

MANAGEMENT AND PREVENTION OF GENETIC DISORDERS AND BIRTH DEFECTS

SERVICE DESCRIPTION

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

NORMS

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

STANDARDS

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

9 COLLABORATION

- 9.1 Clinic staff collaborate with social workers, physiotherapists, speech therapists and other support staff to provide comprehensive care.
- 9.2 Clinic staff to work with South African Inherited Disorders Association, school teachers, and other NGOs and CBOs to provide information and raise awareness on genetic disorders, birth defects and disabilities.

INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS

SERVICE DESCRIPTION.

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

NORMS

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

STANDARDS

1	REFERENCES, PRINTS AND EDUCATIONAL MATERIALS 1.1 National and Provincial wall charts and booklets. 1.2 A copy of the IMCI Standard Treatment Guidelines, relevant to the Province. 1.3 Child Health Charts to supply to new-borns and children without charts. 1.4 Copies of the National Essential Drugs List and Standard Treatment Guidelines. 1.5 Tick charts stuck to the desk as a reminder.
2	EQUIPMENT 2.1 An oral rehydration corner set up for immediate rehydration. 2.2 Emergency equipment available for intravenous resuscitation of severely dehydrated children.
3	MEDICINES & SUPPLIES 3.1 The clinic has litre measures and teaspoon measures, cups for feeding, sugar and salt (for the child that is not dehydrated) and rehydration powder (for the dehydrated child).
4	COMPETENCE OF HEALTH STAFF 4.1 Every clinic has nurse practitioners able to treat clients in accordance with the IMCI guidelines. 4.2 IMCI trainer makes regular mentoring/supervision visits, initially 6 weeks after training, thereafter every 3 months. 4.3 Each clinic has an annual review of quality of care by IMCI Supervisor. 4.4 At least one member of staff takes overall responsibility for the assessment and management of the child. 4.5 Staff are able to establish trust and credibility through respect, courtesy, responsiveness, confidentiality and empathy, approaching consultations in a patient-centred way. 4.6 Staff are able to organise and implement an effective triage system for clients attending the clinic based on the IMCI protocol.
5	REFERRAL 5.1 Children with danger signs and/or severe disease are referred as described in the IMCI provincial protocol.
6	PATIENT EDUCATION 6.1 The mother or caregiver is counselled in accordance with the IMCI counselling guidelines. 6.2 Key family/household practices to improve child health are promoted as described in the IMCI community component.
7	RECORDS 7.1 An adequate patient record system is in place, using the child-health chart as the basic tool. 7.2 Patient details are recorded using the SOAP format.
8	COMMUNITY & HOME BASED ACTIVITY. 8.1 This takes place in line with the IMCI Guidelines for the Community Component. 8.2 The clinic works in close co-operation with community-based health programmes like community health worker schemes or care-groups.
9	COLLABORATION 9.1 Clinic staff collaborate with social workers, NGOs, CBOs, creches and other sectors to improve child health.

MANAGEMENT OF ASTHMA

SERVICE DESCRIPTION

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

NORMS

Reduced incidence of emergency referrals due to asthma

STANDARDS

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

6.3	Carers and patients understand the safety of continuous regular therapy and need for follow up
7	RECORDS
7.1	Clinic records are kept up to date with history of episodes, rate of use of drugs and inhalers, identified allergens and periodic PEFR recorded.
8	COMMUNITY BASED SERVICES
8.1	Conduct educational campaigns in school and community during pollen grain seasons
8.2	Community based programmes stress the need for smoke free environment and give guidelines on reducing common household allergens
9	COLLABORATION
9.1	Staff collaborate with other departments like Environmental health, Education and other sectors to educate and support sufferers and their caretakers.
9.2	Staff collaborate with the National Asthma Education program and the Allergy Society of South Africa to obtain their educational materials

DISEASES PREVENTED BY IMMUNISATION

SERVICE DESCRIPTION

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

NORMS

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

STANDARDS

1	REFERENCES PRINTS AND EDUCATIONAL MATERIALS
1.1	Copies of the latest editions of EPI (SA) <i>Vaccinators Manual Immunisation That Works</i> .
1.2	Copies of the Cold Chain and Immunisation and Operations Manual.
1.3	Copies of the Technical guidelines on immunisation in South Africa.
1.4	Copies of the EPI Disease Surveillance Field Guide.
1.5	Copies of the current Provincial Circulars on particular aspects, e.g. acute flaccid paralysis, flu virus, Haemophilus influenzae type b (HiB surveillance, Adverse Events Following Immunisation (AEFI) investigation and reporting.
1.6	Patient and community information pamphlets in appropriate languages.
1.7	Copies of the EPI Posters and other EPI disease and schedule promotional materials.
2	EQUIPMENT
2.1	Correct needles and syringes according to Vaccinators manual.

	<p>2.2 A working refrigerator, properly packed, with thermometer and temperature recorded and a spare gas cylinder if gas operated.</p>
<p>3</p>	<p>MEDICINES AND SUPPLIES 3.1 An uninterrupted and monitored cold chain of constantly available vaccines as recommended by EDL.</p>
<p>4</p>	<p>COMPETENCE OF HEALTH STAFF 4.1 Staff are able to: 4.1.1 Routinely perform correct immunisation practices according to protocol. Vaccines are checked periodically to ensure no frozen DPT, HBV, TT, HIB and none out of date or indicators showing expiry. 4.1.2 Provide mothers with correct knowledge of what is needed for the child, what is given and possible side effect and when to return for the next immunisation. 4.1.3 Provide group education for mothers and antenatal care attendants. 4.1.4 Follow up suspected cases of measles at home to determine the extent of a possible outbreak. 4.1.5 Take steps to increase coverage using the self-generated vaccination coverage graph (available in the Vaccinators manual) to address progress during the year. 4.1.6 Implement correct disposal of sharps. 4.1.7 Initiate post exposure prophylaxis for HIV in case of needle stick (according to Provincial protocol). 4.1.8 Ensure all reported and notified AFP, measles, NNT and AEFI cases are reported to EPI Coordinator and followed up within 48 hours by district investigation team of which the nurse in clinic is a co-opted member. 4.1.9 Organise immunisation service as a daily component of comprehensive PHC and to minimise waiting/queuing times. 4.2 Community health committees are given the lay case definitions of acute flaccid paralysis, measles and neonatal tetanus and urged to report suspected cases immediately. 4.3 The clinic has a good relationship with the Environmental Health Officer for assistance in outbreaks investigations. 4.4 Ensure that appropriate laboratory specimens are taken for the investigation of all AFP, NNT, measles and AEFI investigations are taken or else referred to the nearest hospital where specimens can be taken. 4.5 A 24 hour toll free number for notification - (0800 111 408) is on the clinic wall. 4.6 All HIV positive children must be immunized with all vaccines except for BCG in children with symptomatic AIDS. 4.7 Clinics arrange mass immunisation or mopping up campaigns in their communities as required by the District Manager. 4.8 Remote villages have mobile outreach sessions to provide routine services and to improve coverage where necessary. 4.9 Reduce missed opportunities and ensure that ill children and women in the childbearing age are immunised as appropriate.</p>
<p>5</p>	<p>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.</p>
<p>6</p>	<p>PATIENT EDUCATION 6.1 All clients attending clinics for immunization services receive the appropriate health education, information and support.</p>
<p>7</p>	<p>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.</p>

	7.6 Case investigation forms for adverse events following immunisation.
	7.7 Supply of child road to health charts.
8	COMMUNITY BASED SERVICES
	8.1 Communities participate in campaigns and national health days.
	8.2 Clinic staff follow up suspected cases of measles at home to determine extent of outbreak.
9	COLLABORATION
	9.1 Staff collaborate with other departments like education and other sectors to promote immunization and improve coverage.

ADOLESCENT AND YOUTH HEALTH

SERVICE DESCRIPTION

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

NORMS

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

STANDARDS

1	REFERENCE, PRINTS AND EDUCATIONAL MATERIALS
	1.1 Clinic has a copy of rights of the child.
	1.2 All legislation relevant to youth and adolescents is kept in the clinic.
	1.3 List of relevant NGOs, CBOs and community youth organisations in district.
	1.4 Planned Parenthood Association of South Africa booklet and other relevant materials to help parents discuss sexuality with youth.
	1.5 IEC materials and a library of youth related materials.
2	EQUIPMENT
	2.1 Adequate equipment suitable for a youth friendly service catering for the health needs of this group.
3	MEDICINES AND SUPPLIES
	3.1 Provided according to EDL.
	3.2 Condoms are placed in areas where it is not necessary to ask for them and where they can be taken without being watched
4	COMPETENCE OF HEALTH STAFF
	4.1 Staff are able to
	4.1.1 Map catchment area and if relevant prisons, orphanages, street children shelters, sports fields, schools and NGOs.
	4.1.2 Provide accessible youth friendly services with times or days to suit youth.
	4.1.3 Encourage youth to ask questions and seek information.
	4.1.4 Communicate well and avoid asking intrusive, irrelevant questions.

	<p>4.1.5 Know and work well with youth organisations, sports coaches, teachers, police and traditional circumcisors in the catchment area of clinic.</p> <p>4.1.6 Educate parents about parenting and provide guidance on improving intra-family and community relationships.</p> <p>4.2 Clinic have at least one member of the staff competent in counselling and able to assist an individual (or group) to gain an understanding of the situation and make and implement appropriate decisions.</p> <p>4.3 Staff ensure no opportunity is missed to assist youth in managing fertility and preventing STDs and HIV/AIDS.</p> <p>4.4 Staff involves adolescent and youth in planning and implementation of services.</p>
5	<p>REFERRAL</p> <p>5.1 Referred according to protocols for the relevant conditions.</p> <p>5.2 Ensure a mechanism for feedback of referred cases</p>
6	<p>PATIENT EDUCATION</p> <p>6.1 Assist in organizing and participate in awareness campaigns on relevant adolescent and youth health issues</p> <p>6.2 Involve youth in peer education and support peer education</p> <p>6.3 Supply of patient information pamphlet in relevant languages on</p> <p>6.3.1 Growth and development</p> <p>6.3.2 Gender specific needs of adolescents</p> <p>6.3.3 Oral care</p> <p>6.3.4 Nutrition</p> <p>6.3.5 risks to health of alcohol, smoking, drugs</p> <p>6.3.6 safe sex, condom use</p> <p>6.3.7 STD, HIV, AIDS, TB</p>
7	<p>RECORDS</p> <p>7.1 Staff use information system records to analyse conditions affecting youth (e.g. STD, accidents, infected circumcisions, sports injuries, behaviour problems, teenage pregnancy, TOP, rape, sexual abuse, etc).</p> <p>7.2 There is a register of disabled youth that indicates all dates of efforts to improve rehabilitation and refer to special school.</p> <p>7.3 Record is kept of occupational problems of youth in the area e.g. sex work, domestic work, agricultural work etc.</p>
8	<p>COMMUNITY BASED ACTIVITY</p> <p>8.1 Staff are aware of community based initiatives aimed to prevent and respond to problems of youth.</p>
9	<p>COLLABORATION</p> <p>9.1 Clinic staff work with social workers, social structures, NGOs and CBOs on adolescent and youth health issues including children at risk problems (adolescents and the law, poor hygiene, sexual abuse, glue sniffing, etc).</p> <p>9.2 Staff collaborate with other sectors to improve youth health especially with teachers in schools in setting up a child-to-child programme.</p>

MANAGEMENT OF COMMUNICABLE DISEASES

SERVICE DESCRIPTION

This chapter deals with the management of communicable diseases in general with the emphasis on prevention, early diagnosis and initiation of measures to prevent transmission and serious morbidity, disability and death. Separate chapters deal with Tuberculosis, HIV infection and AIDS, sexually transmitted diseases, cholera, rabies, leprosy, shigella dysentery and malaria. These are the diseases, which are either priority national public health diseases or are ones associated with the possibility of causing outbreaks.

The communicable diseases, which are included in the South African Expanded Programme of Immunisation, and scabies, are dealt with separately under childhood diseases. Rheumatic fever and helminths are also dealt with separately.

NORMS

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

STANDARDS

1	REFERENCES PRINTS AND EDUCATIONAL MATERIALS 1.1 Each clinic has the National and Provincial protocols and policy documents on communicable Diseases and every 6 months reviews them with the Environmental Health Officer of the area.
2	EQUIPMENT 2.1 See clinic generic equipment
3	MEDICINES AND SUPPLIES 3.1 As per EDL
4	COMPETENCE OF HEALTH STAFF 4.1 All clinics have a book of notifiable disease forms GW17/5 and complete a form for every notifiable disease. Cases confirmed in hospital send a copy back to the clinic with the lower part of the form completed. 4.2 When the district office receives a notification the communicable disease control co-ordinator initiates a response, together with the District Environmental Health Officer and the local clinic staff. The Infection Control Nurse of the Hospital and in the case of an outbreak, the outbreak teams and the laboratory are also involved. 4.3 The clinic staffs are able to commence action by taking more complete patient and family histories and by visiting the home and environment to identify other cases and causes which can be prevented. Clinic staff are responsible for stabilising cases before hospitalisation and for taking initial specimens for the laboratory. 4.4 Clinic staff can interact with community health committees to maintain surveillance for cases and to ensure control measures after suitable education. 4.5 The emphasis is always on prevention, early diagnosis and initiation of measures to prevent transmission and serious morbidity, disability and death. 4.6 In endemic areas for Malaria, Schistosomiasis, Cysticercosis and Trachoma clinics receive extra protocols on management from the District Health Offices.
5	REFERRALS 5.1
6	PATIENT EDUCATION 6.1 All patients attending the service receive health education.

CHOLERA AND DIARRHOEAL DISEASE CONTROL

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

CHOLERA AND DIARRHOEAL DISEASE CONTROL

SERVICE DESCRIPTION

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

NORMS

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

STANDARDS

1 REFERENCES PRINTS AND EDUCATIONAL MATERIALS 1.1 The clinic has the latest copy of Guidelines for Diarrhoeal diseases and Cholera Control.
2 EQUIPMENT 2.1 Cholera packs for diagnosis and the protocol for stool collection.
3 MEDICINES AND SUPPLIES 3.1 List of drugs in accordance with the Essential Drugs List 3.2 The clinic maintains a buffer supply of ORS and intravenous fluids. 3.3 Clinic staff know where extra stocks can be obtained quickly in case of emergency
4 COMPETENCE OF HEALTH STAFF 4.1 Staff have knowledge of the clinical presentation of diarrhoeal diseases and cholera and refer severe cases to hospital having first starting rehydration. Less severe cases are managed at clinic level with oral rehydration. 4.2 Clinic staff are able to manage cases of diarrhoea and dehydration daily during epidemics. 4.3 There is always a state of preparedness for an outbreak of cholera by maintaining a buffer supply of ORS and intravenous fluids. 4.4 Staff are able to recognise the clinical presentation of cholera. 4.5 Suspected cases are reported immediately by phone or other communication method.

	<p>4.6 Oral rehydration (with ORS sachets) are used and the patients state of dehydration is monitored while having the ORS.</p> <p>4.7 Clinic staff encourage use of salt and sugar home-prepared solution when ORD sachets are not available.</p> <p>4.8 Staff know that cholera infection can be asymptomatic or cases can be mild and indistinguishable from other diarrhoea.</p>
5	REFERRALS
	5.1 All severely dehydrated cases should be referred to hospital
6	PATIENT EDUCATION
	6.1 All patients and caretakers receive health education on oral rehydration therapy, refuse disposal and cleanliness.
7	RECORDS
	7.1 Patient's records are kept up to date.
	7.2 A weekly chart is kept in clinics showing diarrhoea cases under 5 and cases over five and any undue rise especially of cases over 5 is reported to the District Manager.
8	COMMUNITY BASED SERVICES
	8.1 Education is carried out in the community on hygiene, latrine use, hand washing, food safety, boiling of water and milk, chlorination of drinking water if feasible, use of tap water or delivered tanker supplies during an epidemic.
	8.2 The value of breast-feeding as a preventive measure is a permanent part of the clinics community health education programme.
9	COLLABORATION
	9.1 Staff collaborate with other departments like Environmental health, Education and other sections within health like MCHW, Health Promotion.

DYSENTERY

SERVICE DESCRIPTION

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

NORMS

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

STANDARDS

1	REFERENCES PRINTS AND EDUCATIONAL MATERIALS
	1.1 Copy of Steps in management of a dysentery outbreak.
	1.2 Pamphlets in local languages.
	1.3 Protocols on management of dysentery.
2	EQUIPMENT
	2.1
3	MEDICINES AND SUPPLIES
	3.1 List of drugs in accordance with the Essential Drugs List.

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

HELMINTHS

DESCRIPTION OF SERVICE

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

NORMS

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

STANDARDS

1	<p>REFERENCES, PRINT AND EDUCATIONAL MATERIALS</p> <p>1.1 The clinics in endemic areas for schistosomiasis are able to obtain from the district health office a copy of <i>Bilharzia in South Africa</i>, JHS Gear and R J Pitchford, latest edition.</p> <p>1.2 The clinic has</p> <p>1.2.1 Posters and public information handouts in endemic areas on schistosomiasis, hydatid disease, cerebral cysticercosis.</p> <p>1.2.2 Posters and public information handouts on common intestinal helminths (ascaris, trichuris, necator, enterobius, taenia).</p> <p>1.2.3 Any dam, river or pond near a clinic in a schistosomiasis endemic area has a notice board about the danger for children of swimming there if the EHO has identified it as having infected snails.</p>
2	<p>EQUIPMENT</p> <p>2.1 Plastic stool jars for urine and stool specimen</p> <p>2.2 Laboratory forms and registers</p>
3	<p>MEDICINES AND SUPPLIES</p> <p>3.1</p>
4	<p>COMPETENCE OF HEALTH STAFF</p> <p>4.1 Staff know whether the clinic is in an endemic area for Schistosomiasis or other helminths.</p> <p>4.2 Staff know the relationship between taenia solium from pigs and neurocysticercosis and epilepsy.</p> <p>4.3 Staff give the correct information to patients on the life cycle of worms and how to prevent future infections.</p> <p>4.4 Staff take a stool specimen for the laboratory and initiate treatment when a mother complains her child has recurrent abdominal pains, occasional blood in stool, recurrent cough, or when mother says she has seen worms.</p>
5	<p>REFERRAL</p> <p>5.1 Referred according to protocols for relevant conditions</p>
6	<p>PATIENT EDUCATION</p> <p>6.1 Staff advise children against swimming in infected pools and especially between 10:00-15:00 hours when <i>S. haematobium</i> cercariae are shed especially in warmer months. <i>S. mansoni</i> shed earlier 08:00-14:00 so people fetching water or washing are at risk.</p> <p>6.2 Staff advise the community on the danger of, and to store water for 48 hours before, washing or drinking if from an identified schistosoma infected dam or pool.</p> <p>6.3 Staff educate mothers on bringing up children to wash hands, wash fruit and vegetables, use a toilet correctly, not swim in dangerous water, not defecate near a river or urinate in water.</p>
7	<p>RECORDS</p> <p>7.1 All records kept according to protocol.</p>
8	<p>COMMUNITY BASED ACTIVITY</p> <p>8.1 Staff help with mass prevention or treatment projects initiated by district e.g. deworming pre-school children, treating school children in hyper-endemic areas of schistosomiasis.</p>
9	<p>COLLABORATION</p> <p>9.1 Staff seek to involve the community with EHO in control measure advocated by District.</p> <p>9.2 Staff work with schools to involve teacher, pupils and parents in district advocated control measures.</p> <p>9.3 Staff discuss the importance of the "health promoting school" with teachers and parent-teacher associations in the catchment area.</p>