services must be of sufficient size and efficiency to avoid competition for transport between children with acute and chronic conditions (Missed appointments may be a medical disaster)
- A parent/carer must accompany a child.
- Emergency transport for some children may need to bypass secondary care facilities. The necessity for this should be specified in the integrated case management plan.
- Across border transport should be arranged where necessary.

## 7. DRUGS, SUPPLIES AND ASSISTIVE DEVICES

The following three principles outline a framework that would ensure *timeous* delivery of appropriate, good quality medicines and products through an efficient procurement and distribution system using appropriate budgeting and financial management methods.

Systems must also facilitate all facets of inter-provincial referrals, particularly the financial issues and timeous availability of products.

### Principles

1. Prescription practices must be in accordance with approved national disease management guidelines. To be revised on a regular basis together with the EDL (2 yearly).
2. Pharmacy management systems should ensure that drugs, supplies, individual monitoring equipment and assistive devices (refer - Assistive Devices Policy) are available at the most appropriate level for the child, as required and should meet the needs of children with non-communicable conditions
3. The financial implications of specialised drugs/supplies shall be borne: by the level of original prescription.

## 8. THE TRANSITION FROM CHILD TO ADULT ORIENTATED HEALTH CARE

Advances in paediatric health care in this country have meant that more children with ever more complex conditions are surviving through childhood and adolescence to adulthood. A disease like cystic fibrosis is no longer lethal in childhood. Many children who have had surgery for complex congenital heart lesions enter adulthood.

The child with a chronic condition becomes an adolescent with a chronic condition who in turn becomes an adult with a chronic condition. The process of change from child-oriented to adult-oriented health care involves a series of changes in the relationship of the young person to his/her condition, family, friends and health care providers. Health services for these young people need to respond appropriately to these changes.

Hard and fast rules regarding the timing and need for transfer of these young persons to adult-oriented care cannot be set. Thirteen years, the age at which some child health services cease to see children, is too young an age for transfer in almost all moderate to severe conditions.

Survivors of childhood cancer may be best followed into adulthood by the service that treated the cancer; there would be little point in transferring an 18 year old dying of muscular dystrophy from the service that has cared for him all his life; a pubertal 14 year old with diabetes mellitus may be ready to move to a sympathetic adult-oriented service; an 18 year old with a rare disease may be best cared for into adulthood by a paediatric expert.

In general, depending on available services, and after adequate preparation, transfer should start at 16 years with a hand over period up to age 18 years.

Health services need to facilitate the transition in the following ways:

### Facilities

- Endorse flexible rules about the age of transfer from child to adult health services
- Provide adolescent-oriented services where possible – especially at secondary and tertiary facilities
- Encourage the development of adult services that can take on young persons coming with chronic conditions and 'new diseases' from paediatric services
- Facilitate easy access to mental health services for adolescents.
- Foster co-operation between paediatric and adult-oriented specialist services

### **Children's health services**

- Provide anticipatory guidance to child and parents/carer re-growing up with a chronic condition.
- Provide anticipatory guidance re transition to adult services.
- Encourage independence in self care for the **child/adolescent**.
- Seek and foster adult-oriented partners in the health care of older adolescents.
- Provide adult-oriented services with all details pertaining to the child's medical history.
- Harmonise management protocols with in adult-oriented health service;

### **Adult health services**

- Accept **parental/carer** involvement in the young person's health care (i.e. the young person is rarely an independent entity at the time of transfer).
- Acknowledge what has gone before in the person's health care (i.e. do not repeat all the tests).
- Foster links with partners in child and chronic care community health services.
- Harmonise protocols with child health services

## **9. IMPLEMENTATION REQUIREMENTS**

- A set of minimum norms and standards for the different levels of service delivery and service management.
- A framework for what is required at each level of service delivery and how the service should move towards instituting the required service.
- A framework for what is required at each level of management and how that level of management should move towards setting up the required management systems and support.
- An estimated set of additional resources, including financial projections that would be required to implement the policy.
- An outline of what additional training would be required by different staff categories.
- Clear case management guidelines for the conditions covered by the policy.

ANNEXURE A

Table 1: Comparison of acute vs. chronic care models

	ACUTE CARE	CHRONIC CARE
<b>Main goal of care</b>	Cure	Control the progression of the condition. Increase survival. Enhance quality of life.
<b>Duration</b>	Limited	Long term, indefinite or life long
<b>Knowledge</b>	Concentrated on health professionals	Health Professionals, patients and families share complementary knowledge
<b>Disease management</b>	Focused on acute and single medical treatment	Relevant multi-drug and self-management strategy with appropriate health system, community and family support. Co-morbidities are usually present.
<b>Providers of care</b>	Usually clinicians and clinical institutions	Broad spectrum of health care organisations, community services and family care
<b>Quality of care</b>	Mostly self-contained approaches within institutions	Relevance of systematic quality approaches

(WHO/MNC/CCH/01.02 – Meeting Report)

ACUTE MEDICINE MODEL	LONG TERM CARE MODEL
<p>Acute <i>illness/infectious</i> disease</p> <ul style="list-style-type: none"> <li>- Maybe a crisis that is a dangerous episode, often life-threatening. Signs and symptoms are evident and appear suddenly; there is urgent need for rapid diagnosis and implementation of treatment.</li> <li>- The approach is reductionist, focusing on the essential/immediate</li> <li>- It is the model used in initial medical training</li> </ul>	<p>Chronic <i>illness/disease/condition</i></p> <ul style="list-style-type: none"> <li>- Is very often incurable</li> <li>- Is silent, apart from the acute attacks</li> <li>- If there is pain, it tends to be persistent</li> <li>- Often shows little correlation between patient's complaints and biological data</li> <li>- May have an uncertain progression</li> <li>- May be associated with lifestyle</li> </ul>

<b>ACUTE MEDICINE MODEL</b>	<b>LONG TERM CARE MODE</b>
<p><b><i>The doctor</i></b></p> <ul style="list-style-type: none"> <li>- Is ready to intervene during the episode</li> <li>- Is aware of his/her professional efficacy</li> <li>- Concentrates on very specific aspects of the illness/disease</li> <li>- Decides on the diagnostic approach, the choice and monitoring of treatment</li> <li>- May work as part of a multidisciplinary team, if life-threatening episode</li> <li>- Manages the crisis with a biotechnological type of approach</li> <li>- Requires a "passive" patient, who lets himself/herself be treated</li> <li>- Has no further contact with the patient once the crisis is over</li> <li>- Often forgets the psychological dimension of the patient</li> <li>- Often does not know the patient</li> </ul>	<p><b><i>The doctor</i></b></p> <ul style="list-style-type: none"> <li>- Prescribes treatment but only to control the illness/disease/condition indirectly</li> <li>- Must empower his/her patients, and thus share his/her medical knowledge with them</li> <li>- Must follow the illness in its silent phase</li> <li>- Must treat acute episodes as an emergency, but prevent them as far as possible</li> <li>- Must be on guard to detect late complications</li> <li>- Must provide psychological and social support</li> <li>- Must accept a new medical identity</li> </ul>
<p><b><i>The treatment</i></b></p> <ul style="list-style-type: none"> <li>- Is codified, often with a specific algorithm</li> <li>- Necessitates hourly and/or daily evaluation</li> <li>- Can be of short duration</li> <li>- Is in direct relation to the illness/disease</li> </ul>	<p><b><i>The treatment</i></b></p> <ul style="list-style-type: none"> <li>- Is important for survival and/or daily well-being</li> <li>- Has variable effects</li> <li>- Must be ensured by the patients themselves</li> <li>- Involves everyday discipline</li> <li>- Involves costs which are not only physical but also psychological, family, professional, social and financial</li> </ul>
<p><b><i>The patient</i></b></p> <ul style="list-style-type: none"> <li>- Suffers directly</li> <li>- Needs immediate relief</li> <li>- Allows himself/herself to be treated, "collaborates passively"</li> <li>- Once the acute crisis is over, forgets the unpleasant/painful episode</li> <li>- Is grateful and admiring of the medical team</li> </ul>	<p><b><i>The patient</i></b></p> <ul style="list-style-type: none"> <li>- Although they cannot be cured, can nevertheless keep their illness under control</li> </ul>

(Therapeutic Education of Patients. 2000)



## **NON-COMMUNICABLE CHRONIC CONDITIONS IN CHILDREN**

### **SERVICE DESCRIPTION**

Contrary to popular belief, non-communicable chronic diseases are highly prevalent in developing countries, not only in adults or older persons, but also in children.

It is of utmost importance that a clear distinction is made and understood between the concepts of acute vs. chronic and communicable (infectious) vs. non-communicable diseases in order to effectively understand the type of care each one needs. Children with chronic conditions and their carers need to make lifestyle adjustments.

Ongoing reliance on acute models has delayed the reforms in the health delivery system that are necessary to address long term interventions for chronic non-communicable conditions.

For outcomes to be improved, health policy and health system changes are essential. Effective treatment of chronic conditions requires the transformation of health care towards a system that is pro-active and emphasises health across a lifespan, with the focus on the patient's role/carer's role and responsibility in health care.

### **STANDARDS**

#### **1. REFERENCES, PRINTS AND EDUCATIONAL MATERIALS**

To be available at all health care facilities:

- 1.1 Copy of the National Policy Framework for Children with Chronic Conditions.
- 1.2 Health promotion and educational materials related to chronic conditions in children.
- 1.3 Disease specific management guidelines.
- 1.4 Patients Rights Charter

Free health services for all children < 6 years of age.

## 2. EQUIPMENT AND HEALTH SUPPLIES

- 2.1 Individual basic monitoring equipment for especially diabetes type 1 patients and children with moderate to severe asthma to be issued.
- 2.2 Nebuliser for emergencies;
- 2.3 O<sub>2</sub> with nasal cannula for emergencies;
- 2.4 Working sphygmomanometer with child cuffs and stethoscope;
- 2.5 Urine test strips for glucose, protein and ketoses;
- 2.6 Blood glucose testing equipment and strips be available at all facilities;
- 2.7 Ensure environmental accessibility for children in prams, push carts and wheelchairs
- 2.8 Accessories and basic assistive device be available and accessible at primary level

## 3. MEDICINES AND SUPPLIES

- 3.1 Ensure availability of drugs, medical supplies prescribed at different levels of care at primary level
- 3.2 Prescription practices be according to approved national management guidelines
- 3.3 Initial waiting period for specialised prescribed drugs shall be limited to one month
- 3.4 Financial implications of specialised drugs/supplies shall be born? by the level of original prescription

## 4. COMPETENCE OF HEALTH STAFF

- 4.1 Every PHC facility has skilled staff to:
  - prevent and early identify non-communicable chronic conditions in children and follow-up
  - to identify children at risk of non-communicable chronic conditions
  - to render emergency care
  - to provide therapeutic education
  - to facilitate the formation of support groups
  - to do basic research
  - to communicate effectively
- 4.2 Show respect and protect the dignity and rights of children with chronic conditions
- 4.3 Ensure a child friendly environment
- 4.4 Build strong partnerships with patients and their families/carers

## 5. REFERRALS

- 5.1 Children are referred to next best level of care when a non-communicable chronic condition has been identified at primary level
- 5.2 Relationships between levels of care be clarified
- 5.3 An efficient transport system to be in place
- 5.4 Rational use of private sector services to be explored e.g. to pay a private hospital for a CT Scan in George that to send the child to Cape Town.
- 5.5 Minimum response time for emergencies.

## 6. PATIENT EDUCATION

- 6.1 Support groups to be encouraged at all times
- 6.2 Children and carers should be empowered and supported to manage their own/child's conditions
- 6.3 Be sensitive to cultural and economic realities

## 7. RECORDS

- 7.1 Patient carried cards available and implemented
- 7.2 "At risk registers implemented
- 7.3 Home-based care records in place
- 7.4 Written integrated care plan for each patient available
- 7.5 All related health records

## 8. COLLABORATION

- 8.1 Close collaboration with other departments, sectors and NGOs
- 8.2 Initiation of support groups/clubs
- 8.3 Close partnership between facilities, carers and child