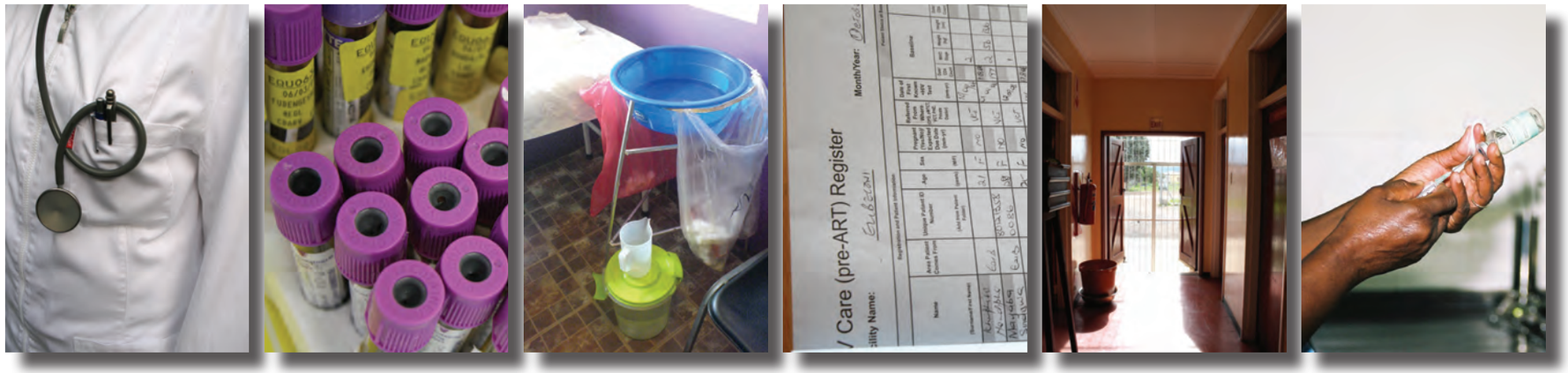
Primary Health Care Supervision Manual

A guide to Primary Health Care Facility Supervision



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Primary Health Care Supervision Manual

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PREAMBLE

This revised version of the Primary Health Care Supervision Manual comes at a time when a renewed focus is being placed on strengthening the delivery and improving the quality of Primary Health Care services, the cornerstone of the national health care system. It follows on the earlier Clinic Supervisor's Manual that was originally introduced to the public health sector at a national workshop in October 2000 and adopted in March 2004 for countrywide use.

Since the introduction of the Manual in 2000, the health care system has undergone significant transformational changes as a result of changes in the burden of disease in South Africa. These changes have resulted in the development of new programmes that were not included in the former manual. Materials used in this revised version draw from a number of sources, all of which have been field-tested and have proven to be very useful tools in supervising primary health care programs.

The ultimate aim of this Manual is to create a supportive environment in which planning, monitoring and evaluation will be done jointly between management and staff, through using structured supervision in their collective quest towards improving the quality of primary health care. The tools included in the Manual will enable management, supervisors and staff to regularly identify critical areas that need urgent action. The tools will also measure the overall progress that is being made towards the delivery of quality primary health care.

Supervisors are encouraged at all times to use this Primary Health Care Supervision Manual as a tool to ensure structured supervision takes place. However, it will not by itself bring about the required results, but will complement supportive and effective policies and implementation guidelines on supervision and management.

DR A MOTSOALEDI
MINISTER OF HEALTH

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The revised Primary Health Care Supervision Manual is a culmination of major efforts from various individuals and organizations over an extended period of wide consultation.

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A special word of acknowledgement is extended to the Health Care Improvement Project (HCI) of the United State Agency for International Development (USAID) and to Management Sciences for Health (MSH) – "the original developers of the manual" and to the Health Systems Trust for their vital and enduring role in providing technical assistance to provinces that has resulted in successful implementation of the manual since 2000.

DR K S CHETTY
ACTING DIRECTOR GENERAL: HEALTH

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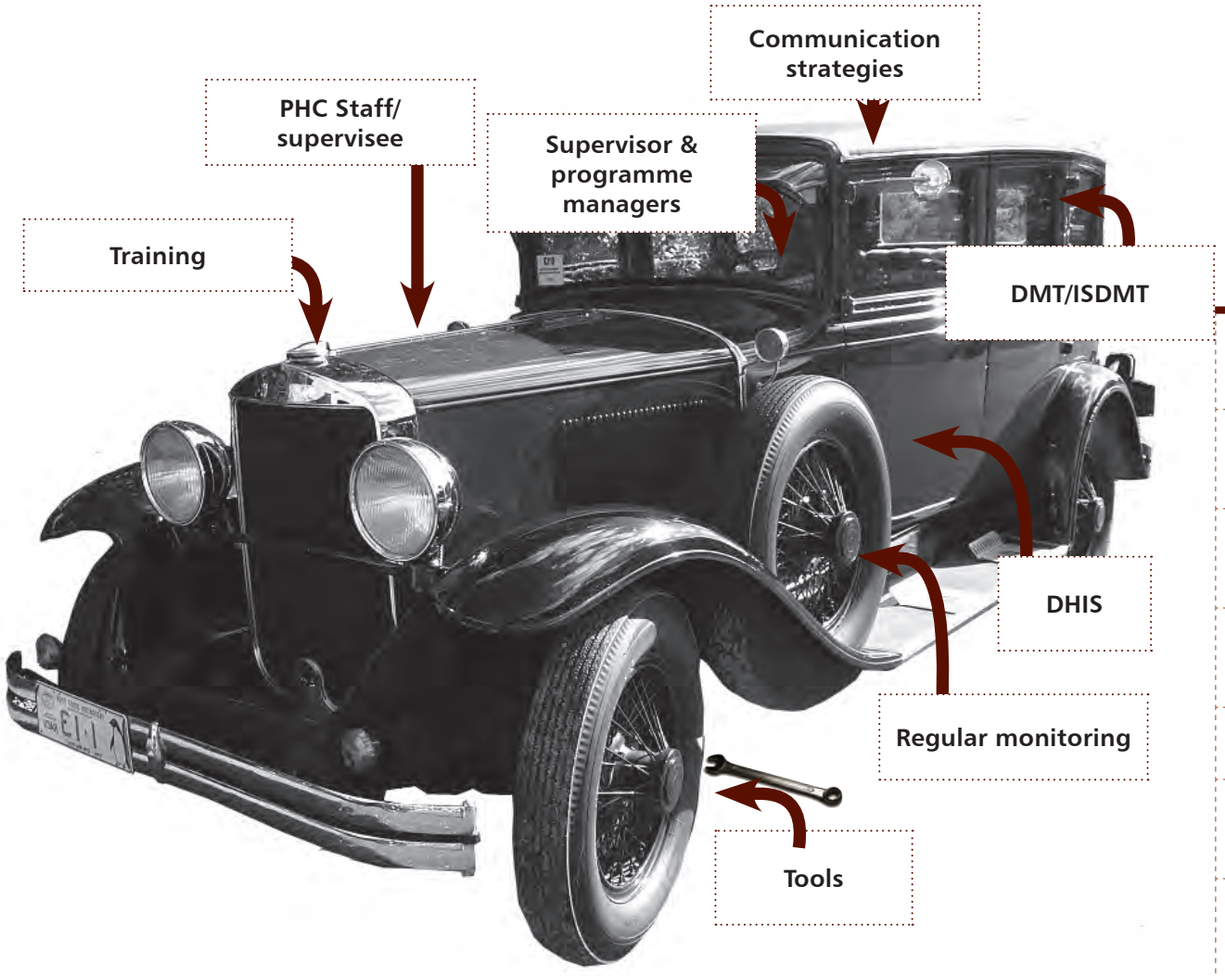
Introduction

The concept of primary health care supervision may be compared to a roadworthy car whose owner constantly ensures that it transports people safely to the desired destination. Obviously the status of a car, particularly its safety and quality, must comply with prescribed standards. No part of the car can perform its intended function without interacting with the other parts. The parts, as well as their condition, are important and therefore need frequent monitoring and maintenance. Some parts can be checked only after the car has done a certain mileage. If the parts are not maintained as they should be, there is always a failure of some sort in the way the car functions. When car parts and fuel malfunction this could result in a fatal car accident, which would impact negatively on all the passengers and possibly on other road users.

It should be noted that a roadworthy car needs an able, willing, qualified driver. It is important to keep in mind that PHC (a car) can only be successful if all stakeholders (car parts) including driver (supervisor) co-operate fully. In our area of work, the stakeholders include, but are not limited to, programme managers, patient care representatives, building infrastructure maintenance staff, suppliers, Primary Health Care (PHC) staff, and patients. The availability and proper functioning of medical equipment also contributes to the successful functioning of PHC. A PHC facility without supplies, medicines and equipment is just as ineffective as the car with malfunctioning or missing parts and without fuel. PHC supervisors are therefore responsible for ensuring that the resources needed for proper functioning of the PHC are available at all times. The PHC supervisors should identify issues that need to be addressed in order for them to drive the PHC in the best direction. Such needs include, but are not limited to, supplies, staff needs (knowledge and technical skills), information systems and patient needs.

The supervisory system



DMT	District or sub-district management team responsible for providing quality care.
Training	Continuous, planned, based on needs identified, formal and on-site training is essential.
Supervisor/ supervisees	Drivers of the processes. There is not supervisor without supervisee and *vice-versa*.
Tools	CMS Manual containing appropriate designed and tested instruments.
Commnication strategies	Including reporting system including two way feedback.
DHIS	Information from monthyly routine data form (raw data) and from reports (processed info).
Regular monitoring	Continuous process of quarterly reviews and developing action plans using the tools in the manual (e.g. Disca, red flag).

For the best provision of primary health care in facilities, there should be a supervisor who facilitates good teamwork and promotes good working relationships among all the structures of the primary health care system. She/he should regularly monitor and maintain good performance in the form of the information system, communication strategies, regular targeted trainings and through comparison of the PHC facility's performance with the prescribed health standards as stipulated in, among others, "*The Primary Health Care Package for South Africa – a set of norms and standards*" and the employees' Performance Management and Development System (PMDS).

This PHC supervision manual provides a guide to structured supervision that is evidence-based and whose requirements can be implemented and measured, thus ensuring good quality primary health care provision in health facilities.

Abbreviations and acronyms used in the manual

AA	Alcoholics Anonymous
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
BP	Blood Pressure
CBO	Community Based Organization
CHC	Community Health Centre
CHW	Community Health Worker.
CLINIC	A Primary Health Care facility smaller than the health centre in terms of infrastructural size, staffing and services.
DHIS	District Health Information System
DM	District Manager
DMT	District Management Team
DOTS	Directly Observed Treatment Short Course
EDL/EML	Essential Drug List / Essential Medicine List
EHP	Environmental Health Practitioner
EN	Enrolled Nurse
ENA	Enrolled Nurse Auxiliary
EPI	Expanded Programme on Immunization
FEFO	First Expiry, First Out
FP	Family Planning
GA	General Assistant
HBP	High Blood Pressure
HBV	Hepatitis B Virus
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IPC	Infection Prevention and Control
IUCD	Intra Uterine Contraceptive Device
IV	Intravenous
MCH	Maternal and Child Health
NGO	Non Governmental Organization
OHS Act	Occupational Health and Safety Act
ORS	Oral Rehydration Solution
PEM	Protein Energy Malnutrition
PHC	Primary Health Care
PN	Professional Nurse
QA QS	Quality Assurance Quality Supervision
RTHC	Road to Health Card
Rx	Treatment
SANCA	South African National Council against Alcohol
STI	Sexually Transmitted Infection
STGs	Standard Treatment Guidelines
TB	Tuberculosis
TTO	Treatment To be taken Out
#	Number

Checklist	A printable document used to examine the accuracy, quality, or condition of a health care activity, aimed to verify or establish if such are realized.
PHC facility manager	A person appointed, delegated or assigned to manage the overall PHC activities and personnel in one local PHC facility – always referred to as a sister in charge of a facility.
Primary Health Care	A set of prescribed services, generally falling within the skill base of a professional nurse, technician, mid-level worker, counsellor, community health worker, midwife and emergency medical practitioner. These services may be first point of contact or for follow-up care.
Supervision	Observation and directing the execution of the work in the PHC facility.
Supervisor	A manager whose duty is to observe and direct the execution of the work in PHC facilities.
Red flags	Critical assessment elements that depict a warning of danger. The elements identified as such require immediate attention.

Purpose of the Primary Health Care Facility Supervision Manual

The purpose of this manual is to support the supervisors, programme managers and PHC facility managers in their roles with the aim of improving the quality of primary health care in PHC facilities.

The manual also aims to address patients' access to PHC facilities and reduce errors in the quality of service at PHC facilities through providing information about:

- Training and professional development to promote capacity that will improve delivery of care
- Identifying and responding to the needs of the primary health care providers and users
- Proper information systems, where the checklist for all programme red flags as well as the overall PHC information is used to measure quality and therefore forms a base for continuous self-monitoring, evaluation and improvement. It may also be used to assist in the process of accreditation.

Legal and regulatory framework

This revised PHC supervision manual draws on the South African legal and regulatory framework, including:

- The Constitution of the Republic of South Africa (section 27)
- The National Health Act, 2003 (No. 61 of 2003)
- White Paper on Transformation of Health Services
- The vision and mission of the Department of Health
- The Primary Health Care Package for South Africa: a set of norms and standards
- The Quality Assurance policy
- Standard Treatment Guidelines and Essential Medicine List (EDL)
- Strategic Health Care Programme Policies & Guidelines
- Government notice R1390 OF 27 December 2001 (Hazardous Biological Agents Regulations) as promulgated in section 43 of the Occupational Health & safety Act of 1993
- Government Notice R908 of 2003 (Hazards Analysis Critical Control Point Regulations) as promulgated in section 15 (1) of the Foodstuffs, Cosmetic and Disinfectant Act of

1972

- The Standards for Quality HIV Care: a tool for quality assessment, improvement, and accreditation (WHO, 2004)
- National Strategic Plan for Health 2007-2011

Section 1

National Norms and Standards* for PHC Facilities (Primary Health Care Package for South Africa – A Set of Norms and Standards, March 2000, NDoH)

PHC norms

PHC standards

PHC management norms and standards

National Norms & Standards*

1.1 PHC norms

1. The PHC facility renders comprehensive integrated PHC services using a one-stop approach for **at least** eight hours a day, five days a week, this excludes CHC's.
2. Access, as measured by the proportion of people living within 5km of a PHC facility, is improved.
3. The PHC facility 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 PHC facility has at least one member of the health care personnel 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. PHC facility 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 PHC facility. In addition, an annual plan is developed based on this evaluation.
8. The PHC facility has a mechanism for monitoring services and quality assurance and at least one annual service audit.
9. Health promotion activities are undertaken by the PHC facility, at least once a quarter.
10. Community perception of services is tested at least twice a year through patient interviews or anonymous patient questionnaires.

1.2 PHC standards

i. References, prints and educational materials

- Standard treatment guidelines and the essential medicine list (EDL) manual.
- All relevant national and provincial health circulars, policy documents, Acts and protocols that have influence on service delivery.
- Copies of the Patients' Rights and Responsibilities Charter and Batho Pele documents must be readily available.

* a set of core standards for all health facilities is in the process of revision and finalization

- Supplies of appropriate information, education and communication (IEC) health material in local languages should be available.

ii. Equipment

- A diagnostic set.
- A blood pressure monitoring machine with appropriate cuffs and stethoscope.
- Scales for adults and children and measuring tapes (for height and head circumference).
- Haemoglobin, glucometer, pregnancy test, HIV rapid test kit and urine test strips.
- Vaginal Speculae (different sizes).
- A reliable means of communication (two-way radio or telephone).
- Reliable emergency transport at all times.
- An oxygen cylinder and masks (various sizes).
- Refrigerators in good working order for vaccines (must have a thermometer) and for medicines respectively. If refrigerators are using gas, a spare cylinder to be always available.
- Condom dispensers are placed where condoms can be obtained with ease, and with an appropriate degree of privacy .
- Sharps disposal containers.
- Instruments sterilisation system.
- Equipment for collecting blood and other samples.
- Adequate number of toilets for health care personnel and users in working order and accessible to wheelchairs (to be kept scrupulously clean at all times).*
- A sluice room and suitable separate storerooms or cupboards for storing cleaning solutions, linen and gardening tools.
- Suitable dressing/procedure room with washable surfaces.
- A resuscitation area with adequate space, table, ORT and suction equipment.
- An adequate number of consulting rooms with wash basins (elbow operated taps), diagnostic light (one for every consulting room).

iii. Medicines and supplies

- Suitable medicine room and medicine cupboards that are kept locked and well-secured, for example, with burglar bars.
- Medicines and supplies as per EDL/EML for Primary Health Care, with a mechanism in place for stock control and ordering of stock.
- Medicines and supplies always in stock, with a mechanism for obtaining emergency supplies when needed.
- Spare batteries and globes for auroscopes and other equipment.

iv. Competence of health care personnel

- Organising the PHC facility

Health care personnel are able to:

- Map the PHC facility catchment area and establish specific and achievable PHC objectives using district, national and provincial goals and objectives as a framework.
- Organise outreach services for the PHC facility catchment area.
- Organise the PHC facility to reduce waiting times to a minimum and initiate an appointment system when necessary.
- Train community health care promoters to educate caretakers and facilitate community action.
- Plan and implement 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 PHC facility level for this purpose.
- Caring for patients
  - Health care personnel 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.

- Health care personnel are positive in their approach to patients, evaluating their needs, correcting misinformation and giving each patient a feeling of always being welcome.
- 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 health care personnel.
- The rights of patients are observed.

v. Managing the PHC facility

- All personnel wear uniforms and insignia in accordance with the South African Professional Councils' specifications.
- The PHC facility has a strong link with the community, civic organisations, schools and workplaces in the catchment area.
- The PHC facility is clean, organised and convenient and accommodates the needs of patients' confidentiality and easy access for older persons and people with disabilities.
- Every PHC facility has a housekeeping system to ensure regular removal and safe disposal of medical waste, dirt and refuse.
- Every PHC facility provides comprehensive security services to protect property and ensure the safety of all people at all times.
- The PHC facility has a supply of electricity, running water and proper sanitation.
- The PHC facility 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.

vi. Patient education

- Health care personnel are able to approach the health problems of the catchment area hand-in-hand with the PHC facility health committee and community civic organisations to identify needs, maintain surveillance of patients, reduce common risk factors and give appropriate education to improve health awareness.
- Culturally and linguistically appropriate educational pamphlets on different health issues are available for free distribution.
- Appropriate educational posters are displayed on the wall for the information and education of patients.
- Educational videos are screened in those PHC facilities with audio-visual equipment while patients wait for services.

vii. Records

- The PHC facility utilises an integrated standard health information system that enables and assists in collecting and using data.
- The PHC facility has daily service registers, road to health charts, patient treatment cards, notification forms, and all necessary laboratory request and transfer forms.
- All information on patients seen and discharged or referred is correctly recorded on the registers.
- All notifiable medical conditions are reported according to protocol. Confidentiality is maintained where necessary.
- All registers and monthly reports are kept up-to-date.
- The PHC facility has a patient carry card or filing system that allows for continuity of health care.

viii. Community & home-based activity

- There is a functioning community health committee in the PHC facility catchment area.
- The PHC facility has links with the community health committee, civic organisations, schools, workplaces, political leaders and ward councillors in the catchment area.
- The PHC facility has sensitised, and receives support from, the community health committee.

- PHC facilities should be linked to appropriate community-based/home-based organisations within the catchment area which conduct regular home visits with appropriate reporting and referral mechanisms.

ix. Referral

- A clear system for referrals and feedback on referrals is in place.
- Patient referral pathways must always be kept in mind when referring a patient.
- All patients are referred to the next level of care when their needs fall beyond the competency of PHC facility health care and personnel.
- Patients with a need for additional health or social services are referred as appropriate.
- Every PHC facility is able to arrange transport for an emergency within at least one hour.
- Referrals within and outside the PHC facility are recorded appropriately in the registers.
- Merits of referrals are assessed and discussed as part of the continuing education of the referring health professionals to improve outcomes of referrals.

x. Collaboration

- PHC facility health care personnel collaborate with departments of social welfare for social assistance and with other health-related public sectors.
- PHC facility health care personnel collaborate with health-orientated civic organisations and workplaces in the catchment area to enhance the promotion of health.

1.3 PHC management norms and standards

i. Leadership and planning

- Each PHC facility has a vision/mission statement developed and displayed in the PHC facility.
- Core values are developed and displayed by the PHC facility health care personnel.
- An operational plan or business plan is written each year.
- District personnel policies on recruitment, grievance and disciplinary procedures are available in the PHC facility for health care personnel to refer to.
- The health care personnel establishment for all categories is known and vacancies discussed with the supervisor.
- New PHC facility health care personnel undergo induction and orientation activities.
- A generic and signed individualised job description for every health care category and personnel is in the PHC facility file.
- There is a performance plan/agreement and training plan in place, and a performance appraisal is carried out for each member of health care personnel each year.
- The on-call roster and the PHC facility task list with appropriate rotation of tasks are displayed.
- A staff attendance (duty) register is in use.
- There are regular health care personnel meetings and targeted In-service training.
- Services and tasks not carried out due to lack of skills are identified and new in-service training sought.
- Disciplinary problems are documented and copied to the applicable supervisor.

ii. Finance

- The PHC facility, as a cost centre, has a budget allocated according to main economic classifications.
- The monthly expenditure of every classification is made known to personnel.
- Deviation in spending (Under and Over) pattern is identified and attended to accordingly. This includes requests for transfer of funds between line items where permissible and appropriate.

iii. Transport and communication

- A weekly or monthly transport plan is submitted to the supervisor or transport co-ordinator.
- The telephone or radio is always in good working order.
- The ambulance for urgent patient transport is available within one hour of being called.

iv. Visits to PHC facility by unit supervisor

- There is a monthly schedule of the supervisors' visits (stating date and time of supervisory support visits) to the PHC facility.
- There is a written record kept of results and outcome of visits.

v. Community

- The community is participating in PHC facility activities as demonstrated by the presence of a community health committee that hold meetings at least monthly.

vi. Facilities and equipment

- There is an up-to-date inventory of PHC facility equipment and a list of non-functional equipment.
- There is a list of required repairs (such as doors, windows, water supply) that have been discussed with the supervisor and PHC facility committee (where necessary).
- There is a logbook containing a report of all repair work done at the PHC facility.

vii. Medicines and supplies

- Stock cards used are up-to-date.
- Orders are placed regularly and on time and checked against the order when received.
- Stocks are stored in order, with FEFO (first expiry, first out) followed. Most importantly, no expired stock is kept on the shelves.
- The ordering of medicines is in relation to level of the health facility and EDL/EML directives.

viii. Information and documentation

- New patient cards and medico-legal forms are available.
- The laboratory specimen register is kept updated and missing results are followed up.
- Births and deaths are reported on time and on the correct form.
- The monthly PHC statistics report is accurately completed on time and sent to the appropriate body while retaining copies in a specialised file in the PHC.
- Monthly and annual data is controlled, displayed in graphs, and displayed in the PHC. Most importantly, personnel and PHC committee to be informed of the analysed data.
- The catchment area map showing the important features, location of mobile PHC facility, public transport route, DOTS supporters, CHWs and other outreach activities is displayed in the PHC.

Section 2

How to use the Supervision Manual

How to Use the Supervision Manual

2.1 How to use the manual

The purpose of this section is to explain how to use the PHC manual. The manual has been designed to support the key elements of a PHC facility supervisory visit as well as the 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.

2.2 Elements of the supervisory visit

i. In-depth programme review

During the course of the year the **Primary Health Care Facility Supervisor** will conduct in-depth reviews of all important health programmes. The correct application of standard treatment guidelines and use of the approved list of essential medicines/medicines is of great importance to ensure high quality care. The **Primary Health Care Facility Supervisor** will concentrate on the correct use of STGs by PHC facility health care personnel to ensure that PHC facility health care personnel will diagnose correctly, treat their patients with the correct medicines, give the correct non-medicine treatment where appropriate and refer patients in an appropriate and timely way for higher level care when necessary, thus reinforcing correct practice and ensuring adherence to established standards.

ii. Problem-solving

Solving problems related to all aspects of the PHC facility is an integral part of the supervisory process. The PHC facility supervisor should engage with PHC facility health care personnel regarding any problems which are being experienced. Many problems can be dealt with on the spot at the PHC facility whilst others will have to be taken by the supervisor 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 PHC facility supervisor visit. The PHC facility supervisor must contact relevant authorities on behalf of the PHC facility to try and address the identified problems.

iii. Information System Review

A functioning PHC information system is essential for the effective management of District Health Services. The PHC facility supervisor plays a very important role in ensuring the accuracy and validity of the information system, such as ensuring the proper use of the PHC facility 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 PHC facility level.

iv. Referral system review

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

v. PHC facility administration

The primary health care facility supervisor, in collaboration with the PHC facility manager, should review certain administrative aspects related to the PHC facility. This would include health care personnel matters, financial matters, infrastructural aspects such as the condition of the building, water supplies, electricity, grounds, equipment, supplies as well as regulatory and legal issues (for example, OHS Act requirements, collection of vital statistics).

vi. Community involvement review

The PHC facility supervisor will enquire about issues related to community involvement during each visit. Regularity and participation of PHC facility health care personnel in PHC facility committee meetings will be assured. Concerns of the PHC facility committee which should be brought to the attention of the District Management and any community problems that need urgent attention (such as malnutrition, disease outbreaks) will be noted. The PHC facility supervisor will also encourage PHC facility health care personnel to plan and conduct specific community outreach activities on a regular basis.

vii. Staff support

The needs of PHC facility staff should be identified and attended to by the supervisor. Such needs could include, for example, the need for additional staffing, or planning for study leaves. Staff should also be updated, trained and coached to perform better. There should be educational sessions at every visit to address specific needs of the staff.

Specific tools have been developed to support activities at every supervisory visit. The tools include checklists (programme review lists, community participation assessment checklists), guidelines (information system) and information, which may support certain activities (problem-solving diagrams, flow charts, graphs).

2.3 Supervisory process

The supervisory process consists of five steps:

i. Regular review of PHC facility performance

This includes the completion of the red flag checklist and monthly checklist. This step will cover and integrate the review of PHC facility administration, the information system, referral system, PHC facility services and community participation activities. These checklists are very important as they allow systematic and standardised assessment of important elements of service provision. The supervisor should verify the 'yes' responses to questions by looking for proof in minutes, registers, statistics, sampling of patients' files, and by asking patients or other staff members etc**.** The completion of the checklist should under no circumstances be an office-bound exercise. The supervisor should engage in managing by doing a walkabout thereby confirming the response. The supervisor needs to illustrate in practice how the data on key performance indicators can be analysed and used.

Review processes similar to those mentioned in (i) are to be followed with other inter-facilities peer reviews.

ii. In-depth programme review

During this step individual programme reviews are conducted and should follow the methodology explained in (i) above.

iii. Problem-solving discussion and improvement planning

PHC facility health care personnel often have personal issues/problems that need to be addressed. The PHC facility supervisor should be available to sympathetically listen to these issues, and to support and assist health care personnel as far as possible in dealing with such personal problems/issues.

iv. Training

The PHC facility supervisor carries a major responsibility to ensure that PHC facility health care personnel are updated, trained and appropriately coached. She/he will conduct educational sessions during each visit designed to address specific needs of the PHC facility health care personnel, covering elements of PHC facility service provision (updating and implementing programmatic changes), health care personnel management (new rules and regulations related to government service) and PHC facility administration. The main focus of this step is to conduct in-service training.

v. Review of previous actions taken during the past month and new actions for the forthcoming month

An essential 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. The duration of the visit should be in line with the policy on primary health care supervision. All steps should be completed at every supervision visit per facility.

It is recommended that this Manual be read and used along with an additional quick reference guide "The 9 Step Guide to Implementing Clinic Supervision", a booklet that provides a number of tools and practical examples for supervisors to follow in their day-to-day supervisory function. The booklet is available at http://www.hst.org.za or webmaster@hst.org.za.

2.4 Organising the Supervisory Work

The purpose of this section is also to identify key aspects of managing a group of PHC facilities and to provide tools and advice in support of this management. The PHC supervisor is responsible for overseeing the general functioning of a collective number of PHC facilities. This entails performing important administrative tasks, scheduling visits, planning the supervisory components visits and monitoring the performance of PHC facilities.

2.5 Administration

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

A second important task is to complete the supervisor's list of contacts, which will enable the PHC supervisor to deal with important issues without having to follow complicated bureaucratic lines of communication. This list should be completed between the PHC supervisor and the District Manager, showing the various authorities from which the PHC supervisor can seek help in carrying out the supervisory responsibilities. The purpose of the list is to have previous authorization to enable the PHC supervisor to contact appropriate persons directly on behalf of the PHC facilities when assistance is needed. Increasingly, the PHC supervisor will be expected to solve problems on behalf of the PHC facility simply with a phone call and the use of this list. The contact list should be regularly updated as many of the contact details may change from time to time.

2.6 Scheduling supervisory visits

The supervisor should use a standardised form indicating the **PHC facility supervision schedule** one year in advance. This is to record the dates on which the PHC supervisor expects to visit each of the PHC facilities for which she/he is responsible. Ideally, these dates will be set well in advance to ensure that monthly visits take place, perhaps even a fixed day each month (for example, the second Tuesday of the month). Should a change in schedule become necessary, the PHC facility should be notified as far in advance as possible. This form also enables the PHC supervisor to record the date that the visit took place, for submission to the District Manager as a critical tool that may be used when assessing the quality of supervision. This will be particularly helpful for the PHC supervisor to submit to the Transport Officer in charge of the vehicle that will be assigned to the PHC supervisor for visiting each of these PHC facilities. A copy of the annual schedule should be provided to the district manager and individual PHC facilities.

2.7 Planning and recording the content of a visit

The form **PHC Facility Planning Schedule** will enable the PHC supervisor to plan the content of one's PHC facility visits in advance. The PHC supervisor will need to photocopy this form so that it can be completed for each of the PHC facilities that are under her/his supervision. This form will help to plan the contents of the supervision visit well in advance, as well as to record what one actually does during the visit (for example, the issues discussed, in-service training, programme reviews, the PHC supervisor's conduct and findings). It also serves as a follow-up on actions that need to be taken. As each PHC facility has its own page to record the PHC supervisor visits, there should be a consolidated recording of the findings and of the jobs that will need to be done on return to the office. A copy of each individual PHC

facility form should be provided to the DM and to individual PHC facilities.

2.8 Monitoring performance of the PHC facility

An important component of the supervisor's role is to monitor the performance of PHC facilities. One way of doing this is by direct visits at the PHC facility. Another important way is to compare the performance of the PHC facilities that one PHC supervisor is supervising. This should be done using the quality supervision tools described, such as graphs or run charts to highlight key aspects of PHC facility performance. This method allows one to identify poorly performing PHC facilities; reasons for the poor performance and possible solutions; as well as to assist the facility manager and staff to understand their own performance better. On the other hand, lessons could be learnt from PHC facilities doing very well in certain areas, which could be used to improve service provision in other PHC facilities.

2.9 Reporting

The district manager needs to receive a regular monthly report from each supervisor and should use this in managing and improving both the services in the district and the activities of the supervisors and support staff. The DM should report quarterly on supervisory visits within the district. A form titled **Quarterly Districts Report on PHC Facility Supervision** can be used. In order to support the District Manager to compile this report, the form **Monthly Supervisors Report on Supervisory Activities** may be used to provide reports to the appropriate unit at provincial level. Each PHC facility 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.

2.10 Rationale for sections included in the manual

Table 1 provides 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 the various tools and the section where specific tools are to be found in the manual.

Table 1

SUPERVISORY STEPS AND ACTIVITIES	OBJECTIVE	TOOLS	REGULARITY OF USE
Regular review			
1. Red flag list	To identify critical elements which can seriously affect service delivery and to identify steps to rectify the matter	Checklist	Monthly
2. Routine review list	To review areas which need monthly review	Checklist	Monthly
2.1. Health care personnel management	Ensure that key health care personnel management activities are done	PHC facility managers checklist	Used when appropriate
2.2. PHC facility management	Ensure that key PHC facility management activities are done	PHC facility managers checklist	Used when appropriate
2.3. 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
2.4. Referral review	To ensure that the referral system is functional	Referral form	
2.5. PHC facility review	To ensure that clients receive a high quality PHC facility service	Guide to use of STGs	Used when appropriate
2.6. 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 that may be used.	Used when appropriate
2.7. Community involvement review	To ensure that there is an effective relationship between PHC facility 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
3. In-depth Programme review	To provide an in-depth review of specific programme areas	• TB checklist • STI Checklist • EPI checklist • Reproductive Health Services checklist • EPI checklist • ANC checklist • Chronic disease checklist • Medicine management checklist	• One or two programme areas per month. • Review checklist quarterly

4. Training	To provide regular and appropriate in-service training to health care personnel	PHC facility Tips – one page guides to improving PHC facility diagnosis and management	Monthly
5. Problem-solving discussion	To discuss problem areas with health care personnel and find ways of dealing with the problems	Problem-solving cycle. Other manuals/guides contained in manual or supplied from other source	Monthly
6. 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
7. Problem-solving discussion and improvement planning PHC facility supervisors – health care personnel relationships	To assess the quality of the relationship between PHC facility supervisor and the health care personnel she supervises as well as her supervisory practices.	Checklists	Biannually or as required

Section 3

Quality Supervision

Quality Supervision

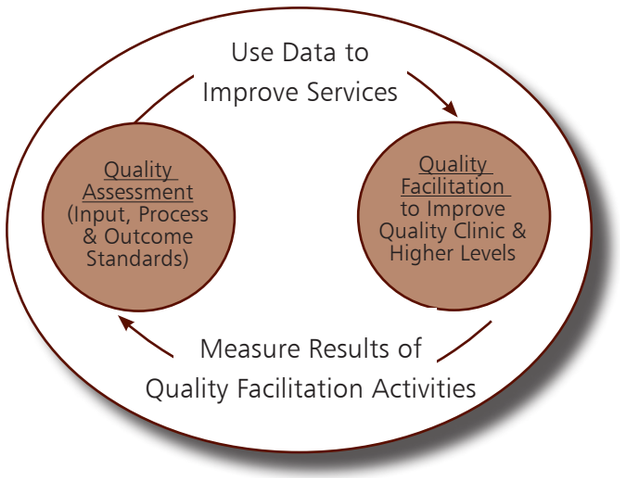
The intention is to improve the current supervision of PHC facilities by applying a quality **assessment** and quality **facilitation** approach to priority PHC services. The assessment and facilitation aspects are integrated to form Quality Supervision (QS). In other words, quality improvement is based on supervision. The aim is to keep QS simple, feasible and useful to PHC facility providers, PHC facility supervisors, and their superiors at district levels. This will also mean that facility managers and staff themselves will be able to apply the principles and skills they have learned (such as regular review of their own data) to monitor their services and introduce improvements on a day-to-day basis. This should form an integral part of the mentoring activities of the supervisor.

3.1 Purpose and objectives of QS

i. Purpose

The purpose of Quality Supervision is to identify in a measurable way the gaps between the current level of quality and the expected level of quality, and to address any such gaps.

QUALITY SUPERVISION FUNCTIONS



Quality Supervision: Achievement of quality requires that performance be monitored to ensure that standards are complied with, that problems are identified and that outcomes of care are measured as benchmarks to be continuously improved.

Figure 2: Quality Supervision - Core functions and relationships.

ii. Objectives

The objectives of QS are to ensure that inputs, processes and outcomes (IPO) are in compliance with norms and standards. Inputs are seen as those resources available to provide a service' processes are those actions necessary for compliance with norms and standards; and outcomes are defined as those targets, outputs, coverage, effects and service standards that need to be met by different programmes within PHC facilities.

3.2 Guiding principles for successful QS

In order to ensure that the purpose of QS is met – that is, to ensure that inputs, processes and outcomes conform to desired standards and are continually monitored and improved, it is essential that the following guiding principles are fully understood.

iii. A systems view

All PHC facility supervisors and health care personnel must understand how various components of the health care system work together, such as the relationships between the Inputs (resources), Processes (activities) and Outcomes (effects of the activities). This is critical for making quality supervision work. It provides a framework for supervisors and PHC facility health care personnel to interpret PHC facility health services; identify problems and causes along the IPO chain and specify appropriate solutions and changes.

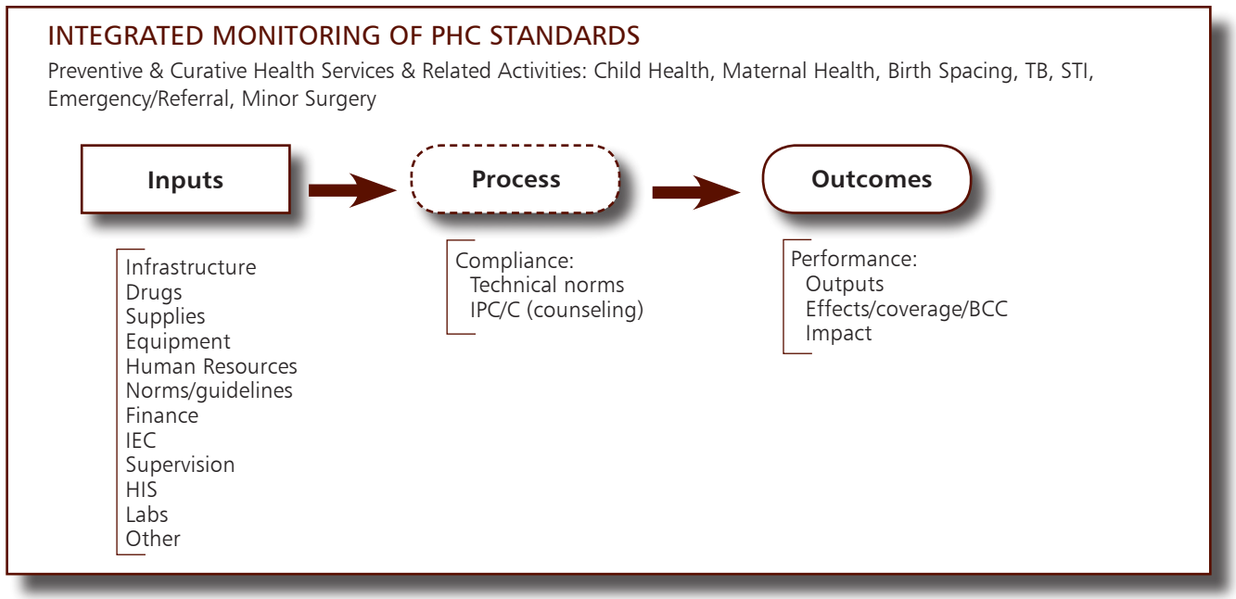


Figure 3: System inputs, processes and outputs required for Quality Supervision

34.3 PHC facility supervision work as processes and systems

It is important for PHC facility supervisors to understand that all work done by PHC facility health care personnel forms part of the process of health care provision, within the whole health care system. Processes are the critical link that transforms resources into results. Understanding and analyzing these processes lies at the core of QS, followed by facilitation to improve quality. Therefore, results are dependent on improving processes, as well as inputs, and the importance of the assessment of processes within the QS framework must be emphasized.

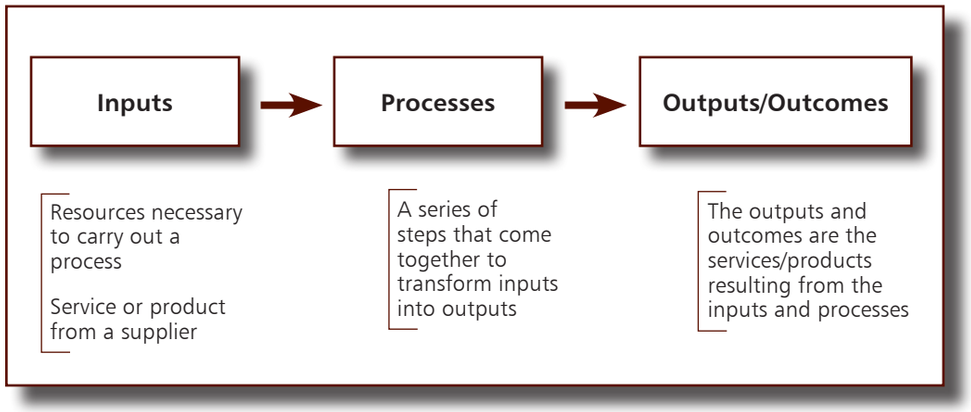


Figure 4: Processes and Systems

3.4 Assessment and facilitation

There are two major integrated activities within QS:

- Assessment: which involves observation and assessment of patient, management (outcomes and processes) and assessment of PHC facility resources (inputs such as medicines, equipment)
- Facilitation: which involves feedback to service providers (or support health care personnel) and problem-solving, planning and monitoring.

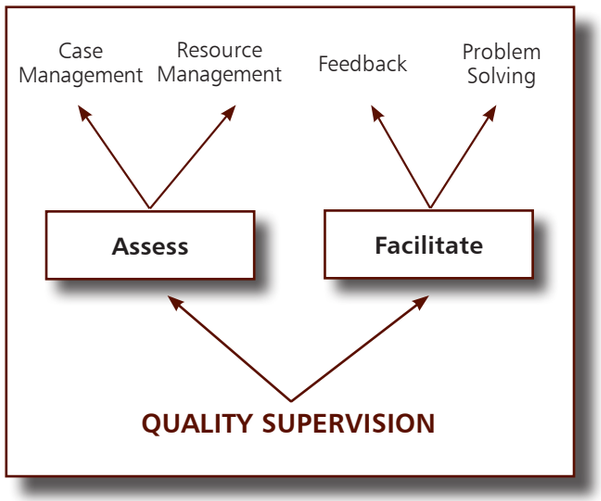


Figure 5: Assessment and Facilitation

In order to enhance the synergistic functioning of these two activities, it is essential to understand the areas of overlap. During a supervisory visit, quality facilitation is directly related to assessment. For example, as soon as patient management is assessed, the supervisor provides direct feedback as a means of facilitative quality improvement. Facilitation in the form of feedback is done immediately to correct and further reinforce compliance with standards for all health care personnel.

3.5 Expansion of QS

The introduction of QS is a gradual and incremental process requiring both organizational and behaviour change on the part of managers, supervisors, and PHC facility health care personnel. It is essential to begin the process to fit existing resources and programmes and expand gradually, ensuring ongoing support and maintenance.

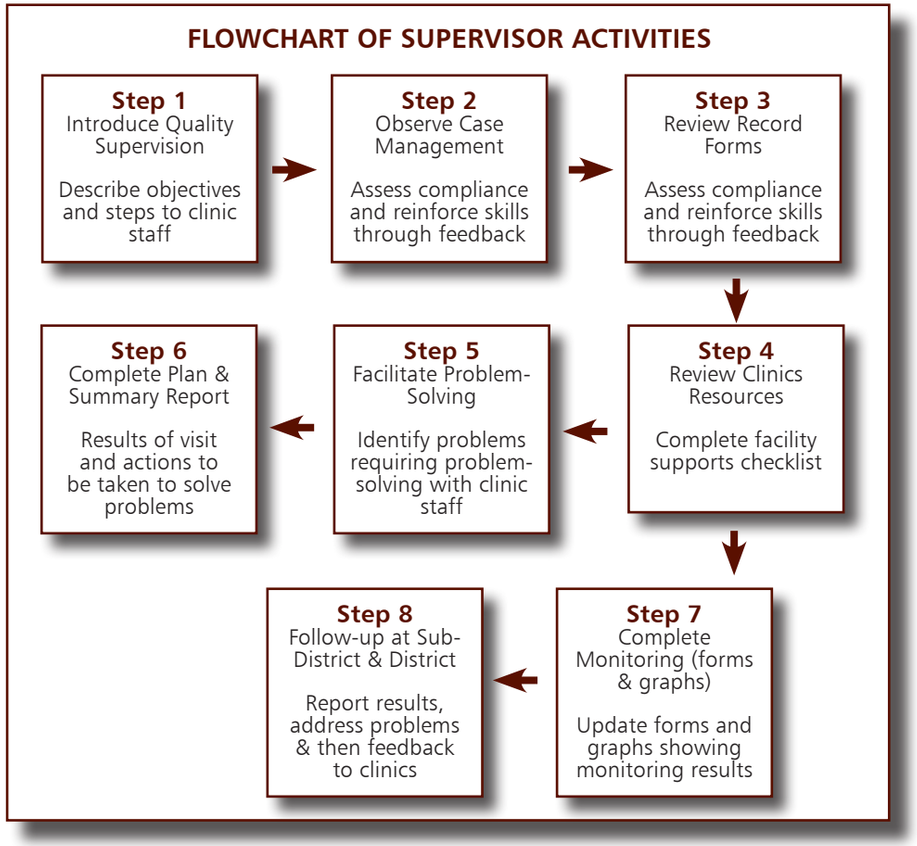


Figure 6: Flow of activities during supervision visit

Table 2: Guiding principles of Quality Supervision (summary)

1.	Systems perspective	Supervisors apply a systems approach during assessment and facilitation.
2.	Integration of assessment and facilitation	Supervision visits consist of assessment and facilitation (feedback and problem-solving), plus planning and monitoring. Assessment and facilitation to improve performance and quality are integrated as much as possible. Many problems are thus addressed immediately through feedback that is supportive and corrective) rather than longer problem-solving processes being used.
3.	Monitor quality improvement	Essential element of QS. PHC facility supervisors should review plans from the last visit and identify activities to be completed by the next supervisory visit. The supervision checklist and quality improvement (QI) plan provide an opportunity to monitor progress and planned activities for the next period.
4.	Address problems at multiple levels	Supervisors address problems at the PHC facility level and higher levels through follow-up of plans and specific support to resolve problems.
5.	Change and ongoing needs	For QS to result in improved outcomes, the following are essential: • organizational and health care personnel behaviour change • supervisor and health care personnel learning and support • ongoing support from sub-districts, districts and provinces.

3.6 Assessment of the quality of services

The following are used in order to collect information regarding the quality of services at a PHC facility:

Checklists – these are most commonly used to assess inputs (resources) and outcomes (effects). This may also include questionnaires / surveys.

Review of statistics and registers (Step 3 in Figure 6) – the supervisor should at all times discuss and analyse (using appropriate monitoring tools) with the staff the routine statistics they are collecting and submitting on the services they provide. This also provides an opportunity to identify any errors in the data collection and recording as well as service delivery problems (see chapter 6).

Direct observation – this is the best method for assessing the processes of service delivery and compliance with norms and standards between health care providers and patients/caregivers. However, this may not be feasible for all patients because of confidentiality considerations.

Combination of questions and patient scenarios – may be used to determine the knowledge of health care personnel.

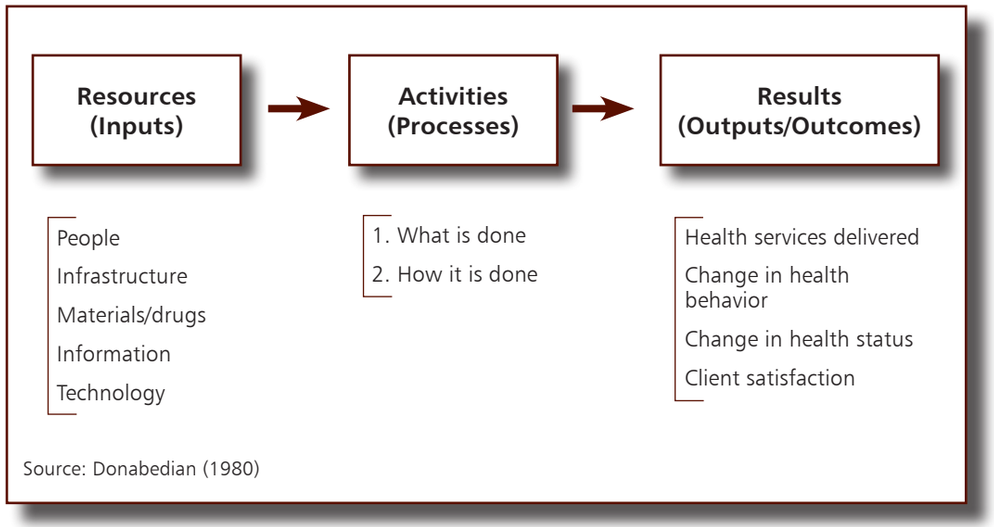


Figure 7: A systems approach - inputs, processes and outcomes

Facilitation of Quality Improvement – Facilitation within the context of quality improvement involves direct feedback and problem solving.

3.7 Direct feedback

Direct feedback may be of two types:

- **Supportive** - to support an effective or desirable behaviour
- **Corrective** - to change behavior, including alternative ways of behaving or doing things.

The supervisor uses the direct feedback obtained during the assessment process to immediately address problems and aid the learning and performance of health care personnel. It involves:

- Explaining verbally
- Presenting the problem and facilitating a correct response

- Demonstrating how to do something (with IEC materials, guideline, booklet).

Direct feedback is most effective when used with direct observation. Most feedback involves a combination of supportive and corrective feedback. Giving feedback is probably the most important quality improvement skill for a supervisor.

3.8 Problem-solving at the PHC facility level

Problem-solving is used to address problems that cannot be improved by direct feedback and require additional review by the supervisor and PHC facility health care personnel. It is a 4-step method to identify and analyse problems, develop solutions and test interventions to address problems.

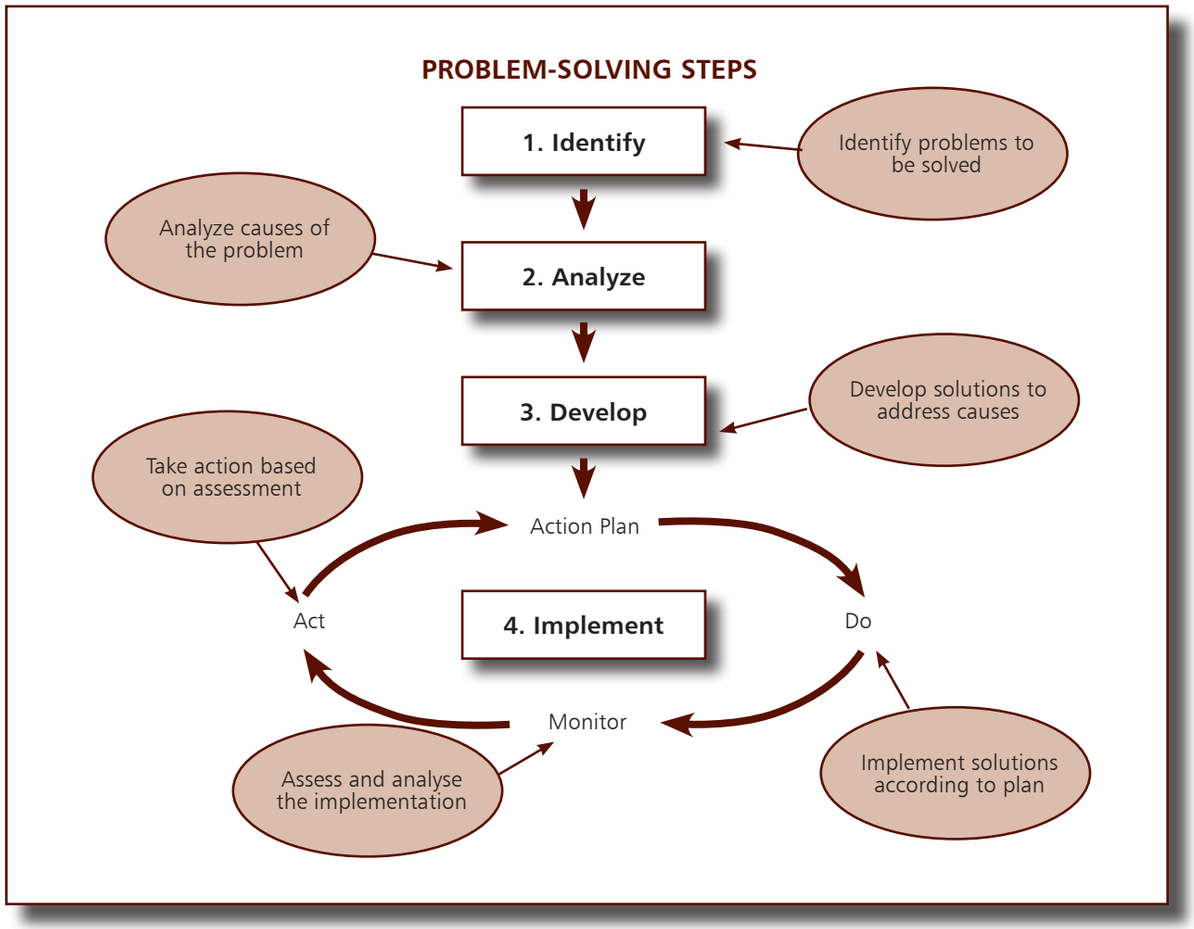


Figure 8: Problem-solving steps

Within the PHC facility, it is important to include all PHC facility health care personnel directly involved with providing the health service, as well as the PHC facility manager in order to enhance the process of problem-solving and address common issues that affect the entire PHC facility and its health care personnel. This would include improvements in reporting, communication and accountability, and developing skills and self-confidence among the staff.

To begin the process, the supervisor convenes a debriefing and problem-solving session with health care personnel. Using information collected from the assessment, the supervisor starts with a discussion of the strengths and good practices seen. Together with the health care personnel, the supervisor identifies and prioritises the main "problem" areas in the implementation of the service, which are then dealt with appropriately. Over time and given a supportive relationship and encouragement, the facility staff will themselves become skilled at applying the method to their daily work.

The following figure illustrates a system model for malaria treatment. A similar model can be used by supervisors to identify problems (using assessment tools) then trace back in the system to determine the cause(s). If a problem is found with medicines, for example, then the supervisors can apply a more detailed fishbone or flow chart of the medicine management sub-system. This is a generic tool that can be adapted and used for all PHC services.

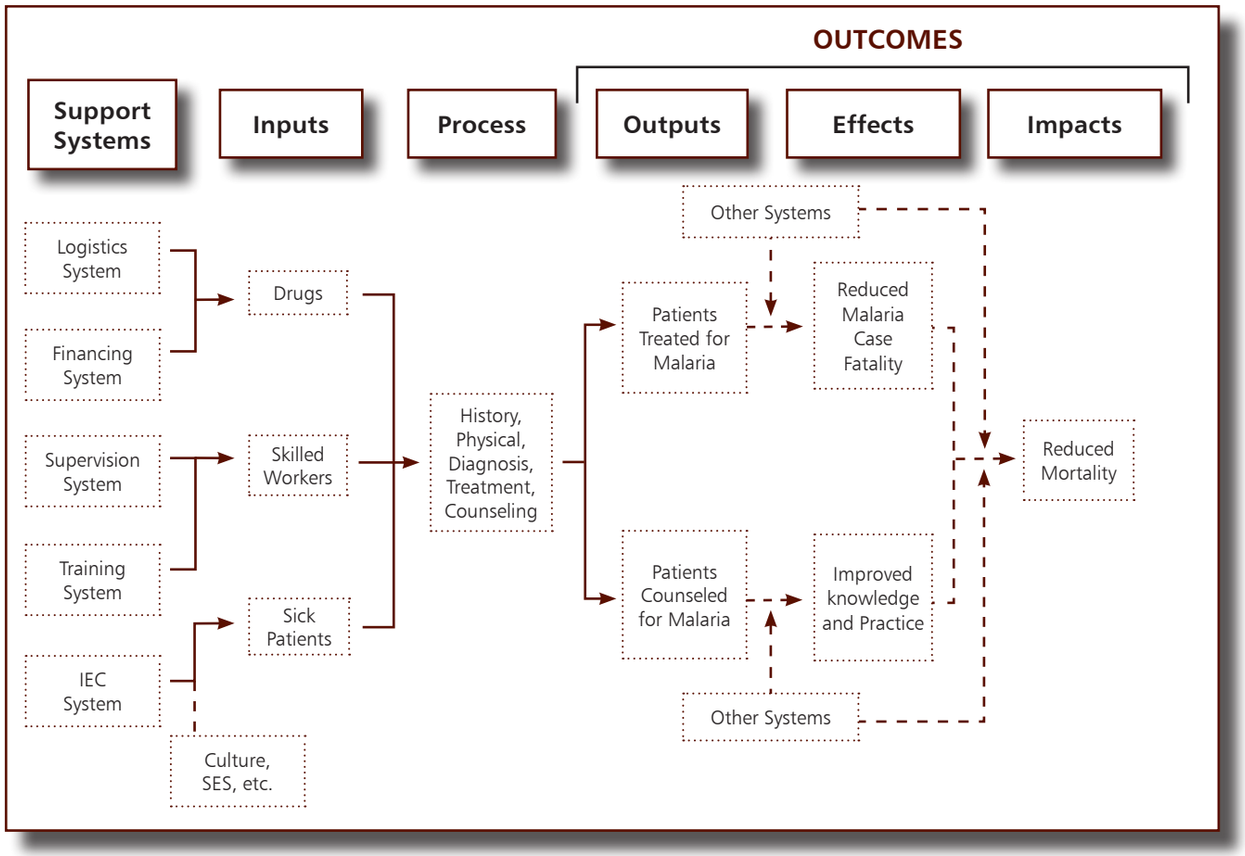


Figure 9: Systems model for Malaria Treatment

Problem-solving may be at two levels:

Level 1 – Rapid problem-solving:

This is often used to address causes and solutions that are obvious to the PHC facility health care personnel and supervisor. Brainstorming is a common method for rapidly identifying possible causes and solutions.

Level 2 - Detailed causal analysis and solution development:

This is used when the causes or solutions to problems are not obvious and require a more systematic analysis. The process of problem-solving is commenced with a quality improvement (QI) tool such as the fishbone or flowchart to identify system components (such as equipment, health care personnel skills, financial resources, guidelines) and possible causes. The PHC supervisor should help the staff to develop their own chart or diagram for the identified problem, preferably through drawing it on a board or flipchart so that everyone can participate in generating the ideas.

Fishbone diagrams are used to diagrammatically indicate technical areas that may be related to the problem at hand.

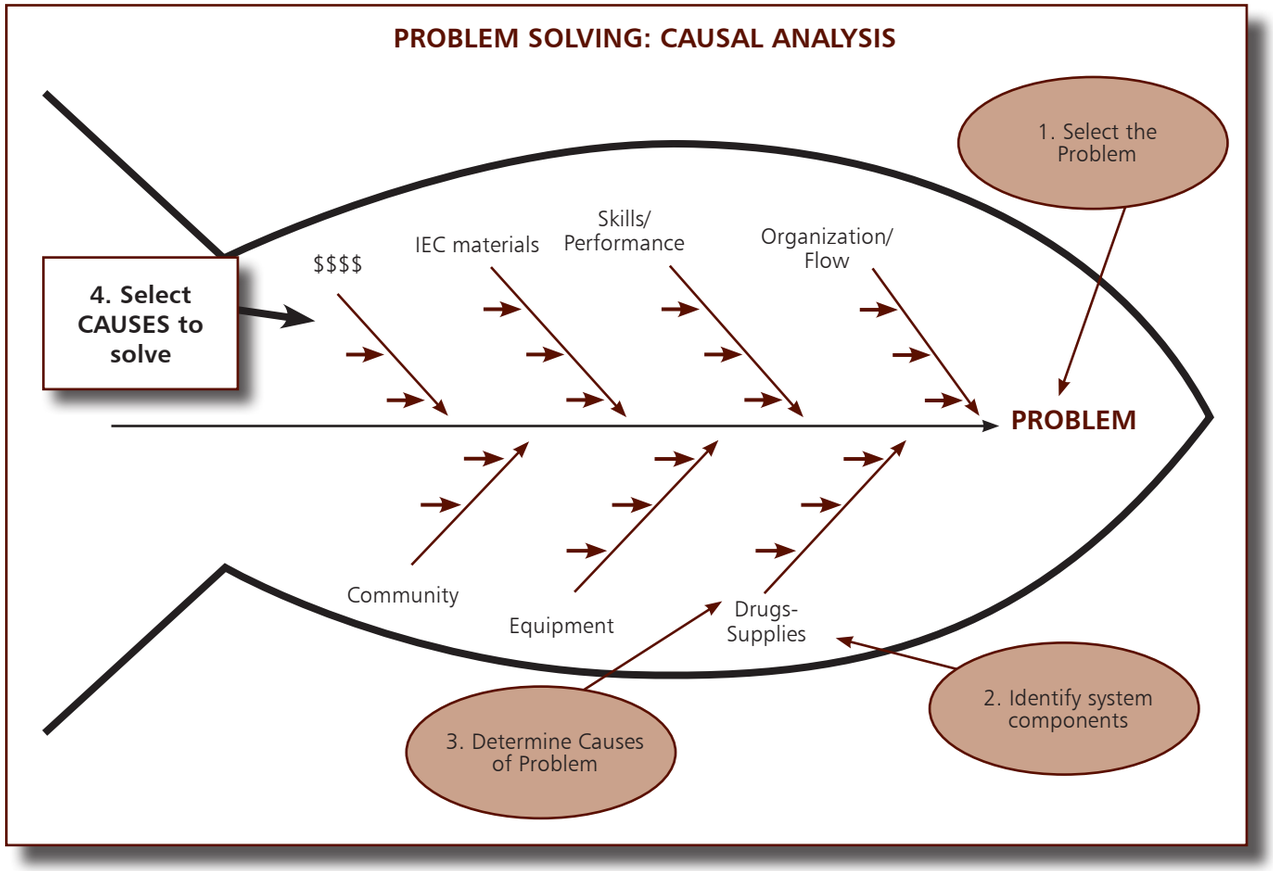


Figure 10: Fishbone diagram

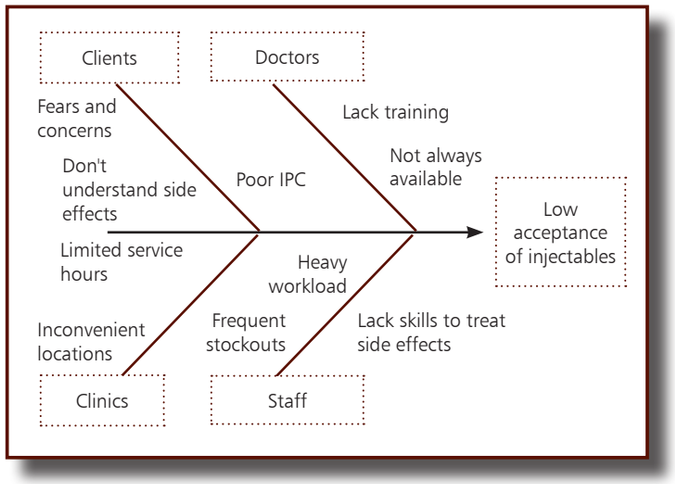


Figure 11: Analysis of low injectable contraception use among reproductive age women

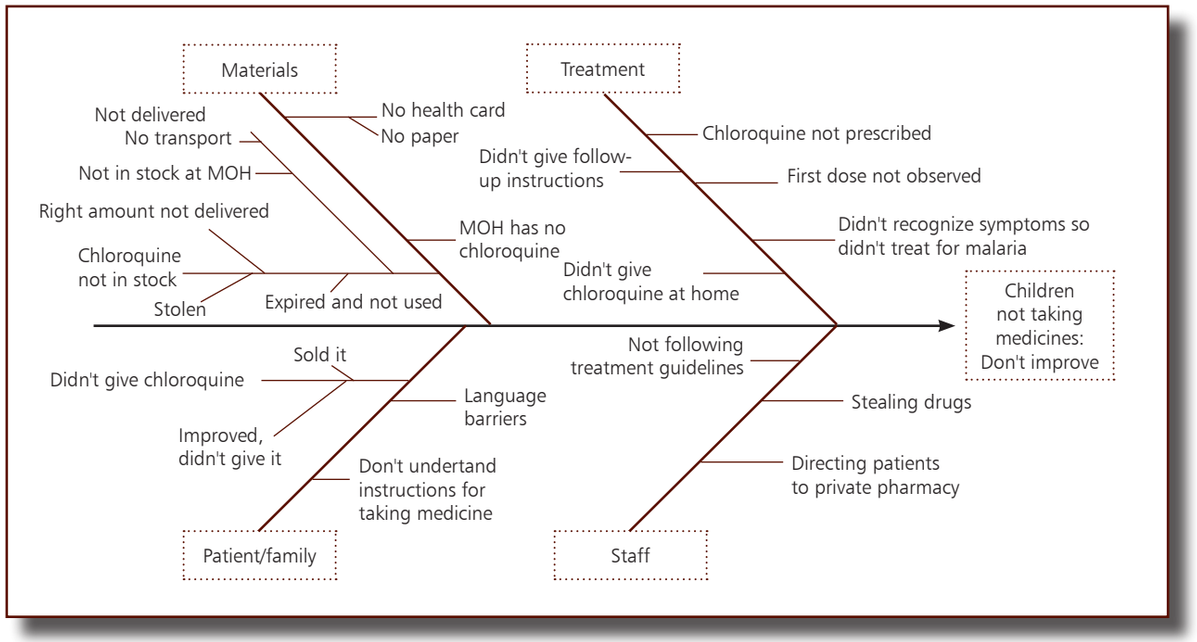


Figure 12: Detailed causal analysis of malaria in children

Flow charts clarify the actual steps in a process (procedure or technical protocol or path followed by a patient through the service) so that the supervisor and PHC facility health care personnel can graphically view the process and begin to identify specific problems and causes.

They are utilized during problem solving to:

- Describe the actual process
- Involve the people that work in the process and know it
- Provide a shared understanding of the process
- Uncover problems and bottlenecks in the continuum of care including patient flow and how this can result in delays or wasted time
- Uncover the sub-steps that are required for each major step in the continuum of care
- Guide discussion to identify problems, causes and solutions
- Facilitate action planning by helping to determine where to start.

Flow charts are based on technical and procedural norms and the actual flow within a province or district. By flow-charting the actual process and comparing with the desired norm or standard, the problems, the causes and perhaps even the solutions become apparent. It is imperative that patients' waiting times be determined in the local service standards. Similar flow charts can be developed and applied for technical standards dealing with IMCI, VCT, ART, ANC and PMTCT. Some of the norms such as patients' waiting time can, along with service standards, be locally developed.

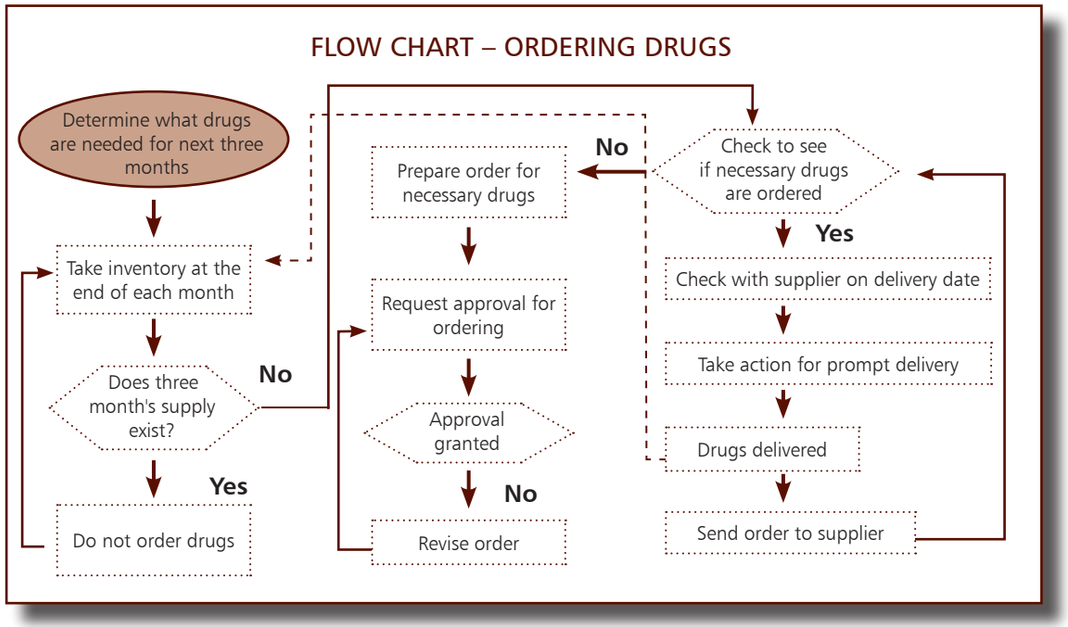


Figure 13: Ordering of medicines

Where there are a limited number of causes for a problem, a step-by-step flow chart is useful.

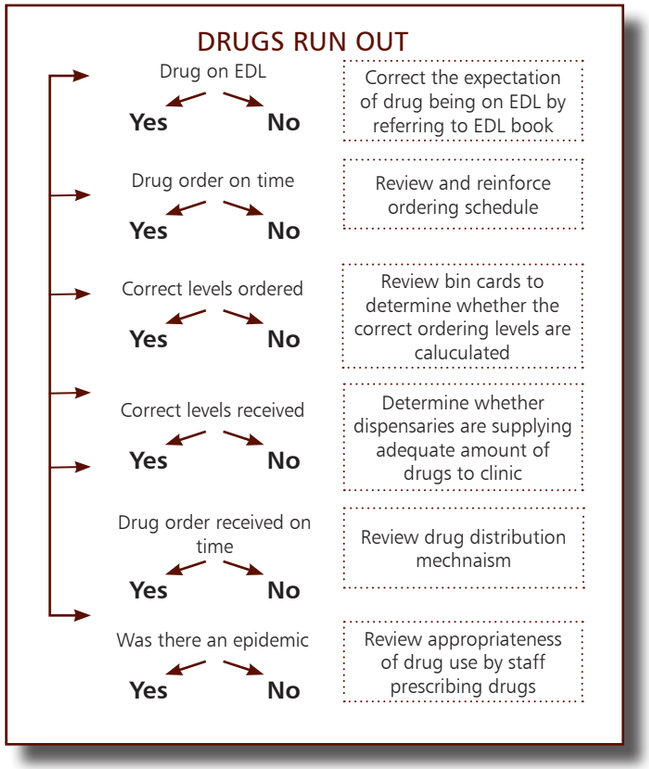


Figure 14: Step-by-step flowchart

Where problem-solving job aids are available, the process of problem-solving is performed faster, resulting in appropriate action plans.

When the team has completed a problem-solving process the problem(s), causes and solutions are recorded on the Action Plan form.

In summary, solutions that are not obvious and require additional causal analysis and solution development require the use of QA/QI tools such as fishbone and flowcharts. Some problems can be addressed at the facility level while others require interventions at the district and provincial levels. Problems and solutions that are common and/or need to be addressed at higher levels (district and provincial levels) often require additional problem-solving with supervisors or managers at the district and provincial levels.

3.9 Problem-solving at the district and provincial levels

Some problems identified at the PHC facility level or district level can only be analysed and solved at the district and provincial levels (where the cause is located at these levels). Thus QS problem-solving tools can also be used at the district and provincial levels to address problems.

This level of problem-solving will usually take place in monthly meetings of supervisors, programme and Quality Assurance co-ordinators, as well as in special meetings with supervisors designed to address common problems or problems requiring intervention at a higher level.

At these problem-solving meetings, the following should be addressed:

- Problems related to the supervision process itself (for example, transport, time, preparation, communication)
- Problems and solutions emanating from PHC facility visits that should be shared among the group
- Problems which need to be addressed by specific stakeholders, for example, progamme, QA co-ordinators or district/provincial managers.

Action Plan

During the problem-solving process, the supervisor should ensure that the problems, possible causes and solutions are clearly identified. The next tasks involve translating the solutions into specific activities, responsibilities (internal and external to the PHC facility), and specific timelines (beginning and end dates). All these should be documented on an Action Planning form, with meticulous follow-up. This form of action plan may be used locally between the PHC supervisor and the PHC facility manager where problems are identified.

TABLE 3: Action Plan Form

#	PROBLEM	CAUSES	SOLUTIONS	PLANNED ACTIVITIES	TARGET DATES	RESPONSIBLE	COMMENTS
1							
2							

Use the SMART approach to check the PHC supervisor's plan.

SMART METHOD		
S	**Specific**	What action will be done? By whom?
M	**Measurable**	How will we know when it has been done?
A	**Attainable**	Is it something we will be likely to acheive?
R	**Realistic**	What is feasible? This overlaps with attainable, but includes identifying the resources that will be needed. Are the necessary materials, finances and personnel available? Local conditions will influence what is attainable and/or realistic.
T	**Time frame**	By when will this be done i.e. action completed? Do some of the plans need interim time frames?

3.10 Monitoring of quality improvements

A monitoring system consists of an ongoing process for regular collection and analysis of a core set of indicators. The data can be used for assessing problems, making decisions to improve the situation, and monitoring progress. As such, monitoring is actually part of implementation, and should not be seen as something that is only done "at the end" once the plan is completed. An effective monitoring system should meet the following criteria:

- Data is collected to monitor the trend of indicators over time
- Data is used to identify the presence and causes of problems
- Data is used to guide management decisions, planning and quality improvement activities
- Data is used on a day-to-day or week-to-week basis to check that implementation is proceeding as planned and no changes are needed.

A system that monitors quality not only collects information on inputs (i.e. resources) and outcomes (i.e. outputs, coverage/effects, and impact) but also focuses on processes to determine if services meet defined standards (technical, communication, procedures).

Presentation of data: Data is most commonly presented in table form. However, the impact of this data may be significantly improved if presented along with a run chart or graph showing changes over time (against a target or standard).

The following graphs show how improvements in health care are tracked over time, as a result of the assessment and facilitation processes.

The situation found on the initial assessment will be reflected as the baseline. Run or bar charts may be utilized to detect trends over time and to determine whether there is a change in the process or not. They may also be used for presentation of data to PHC facility health care personnel or to aggregate data of a sub-district or district.

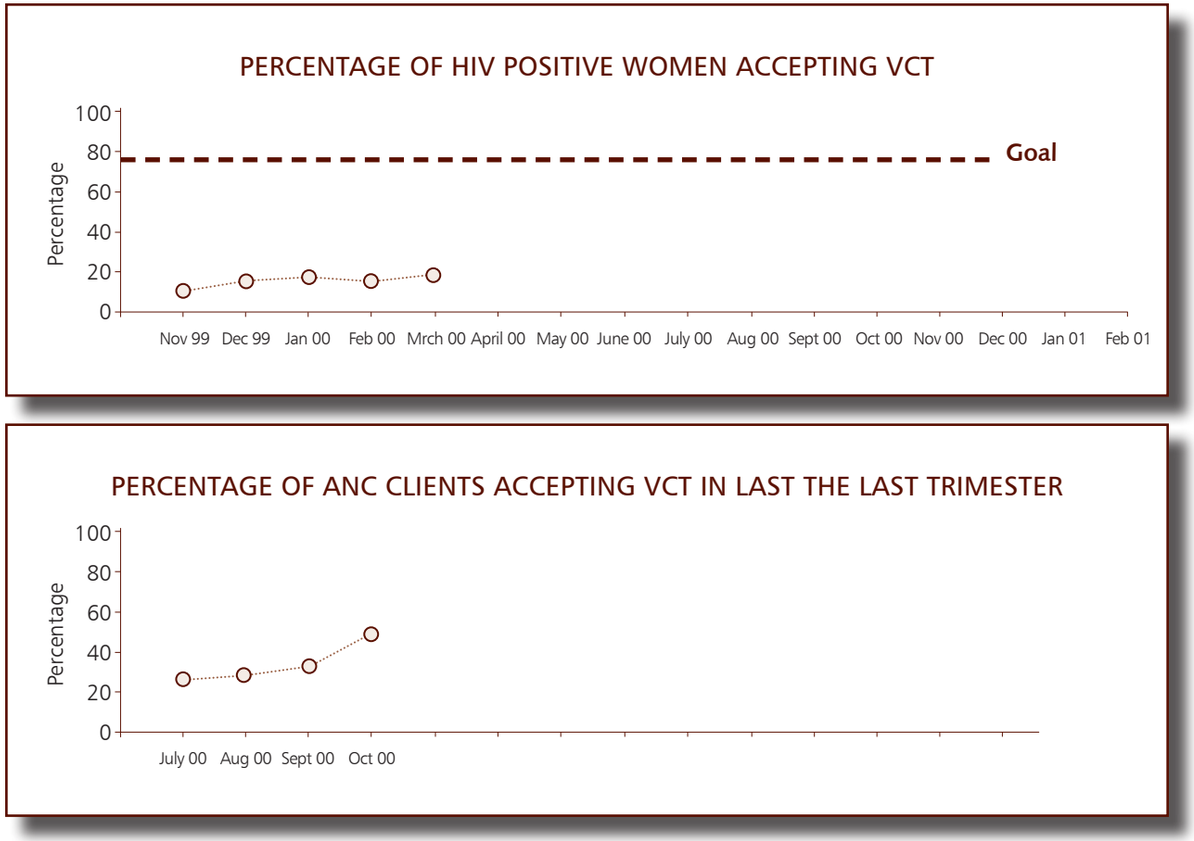


Figure 15: VCT acceptance rates

The following figure also shows how monitoring results are presented as a bar graph, particularly when the PHC supervisor wants to combine several different types of indicators or geographic locations on a single graph. The limitation of bar charts is that, when many points of time are required, the chart becomes more difficult to interpret and a run chart is preferred.

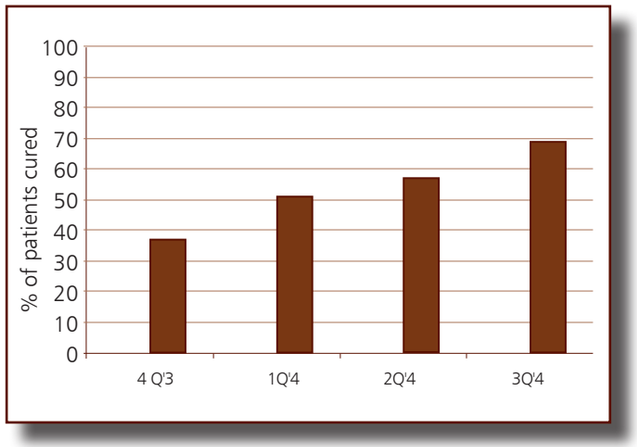


Figure 16: Quarterly improvements (in TB services)

As noted, data shows what has been achieved and what has not been achieved. Data also displays (after analysis) what needs to be addressed through supervision. Monitoring data reminds PHC facility health care personnel about where they are and where they need to go and serves as a point of entry for problem solving (since these data often tracks outcome and process measures).

Conclusion

Improving quality can be a unifying goal that is able to unite health care providers and supervisors. The combined QS assessment checklist and the QS monitoring graphs

provide the documentation needed to justify the decisions made for quality improvement. Information is used with the objective of improving performance and quality within the health system without threatening the people whose performance is being assessed (see chapter 6).

3.11 Strategic action

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. Such a plan does not always have to be very detailed and time-consuming to draw up, but with practice all the steps can easily be followed for each specific problem.

Table 4: Strategic action

Vision	Use an overall vision for the PHC facility as a whole, but use a more specific vision when planning or problem-solving for a service or programme.
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 the PHC supervisor is investigating.
Select problem	From the situation analysis, identify areas that need attention. From these, determine what most seriously needs attention, and what is feasible to work on with the available skills and financial resources. Often a good choice to start on is an area that the team is motivated and enthusiastic about addressing. This does not exclude the fact that there are things that must be worked on because they are serious, even if they need resources or higher level solutions.
Clarify and define problem	Using a systematic approach as described above, identify various components and roots of the problem. Try not to define the problem as the absence of an assumed solution (for example, transport, separating PHC health care personnel from hospital personnel) but rather in terms of what is needed or what the situation should be. This allows for more creativity in identifying optional strategies.
Measure baseline of problem	Once the problem is more clearly defined, establish the starting point, or baseline, in other words, the current state. The more objectively the starting point can be expressed, the more effectively progress can be measured.
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 the PHC supervisor setting.
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 (e.g. 3 nurses trained, or a manual written) and describe the phases of progress to be made. Time-frames are essential.
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.
Implement plans	Carry out the above plan!
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.
Evaluate: measure achievements	Using the same technique as when establishing the baseline, assess progress made. Is there an improvement in the situation? If not, why not? If yes, is progress sufficient? What other related gains were made?
Reconsider strategies	If more progress is needed, what is needed next? Is a change in strategy needed to make more progress?
Redefine problem	Follow the steps above to re-clarify and re-define the problem as it is now, establish new baselines, etc. Follow the cycle through again.

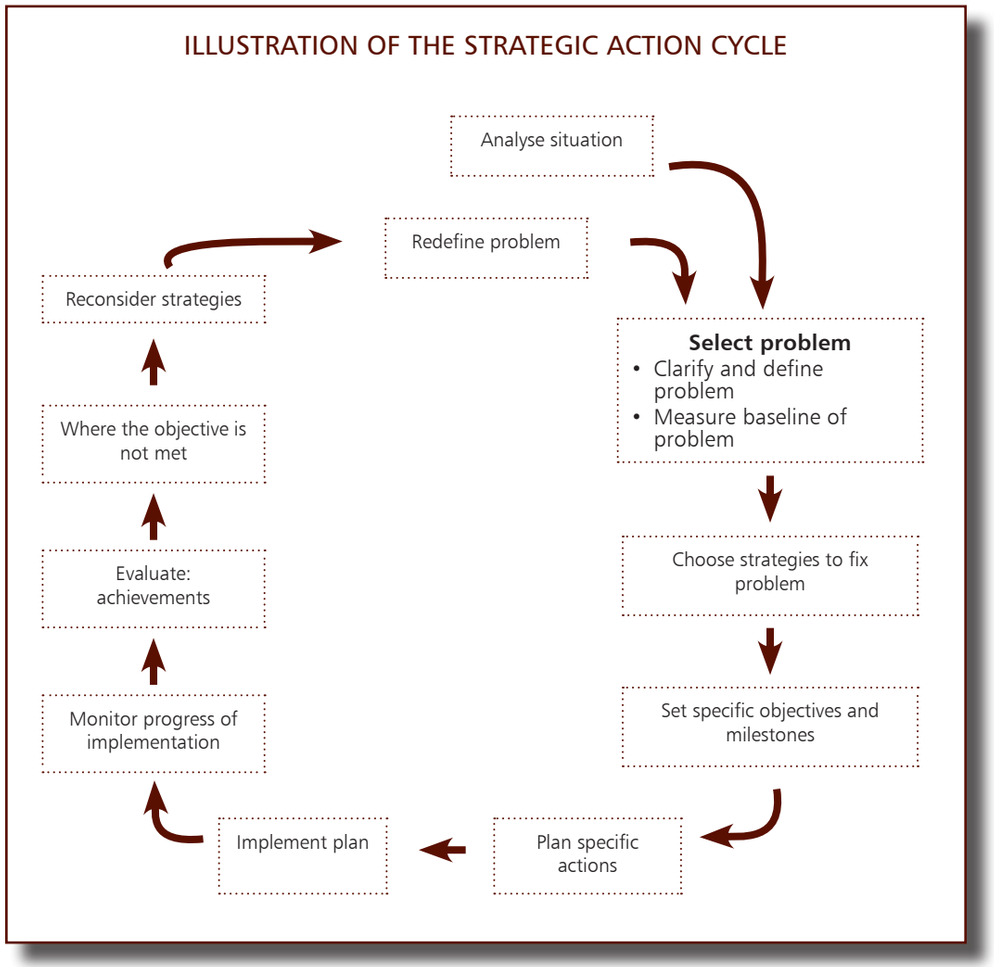


Figure 17: Strategic Action Cycle

Section 4

Supervisors' Support Lists

Supervisors' Support Lists

4.1 Guidelines on the use of Supervisors' Support Lists

The checklists should be seen as a tool to support the PHC supervisor as the PHC supervisor conducts a supervisory visit. It supports the PHC supervisor to systematically review important aspects related to PHC facility service provision, and consists of three sections.

4.2 Red flag (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 with a 'yes' or a 'no' whether there are stock-outs, problems with the refrigerator, broken equipment or absent health care personnel (the number of days of health care personnel 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.

Checklist: Red flag

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

INFRASTRUCTURAL ISSUES ARE THE FOLLOWING AVAILABLE OR ACCEPTABLE? ANSWER WITH YES / NO / NA

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1. Does the physical access cater for people with disabilities?(e.g. wheelchair patch and rails) (See NDoH QA Policy.)												
2. Is the building in good repair (e.g. no broken window, peeling paint or broken windows, proper lighting, roof and carpets in good condition, no exposed wiring or pipes.)												
3. Are there taps and piped water available?												
4. Is the telecommunication system in good working order?												
5. Is there an electrical power supply?												
6. Are there functional fire hydrants and extinguishers?												

HEALTH CARE PERSONNEL NOT ON DUTY (LEAVE, TRAINING, ABSENT WITHOUT LEAVE)

Enter the ratio of absent to on-duty professional nurses.

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1. Professional												
2. Non-Professional												
3. Is the staffing for the month acceptable?												

CUSTOMER CARE ARE THE FOLLOWING AVAILABLE OR ACCEPTABLE? ANSWER WITH YES / NO / NA

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1. PHC facility Catchment Map displayed												
2. Batho Pele, Patients' Rights wall charts accessibly displayed												
3. PHC facility's service standards displayed												
4. PHC facility management *(organogram & contact details)* displayed												
5. Patient / Customers' PHC facility & care evaluation forms available and used.												

CLEANLINESS AND INFECTION PREVENTION

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1. Pumped liquid soap dispensor												
2. Disposable paper towels												
3. Disposable gloves												
4. Sharps containers												
5. Refuse containers												
6. Clean public toilets (with toilet papers and hand washing apparatus).												
7. Patients wait in well ventilated areas												
8. The facility and surrounding areas are spotlessy clean (no litter or any other form of dirt)												
9. Medical instruments are sterilized before use on individual patients												
10. Quality checks are conducted on sterilizers according to manufacturers recommenations (there should be written proof in the form of checklists)												

FUNCTIONAL EMERGENCY TROLLEYS

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1. HIV Rapid Test kit												
2. Quality testing kit												
3. Oral rehydration												
4. Intravenous infusion (and complete set)												
5. Sputum specimen bottles												
6. Sputum turnaround time within norm												
7. Condom availability												

EMERGENCY MEDICAL SERVICES (EMS)

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Ambulance turnaround time												

MEDICINE STOCK-OUTS

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1. Reproductive health services												
2. STI												
3. TB												
4. ANC												
5. EPI and Vitamin A												
6. Chronic												
7. ART												

REFRIGERATOR FUNCTIONALITY / MONITORING DEFECTS

TYPE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1. Electrical												
2. Gas												
3. Thermometer												
4. Temperature chart (twice daily completed)												
5. Refrigerator safe for storing medicines?												

AVAILABILITY AND FUNCTIONALITY OF MEDICAL EQUIPMENT AND SUPPLIES

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1. Oxygen supply/ source												
2. Ambu-bag (adult & paediatric)												
3. Baumanometer												
4. Stethoscope												
5. Adult scale												
6. Baby scale												
7. Glucometer												
8. Haemoglobinometer												
9. Ear, nose & throat set												

AVAILABILITY AND/OR FUNCTIONALITY OR WITHIN NORM

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1. HIV Rapid Test kit												
2. Quality testing kit												
3. Oral rehydration												
4. Intravenous infusion (and complete set)												
5. Sputum specimen bottles												
6. Sputum turnaround time within norm												
7. Condom availability												

*RED FLAG COMMENTS IN RELATION TO ACCEPTABILITY AND AVAILABILITY AND SUBSEQUENT CORRECTIVE ACTIONS UNDERTAKEN

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

4.3 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. The blank list is included for completion by the supervisor.

- **Y/N** - blocks containing Y/N should be ticked depending on the outcome of the 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 the checklist.
- **STG use** - from the register/minor ailments book, select five interesting curative care patients managed at the PHC facility – using the Standard Treatment Guidelines ("*Green Book*") check for the correctness of the treatment for that specific patient. Indicate the diagnosis/symptom complex of the patient reviewed in the appropriate block and whether it was correctly managed. When finished add up the number of correctly managed STGs and enter the number in the row titled STGs followed # correct.
- **Public Health Impact** - 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.
- **PHC Facility Visits** – indicate whether the doctor or other persons (district manager, EHO, programme manager, etc) visited the PHC facility in the last month.
- **Supervisory Actions** – from the PHC supervisor notes, observations and discussions with health care personnel, determine how many actions need to be completed subsequent to the PHC supervisor visit. Enter this figure into the area before the forward slash of the next month. For example, if the PHC supervisor visited the PHC facility in February the number of actions should be written in the column under March. During March the PHC supervisor 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.
- **Notes:** The note section allows the PHC supervisor to write important notes/comments and identify actions by both supervisor and PHC facility health care personnel over the next month.
- The number of actions is totalled and entered into the row "**Supervisory-Actions Completed**".
- **Quarterly Supervisory Support List**: This list is completed once every three months and provides a more in-depth perspective on the functioning of the PHC facility.

PHC supervisors/supervisee relationship: The Primary Health Care Facility Supervisor uses the checklist to assess one's relationship with the supervisees. It may be used monthly or more frequently as necessary.

NOTE – given everything we know about invented data, can we not include in this section the actual review of how monthly returns are compiled? The supervisor should actually sit with the sister-in-charge to see how she does this in order for us to start impacting on the "invented data" issue.

Checklist: Regular Review List

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

ROUTINE REVIEW (YES OR NO)	JAN	FEB	MAR	APR	MAY	JUN
1. Health care personnel Management						
1.1. Leave forms completed						
1.2. Attendance register correct						
1.3. Health care personnel meetings took place						
1.4. # In-service training activities						
1.5. # Days people absent (*)						
2. PHC facility Management						
2.1. Fridge packing correct						
2.2. Fridge temperature correct						
2.3. Sharps disposal correct						
2.4. Bin cards correct and up-to-date						
2.5. Medicine stock-outs (Depot/ Local)						
2.6. Monthly stock-take done						
2.7. # Report breaks repaired						
3. Information Review						
3.1. Data returned to the PHC facility for correction						
3.2. DQSA						
3.3. Referral Review						
3.4. Back referrals received						

4. PHC facility care							
4.1. RTH Card correct	/ 5	/ 5	/ 5	/ 5	/ 5	/ 5	
4.2. STGs followed							
4.3. Diagnosis/Correct Management							
4.4. Diagnosis/Correct Management							
4.5. Diagnosis/Correct Management							
4.6. Diagnosis/Correct Management							
4.7. Diagnosis/Correct Management							
5. Public Health Impact							
5.1. Fully immunized children rate							
5.2. Women year protection rate							
5.3. STI contact tracing rate							
5.4. TB cure rate							
5.5. TB contact tracing rate							
6. PHC facility committee							
6.1. Meeting held last month							
6.2. New projects initiated							
7. PHC facility visits							
7.1. Doctor visits							
7.2. Other							
8. Supervisory visit actions completed							

(*) Indicate the number of days each category is absent i.e. Professional Nurse (PN) 5, Enrolled Nurse (EN) 5, Enrolled Nurse Assistant (ENA) 8 and General Assistant (GA) 2

4.4 Supervision Support Lists – Notes

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

MONTH	NOTES	ACTIONS	DONE
JANUARY			
FEBRUARY			
MARCH			
APRIL			

MAY			
JUNE			
JULY			
AUGUST			
SEPTEMBER			

OCTOBER			
NOVEMBER			
DECEMBER			

4.5 Checklist: Quarterly Supervisory Support

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

MANAGEMENT FUNCTIONS	TICK APPROPRIATE BOX [√]		
1. Personnel			**Action to be taken**
1.1. Vacant posts pending	#		
1.2. Disciplinary action pending	#		
1.3. Employer folder updated	Y	N	
1.4. Health care personnel training plan	Y	N	
1.5. Health care personnel meetings weekly	Y	N	
2. Logistics			
2.1. Telecommunication in working order	Y	N	
2.2. Ambulance service available	Y	N	
2.3. Transport plan	Y	N	
3. Supervision			
3.1. Monthly visit schedule	Y	N	
3.2. Visits as per schedule	Y	N	
3.3. Written report of supervision	Y	N	
3.4. In-service training offered to PHC facility personnel.	Y	N	
4. Information			
4.1. Registers used properly	Y	N	
4.2. Monthly stats feedback	Y	N	
4.3. Data graphed	Y	N	
4.4. Catchments map update	Y	N	
4.5. Posters up-to-date/ display	Y	N	
5. Equipment			
5.1. Refrigerator–temperature record	Y	N	
5.2. Polio VVM	Y	N	
5.3. Vaccines expiry	Y	N	
5.4. BP cuff	Y	N	
5.5. Scales	Y	N	
5.6. Other requirements (lists)			
5.7. Repairs not completed/awaited	Y	N	
6. Medicines/Supplies			
6.1. Review monthly out-of-stock	Y	N	
6.2. Out > 1 full month	Y	N	
6.3. Storage conditions/records in order	Y	N	
7. Community			
7.1. Was there a community meeting held in the last quarter?	Y	N	
7.2. Was there a CHW meeting held in the last quarter?	Y	N	
7.3. Condoms in PHC facility freely available	Y	N	
7.4. Condoms available in community places	Y	N	

PROGRAMMES		
1. EPI	#	
1.1. Sharps disposal correct	Y	N
1.2. Records correct	Y	N
1.3. Return date indicated	Y	N
2. FP	#	
2.1. Continuity of patients	Y	N
2.2. All choices available	Y	N
2.3. HIV counselling	Y	N
3. ANC	#	
3.1. RPRs sent/treated	Y	N
3.2. Iron supplement tablets	Y	N
3.3. Tetanus Toxoid	Y	N
4. STIs	#	
4.1. Contact tracing	Y	N
4.2. FP	Y	N
4.3. HIV counselling	Y	N
5. Mental	#	
5.1. Violence counselling	Y	N
5.2. Psychiatric disease	Y	N
5.3. Epilepsy f/u	Y	N
5.4. Diabetes managed	Y	N
5.5. Hypertension patients checked	Y	N
5.6. Home patients	Y	N
6. Child Curative	#	
6.1. IMCI protocol use	Y	N
6.2. EPI checked	Y	N
6.3. Nutrition advice	Y	N
7. Nutrition Growth Promotion	#	
7.1. WT Chart used for advice	Y	N
7.2. No bottles	Y	N
7.3. Vitamin A	Y	N
8. Adult Curative	#	
8.1. HIV counselling	Y	N
8.2. BP > age 50	Y	N
8.3. Gloves for blood	Y	N
8.4. All services 5 days	Y	N

OTHER VISITS TO PHC FACILITY OVER THE PAST QUARTER

PROGRAMME MANAGER	# OF VISITS
1. Environmental health officer	#
2. Oral health care	#
3. Genetics	#
4. Ophthalmology	#
5. Other (doctor, psychologist, etc)	#

QUALITY OF SERVICES	
6. Of 10 infants reaching age 1, # fully immunized	
7. Of 10 women reaching delivery, # ANC visit 3/ more	
8. Of 10 STIs treated, # syndrome Rx	
9. Of 10 diarrhoea, # only ORS	
10. Of 10 TB, # regular Rx last month	
11. Of 10, # nutrition chart used to advise	

NOTES:

ACTIONS TO BE TAKEN BY PHC FACILITY

Supervisor signature:	
PHC facility manager signature:	
Date:	

4.6 Checklist: PHC Supervisor/Supervisee Relationship

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

Note! Supervisors to complete this self-assessment before starting their new supervisory schedule and monthly after PHC facility visits to help make decisions about changing/improving their supervisory approach. It will help to keep track of one's progress in enhancing good interpersonal relationships with the person in charge of the PHC facility and other health care personnel.

Facilities visited:	**Date:**
1.	
2.	
3	
4.	
5.	
6..	

Does the PHC supervisor:			**If not, give comments**
12. Review/study PHC facility file prior to visit to note agreements/issues raised previously	Y	N	
13. Note strengths and limitations regarding PHC facility performance in delivery of integrated package of PHC services and community participation	Y	N	
14. Note health care personnel complement and technical preparation	Y	N	
15. Show an awareness of important community issues already known/reported	Y	N	
16. Note any known recent personal experiences of individual health care personnel members that may need the supervisor's words of comfort, best wishes, or congratulations	Y	N	

Communication before visit

1. Does the PHC supervisor:			If not, give comments
1.1. Make sure PHC facility sister/health care personnel are aware of intended supervisory visit and date	Y	N	
1.2. Share written agenda for visit with in-charge ahead of visit	Y	N	

Approaching and treating PHC facility health care personnel and their clients well

2. Does the PHC supervisor:			If not, give comments
2.1. Greet health care personnel and announce arrival politely	Y	N	
2.2. Show warmth, respect and patience when handling in-charge and others throughout the supervisory visit	Y	N	
2.3. Allow time for health care personnel to complete any consultations underway and for any hand-over	Y	N	
2.4. Help to create calm atmosphere by waiting for appropriate timing before making comments or asking about health care personnel behaviour/performance or mistakes (for example, only when seated, once there is privacy, when the atmosphere is conducive)	Y	N	
2.5. Ensure that any emergencies have been attended to and in-charge is free to attend to the supervisor	Y	N	
2.6. Explain or review agenda for day's visit with in-charge	Y	N	

Team enhancing approach used throughout the supervisory activities

3. Does the PHC supervisor:			If not, give comments
3.1. Practice active listening during discussions and throughout the interactions	Y	N	
3.2. Encourage health care personnel to express what they liked about their work in the past month and their wishes for coming weeks	Y	N	
3.3. Give in-charge and other health care personnel complements for jobs done well, new initiative and innovations or jobs done well to improve quality of care	Y	N	
3.4. Take enough time to understand the issues of PHC facility health care personnel and problems or opportunities at the facility	Y	N	
3.5. Correct errors and wrong practices gently and constructively rather than criticizing or scolding	Y	N	

3.6. Assist, involve and encourage PHC facility in-charge and other health care personnel to identify problems and in problem-solving	Y	N	
3.7. Give health care personnel the information they need to do their jobs well (using the relevant sections in the supervisors' manual and standard guidelines)	Y	N	
3.8. Give health care personnel practical, workable suggestions on how they can obtain the supplies, equipment, and other materials they need to do their jobs well	Y	N	
3.9. Maintain open and focused discussions by asking open-ended questions, paraphrasing, and summarizing findings and agreed solutions from time to time	Y	N	
3.10. Speak with other levels of health care personnel and not only the sister in-charge	Y	N	

Concluding the visit

1. Does the PHC supervisor:			**If not, give comments**
1.1. Summarize with in-charge the specific aspects of care that are going well and commend them for it	Y	N	
1.2. Summarize the specific aspects that need change and discuss/ review what needs to be done and how	Y	N	
1.3. Share with health care personnel 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 PHC facility in-charge later)	Y	N	
1.4. When ready to leave, thank PHC facility in-charge and others where possible	Y	N	
1.5. Bid them goodbye	Y	N	

Section 5

In-depth Programme Reviews

- Women's reproductive health
- Sexual, reproductive and youth health services
- Reproductive health services
- Integrated management of childhood illness
- Diseases prevented by immunisation
- Sexually transmitted infections
- Comprehensive management & treatment of HIV and AIDS
- Tuberculosis
- Chronic diseases and geriatric care
- Mental health and substance abuse
- School health services
- Oral health
- Victims of abuse and violence
- Chronic diseases and geriatric care
- Rehabilitation services
- Health promotion

In-depth Programme Reviews

5.1 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

- Increase the percentage of pregnant women receiving antenatal care (ANC) from the existing level to at least 70%
- Increase the percentage of ANC first visit to less than 13 weeks from existing/current baseline
- Increase the deliveries in institutions by trained birth attendants from the existing level to at least 75%
- Reduce the proportion of pre-term deliveries and low birth weight babies by at least 20%
- Reduce the proportion of births in women below 16-18 years from the existing level.

Standards

References, prints and educational materials

- The South African Constitution, Act 108 of 1996.
- National Health Act 2003, Act 61 of 2003.
- Midwifery protocols.
- Contraception protocols.
- C-Termination of pregnancy protocols.
- Human Sterilisation Act.
- All Provincial circulars and policy guidelines regarding women's health issues.
- A library of suitable references and learning material on women's health issues.

Equipment and special facilities

- Delivery beds, side lamps, weighing scales, ANC cards, maternity patient records and registers.
- Delivery set including specula and foetoscopes.
- Neonatal resuscitation trolley.
- Women's health charts.
- Postnatal beds, linen, gestational (obstetrical) wheels and tape measures.

Medicines and supplies

- Ferrous and folic acid tablets.
- Oxytocin.
- Vitamin K injections.
- Contraceptive barrier methods e.g. condoms.
- Vaginal contraceptives e.g. spermicidal jelly.
- Intrauterine contraceptive devices.
- Injectable hormonal contraceptives.
- Oral hormonal contraceptives.
- Post-coital contraceptives.
- Multivitamin tablets for mothers.
- Competence of health care personnel
- Nurses receive training in the peri-natal education programme (PEP), contraception and post-abortion care management.
    - Health care personnel are able to take a history and perform a physical examination and tests according to protocols and guidelines.
    - Health care personnel provide routine management, observations and service according to the ANC protocol at each step of the pregnancy including at least three visits during pregnancy.
    - Health care personnel provide education and counselling to each pregnant woman and partner on monitoring signs of problems (e.g. bleeding), nutrition, child feeding and weaning, STDs/HIV, delivery, newborn and child care, advanced maternal age, family planning and child spacing.
    - Health care personnel offer appropriate counselling, advice and service to pregnant women requesting termination of pregnancy.
    - All professional nurses are able to:
        - Assist with delivery of uncomplicated pregnancies.
        - Make routine observations according to the postnatal care protocol.
        - Make usual routine observations and select and prescribe appropriate family planning methods according to national protocol.
        - Screen, advice and refer infertility patients as per national guidelines.
        - Conduct breast cancer and cervical screening for women aged 30 years and older as per protocols.
        - Conduct home visits to provide support and supervise care.
        - Provide services on family planning, sexuality, health education and counselling for adolescents.

Patient education

- Information is given to mothers on booking for delivery, child preventive care, education about child feeding and the introduction of solid food.
- 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.
- Patients are given group education.
- Patients' relatives and the community receive continuous, appropriate high quality information on the importance of antenatal care and institutional deliveries.
- Information, education and counselling are offered to adolescents and the PHC supervisor.

Records

- All information on patients and outcome of deliveries are correctly recorded in the register.
- All registers and monthly reports are kept up to date.

Community & home based activity

- The PHC facility receives support from the community health committee and home-based carers about the positive outcomes of attendance of all pregnant women at PHC facility.
- Health care personnel conduct regular home visits using a home visit checklist.

Referral

- Personnel at PHC level attend (on site) to all manageable patients.
- All referrals within and outside the PHC facility are motivated and indications for referral written clearly on the referral form.
- Patients with a need for additional health or social services are referred according to protocols.
- Referrals from traditional birth attendants (TBA) should be encouraged and associated with the training of the TBA and follow-up of the training.

Collaboration

- PHC facility health care personnel collaborate with social development/welfare for social assistance as well as with other role-players.
- PHC facility health care personnel collaborate with PHC facility health committee, the civic organisations and workplaces in the catchment area to enhance health promotion.

Checklist: ANC/PNC

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

TICK APPROPRIATE BOX [√]

1. Service availability	Daily	Special days
1.1. Does the PHC facility have a system to keep a record of pregnant women	Y	N
1.2. Does the PHC facility have a system to trace pregnant women who do not attend the PHC facility regularly	Y	N
1.3. PHC facility management of pregnant women	Y	N
2. ANC first visit		
2.1. Full physical exam – palpation correct, symphysis-fundal height measurements correctly done	Y	N
2.2. Weight/BP/Urine/HB done	Y	N
2.3. Bloods taken – VDRL/Grouping/HB	Y	N
2.4. Previous immunisation records checked and tetanus toxoid given	Y	N
2.5. 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
2.6. How is visit conducted?	Individually	Groups
2.7. All other visits		
2.7.1 Examination, outstanding tetanus toxoid immunisation provided	Y	N
2.7.2 Weight, BP, urine checked	Y	N
2.7.3 Blood results checked and entered/appropriate treatment given/ syphilis treated according to protocol	Y	N
2.7.4 Ferrous/folic supplements and multivitamins given	Y	N
2.7.5 Health Education – care of baby/maternal care	Y	N

2.8. Is VCT offered to all pregnant women at the 1st visit?	Y	N
3. Maternal Health Administration		
3.1. Correct recording of each pregnant woman – tick register, patient ANC card, graphs, laboratory register	Y	N
3.2. ANC coverage indicated on graph	Y	N
3.3. Clients booked at hospital for delivery	Y	N
4. Protocols followed		
4.1. Managing STDs in pregnancy	Y	N
4.2. Exclusive breast feeding promoted	Y	N
4.3. Pregnancy-induced hypertension management	Y	N
4.4. Tetanus prevention protocol	Y	N
4.5. Referral protocols – who and when to refer	Y	N
4.6. At risk patients – primipara, previous C/sections, abnormal presentations, twins/multiple pregnancies	Y	N
4.7. Complications of pregnancy – pregnancy-induced hypertension, haemorrhage, intra-uterine growth retardation	Y	N
4.8. Follow-up visit schedule followed/completion of cards for return dates	Y	N
4.9. Infection control – gloves used for venupuncture	Y	N
4.10. Essential equipment available and in working order	Y	N
4.11. PMTCT guidelines	Y	N
Delivery and Labour		
5. Important equipment/supplies available and working		
5.1. Sterile delivery packs	Y	N

5.2. Suction	Y	N
5.3. Baby resuscitation table	Y	N
5.4. Supply availability – IV fluids available, suturing materials, local anaesthetic	Y	N
5.5. Ready-to-use oxygen	Y	N
5.6. Emergency tray with relevant drugs f or both mother and baby	Y	N
5.7. Medicines – syntometrine, ATT, Nevirapine	Y	N
6. Delivery protocols followed		
6.1. Universal precautions followed	Y	N
6.2. Correct practices followed – first, second, third stages of labour	Y	N
6.3. Health care personnel able to use and interpret partogram	Y	N
6.4. Correct disposal of placenta/materials used during delivery	Y	N

Postnatal Care

1. Full physical exam of mother and child done	Y	N
2. Immediately after delivery (PHC facility delivery)	Y	N
3. Home delivery - soon as feasible	Y	N
4. 2 week repeat visit	Y	N
5. Do follow-up visits occur within seven days after delivery	Y	N
6. Does the mother receive FP advice	Y	N
7. Check that first immunisations given Check that first immunisations given	Y	N
8. Are BCG and polio vaccines given	Y	N
9. Is the Road to Health card completed	Y	N
10. Is the birth registered	Y	N
11. Ensure the promotion of breast feeding - check physically that mothers are breast-feeding properly (well baby PHC facilities)	Y	N

NOTES:

ACTIONS TO BE TAKEN BY PHC FACILITY

Supervisor signature:	
PHC facility manager signature:	
Date:	

Checklist: Sexual, Reproductive and Youth Health Services

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

** Explanation at end of tool

Complete 'Section A' irrespective of the particular SR&YH component that is being monitored today, because this information is relevant to all services. **In addition**, complete the specific section for the component that is being monitored today e.g. Section C: Cervical Cancer Screening.

SECTION A

HEALTH CARE PERSONNEL ESTABLISHMENT

1. Record number of health care personnel	**Full Time**	**Part Time**	Use this information to determine: • Client: provider ratio (health care personnel norms) • Category of health care personnel available to render SR&YH services e.g. prescribing contraception, management & follow-up of clients for abnormal Pap smear results, YFS, etc. Use in conjunction with the section for specific component that is being monitored today.
1.1. Medical Officer			
1.2. Professional Nurse			
1.3. Enrolled Nurse			
1.4. Enrolled Nursing Assistant			
1.5. Auxiliary Services Officer			
1.6. CHW/ Lay Counsellors			
1.7. Other			

AVAILABILITY	**Daily**			
2. Are the following services available?			**If not daily, how often**	**If referred, where to?**
2.1. Contraceptive services (FP)	Y	N		
2.2. Youth-Friendly Services	Y	N		
2.3. Termination of Pregnancy counselling & referral	Y	N		
2.4. Termination of Pregnancy procedure (MVA)	Y	N		
2.5. Counselling & referral for violence, abuse & rape	Y	N		

2.5.1 Post Exposure Prophylaxis (PEP)	Y	N		
2.5.2 STI information & counselling	Y	N		
2.5.3 Syndrome Management for STIs	Y	N		
2.5.4 HIV / AIDS information & counselling	Y	N		
2.5.5 VCT	Y	N		
2.5.6 ARV	Y	N		
2.5.7 PMTCT	Y	N		
2.5.8 Other services for women between 20 – 65 years	Specify			
2.6. Are there are clear & visible signs advertising available SR&YH services?	Y	N		
2.7. If yes, where are these signs posted?				

3. EQUIPMENT, INSTRUMENTS & SUPPLIES				COMMENTS If available but not in working order, how many not in working order, how long out of order, systems for repair, etc.
3.1. The following are available and in working order today (Record the number available today):			#	
3.1.1 Angle poise lamp	Y	N		
3.1.2 Sink (or equivalent) for hand washing	Y	N		
3.1.3 Weighing scale (not bathroom scale)	Y	N		If bathroom scale – mention so
3.1.4 Examination couch	Y	N		
3.1.5 Baumanometer	Y	N		
3.1.6 Stethoscope	Y	N		
3.1.7 Vaginal speculae (different sizes)	Y	N		
3.1.8 Spatulas (specify e.g. Aylesbury)	Y	N		
3.1.9 IUD insertion kit	Y	N		
3.1.10 Sterilizer/autoclave	Y	N		
3.1.11 Pregnancy testing kit	Y	N		
3.1.12 Syringes	Y	N		

3.1.13 Hypodermic needles	Y	N		
3.1.14 Urine dipsticks	Y	N		
3.1.15 Glass slides for Pap smears	Y	N		
3.1.16 Fixative for Pap smears	Y	N		
3.1.17 Gloves	Y	N		
3.1.18 Anatomical models i.e. dildo. Specify	Y	N		

4. COMMUNICATION SYSTEMS			COMMENTS
4.1. The service has:			
4.1.1 An effective communication system	Y	N	Telephone, fax, etc.
4.1.2 An established and effective referral system	Y	N	Referral for SRH services e.g. Colposcopy, TOP, etc.
4.1.3 An established communication feedback system	Y	N	Feedback from referral facilities

5.2 Checklist: Sexual, Reproductive and Youth Health Services

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

These services are based on the following Acts, policies, protocols and guidelines

	Available?		Familiar with?		COMMENTS
1. National Contraceptive Service Delivery Guidelines	Y	N	Y	N	
2. National Contraceptive Policy Guidelines	Y	N	Y	N	
3. National Youth & Adolescent Health Policy Guidelines	Y	N	Y	N	
4. Youth-Friendly Service Standards & Criteria (YFS Manual)	Y	N	Y	N	
5. Provincial Cervical Cancer Screening Policy & Protocol 2004	Y	N	Y	N	
6. The Choice on Termination of Pregnancy Amendment Act, 2004	Y	N	Y	N	
7. The Sterilisation Amendment Act, 2004	Y	N	Y	N	
8. Provincial Protocol for Managing Child Abuse at PHC level	Y	N	Y	N	
9. Provincial Protocol for Rape and Abuse	Y	N	Y	N	
10. Provincial School Health Services Policy & Implementation Guidelines	Y	N	Y	N	
11. Protocol for Needle Stick Injuries	Y	N	Y	N	
12. Contraceptive Desk References	Y	N	Y	N	
13. Provincial NOPEP / OPEP Protocol & Guidelines	Y	N	Y	N	
14. How were these Policies & Protocols, and Guidelines disseminated to facility health care personnel?	Explain				

1. Training

1.1. How many health care personnel members in this service completed the prescribed training course for the following:	Last 3 years		Never		Render services at the moment	
	PN	**Other**	**PN**	**Other**	**PN**	**Other**
1.1.1 Contraception (FP)						
1.1.2 Adolescent & Youth Health						
1.1.3 Youth-Friendly Services (including value clarification)						
1.1.4 Cervical Cancer Screening (and Pap smears for PNs)						
1.1.5 Violence and Abuse						
1.1.6 Termination of Pregnancy value clarification, counselling & Act						
1.1.7 STI counselling and/ or Syndrome Management						
1.1.8 HIV / AIDS						
1.1.9 Health Promotion / Health Promoting Schools						
1.1.10 School Health Services						
1.1.11 PEP						
1.2. When was the last in-service training for SR&YH?	Date:					
1.3. What topics were covered in the last in-service? (Refer to SR&YH training only)						
1.4. Does the service have a SR&YH training plan?	Y	N				
1.5. Is the training plan implemented (is there evidence available)?	Y	N				
1.6. How are training outcomes monitored?	Explain					

2. Supervision

2.1. When was the last programme manager's visit to this service?	Date:				
2.2. Did the programme manager monitor SR&YH services during the last visit?	Y	N			
2.3. What services were monitored?	Y	N			
2.4. What recommendations were made during the last visit?	(Only refer to SR&YH services)				
2.5. Were the above recommendations implemented? **	Y	N			
2.6. Does this service have a Quality Improvement Programme**?	Y	N			
2.7. If yes, how is this programme monitored?	Explain:				

** **Recommendations implemented**: Check if the supervisor used the Supervisor's Checklist during the last visit, if the recommendations were recorded, and check for proof of implementation.

** **Quality Improvement Programme**: Check the strategy/action plan for quality improvement and record, and whether targets were set and are being monitored.

NOTES:

ACTIONS TO BE TAKEN BY PHC FACILITY

Supervisor signature:	
PHC facility manager signature:	
Date:	

5.3 Checklist: Reproductive Health Services

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

	TICK APPROPRIATE BOX [√]	
1. Service availability at PHC facility		
1.1. When are services available?	Daily	Special Days
1.2. If special days, can clients obtain contraceptive services on other days as well?	Y	N
1.3. Are professional nurses adequately trained?	Y	N
1.4. Does PHC facility offer the following range of methods:		
1.4.1 Injectables (Depo Provera, Nur Isterate)	Y	N
1.4.2 Intra-Uterine Device (IUD)	Y	N
1.4.3 Oral contraceptives (e.g. Triphasil, Nordette, Ovral 28)	Y	N
1.4.4 (POP e.g. Microval)	Y	N
1.4.5 Condoms	Y	N
1.4.6 Female and male voluntary surgical contraception (sterilisation)	Y	N
1.5. If NO – is there a facility to refer clients?	Y	N
1.6. Is referral system effective – do clients get services they need promptly?	Y	N
1.7. Is there a fast line service available for re-supply?	Y	N
2. Service quality		
2.1. Do consulting or counselling rooms provide adequate privacy?	Y	N
2.2. Are adolescents helped in a supportive, friendly manner?	Y	N
2.3. Are they provided with methods if requested?	Y	N
2.4. Does the PHC facility experience contraceptive method stock-outs?	Y	N
2.5. Do nurses have a good knowledge of medicine interactions, which may influence the contraceptive method effectiveness, such as TB medicines (rifampicin) and anti-epileptic medicines?	Y	N
2.6. Is there a quick reference available in each consulting and treatment room?	Y	N
2.7. Is there a Papaneculeau smear register?	Y	N
3. Counselling		
3.1. Are there guidelines on the information that health care personnel should cover during counselling sessions?	Y	N
3.2. Are methods explained to new clients before providing counselling/ contraception?	Y	N
3.3. Does each client have a choice of methods that are safe and suitable for her/him?	Y	N
3.4. Are clients aware of side-effects?	Y	N
3.5. Where appropriate, is the partner encouraged and involved in making a choice about the method?	Y	N
3.6. Do clients have knowledge of HIV and STDs and how to prevent STDs?	Y	N
3.7. Do clients have adequate information about emergency oral contraception?	Y	N
3.8. Does the PHC facility routinely provide counselling and education on TOP?	Y	N
3.9. Are medical eligibility criteria guidelines easily available for reference to providers?	Y	N
3.10. If available, are they adhered to?	Y	N
3.11. Is dual protection and its role in preventing HIV infection discussed?	Y	N

4. History and PHC facility examination of contraceptive service clients:		
4.1. Initial visit	Y	N
4.1.1 History examination according to programme guidelines and client record	Y	N
4.1.2 Physical examination according to programme guidelines	Y	N
4.1.3 Pelvic examination according to programme guidelines	Y	N
4.1.4 PAP smear according to age and intervals stipulated in the CA Cervix Policy guidelines	Y	N
4.1.5 Breast examination	Y	N
4.2. Follow up visits	Y	N
4.2.1 Weight/Blood Pressure	Y	N
4.3. Are abnormal findings managed accordingly (for example, vaginal bleeding, vaginal discharge, lower abdominal pain and fever, follow-up on positive RPR and HIV tests)?	Y	N
5. Equipment available and working		
5.1. Scales, sphygmomanometer	Y	N
5.2. Vaginal speculaee, light source, gloves, all decontaminant/ disinfectant requirements	Y	N
5.3. Aryre's spatulae, cervical brushes, slides and fixative	Y	N
5.4. IUD insertion kit	Y	N
5.5. Counselling kit (samples of methods, charts/pictures)	Y	N
6. Is there a continuous, regular and adequate supply of methods?		
6.1. Injectables	Y	N
6.1.1 Medroxyprogesterone acetate (Depo Provera)	Y	N
6.1.2 Norethisterone enanthate (Nur Isterate)	Y	N
6.2. Oral contraceptives	Y	N
6.2.1 Microval	Y	N
6.2.2 Nordette	Y	N
6.2.3 Ovral	Y	N
6.2.4 Biphasil	Y	N
6.2.5 Triphasil	Y	N
6.3. Are IUDs available at the referral facility?	Y	N
6.4. Condoms?	Y	N
6.5. Medicines for STDs?	Y	N
7. Does the PHC facility offer facilities for clients/community to give feedback about the service they receive		
7.1. Has the PHC facility committee included contraceptive services programme in discussions within last 6 months?	Y	N
7.2. Have the PHC facility health care personnel sought or received any information about how to improve the services from the community recently?	Y	N
7.3. Is there a suggestion box?	Y	
8. Records and register		
8.1. Is the tick register correctly completed?	Y	N
8.2. Is there adequate written information on client cards?	Y	N
8.3. Are graphs correctly completed and kept up-to-date?	Y	N
8.4. Is the graphed information appropriate for decision-making?	Y	N

NOTES:

ACTIONS TO BE TAKEN BY PHC FACILITY

Supervisor signature:	
PHC facility manager signature:	
Date:	

5.4 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 the most recent IMCI chart booklet at all times that the PHC facility is open.

Norms

- 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).
- 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).
- 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).
- Eradicate poliomyelitis by 2002 (National Year 2000 Goals, Objectives and Indicators).
- Increase regular growth monitoring to reach 75% of children under 2 years of age (National Year 2000 Goals, Objectives and Indicators).
- Increase the proportion of mothers who breast-feed their babies exclusively for 6 months, and who breast-feed their babies at 12 months (National Year 2000 Goals, Objectives and Indicators).
- Reduce the prevalence of underweight-for-age among children below age 5 years to 10% (National Year 2000 Goals, Objectives and Indicators).
- Reduce the prevalence of stunting among children below 5 years of age to 20% (National Year 2000 Goals, Objectives and Indicators).
- Reduce the prevalence of severe malnutrition among children under age 5 to 1% (National Year 2000 Goals, Objectives and Indicators).
- Eliminate micro-nutrient deficiency disorders (National Year 2000 Goals, Objectives and Indicators).
- All children treated at the PHC facility are treated according to IMCI Guidelines.
- At least 60% of Professional Nursed in every PHC facility have undergone IMCI case management training.
- 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

References, prints and educational materials

- National and Provincial wall charts and booklets.
- A copy of the most recent IMCI Chart Booklet.
- IMCI Recording Forms – either to use as notes or stuck to the desk as a reminder.
- Road to Health Charts to supply to new-borns and children without charts.
- Copies of the National Essential Medicines List and Standard Treatment Guidelines.

Equipment

- An oral rehydration area set up for immediate rehydration.
- Emergency equipment available for intravenous resuscitation of severely dehydrated children.
- Oxygen to give to childern who require it.

Medicines and supplies

- The PHC facility 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).

Competence of health care personnel

- Every PHC facility has nurse practitioners able to treat clients in accordance with the IMCI guidelines.
- IMCI trainer makes regular mentoring/ supervision visits, initially 6 weeks after training, thereafter every 3 months.
- Each PHC facility has an annual review of quality of care by IMCI Supervisor.
- At least one member of health care personnel takes overall responsibility for the assessment and management of the child.
- Health care personnel are able to establish trust and credibility through respect, courtesy, responsiveness, confidentiality and empathy, approaching consultations in a patient-centred way.
- Health care personnel are able to organise and implement an effective triage system for clients attending the PHC facility based on the IMCI protocol.

Referral

- Children with danger signs and/or severe disease are referred as described in the IMCI provincial protocol.

Patient education

- The mother or caregiver is counselled in accordance with the IMCI counselling guidelines.
- Key family/household practices to improve child health are promoted as described in the IMCI community component.

Records

- An adequate patient record system is in place, using the Road to Health Chart as a basic tool.

Community and home-based activity

- This takes place in line with the IMCI Guidelines for the Community Component.
- The PHC facility works in close co-operation with community-based health programmes like community health worker schemes or care-groups.

Collaboration

- PHC facility health care personnel collaborate with social workers, NGOs, CBOs, crèches and other sectors to improve child health.

Checklist: IMCI

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

PART 1. AVAILABILITY OF SERVICES

TICK APPROPRIATE BOX [√]

• IMCI (including EPI and growth monitoring and promotion) services are available every day (at least five days a week).	Y	N
• A triage system which identified children who need urgent attention is in place.	Y	N
• Children with HIV infection are identified and followed-up (referred when necessary).	Y	N
• System are in place for providing care to children with chronic conditions.	Y	N
• Is there a system in place to trace children who do not attend regularly?	Y	N

PART 2. SPACE AND EQUIPMENT

1. Triage Area		
• Chair for health worker and caretaker? Table?	Y	N
• Weighing scale	Y	N
• Thermometers	Y	N
• Road to Health Chart	Y	N
• Child Health area	Y	N
2. Consulting rooms		
• Number of consulting rooms	Y	N
• Examination area is private	Y	N
• Enough space to see patient	Y	N
• Chair and table for health worker and chair for care-giver	Y	N
• Adequate space for counselling	Y	N
3. Watch or other timing device	Y	N
4. IMCI chart booklet	Y	N
5. IMCI patient recording forms (child 2 months to 5 years and Sick Young Infant)	Y	N
6. Tools for case management		
• Supplies for assessing child (water, cup,spoon)	Y	N
• Dextrostix or functioning glucometer	Y	N
• Functioning Heamoglobinometer	Y	N
7. Functioning ORT corner:		
• Child with some dehydration receives ORS at the facility.	Y	N
• Adequate space to give ORT	Y	N
• Table (for mixing ORS), chairs for caregiver	Y	N
• Source of drinking water	Y	N
• Supplies (cups, spoons, measuring/mixing utensils)	Y	N
• ORT register – available and correctly filled in	Y	N

PART 3. IMMUNIZATIONA

8. Vaccine conditions		
• Adequate number of ice packs	Y	N
• Cool boxes in consulting rooms	Y	N
• Functioning refrigerator and cool box thermometers?	Y	N
• Correct vaccine conditions maintained (0- 8C)?	Y	N
• Vaccines properly stored?	Y	N

• Vaccine Vial Monitor?	Y	N
9. All vaccines available and viable (BCG, OPV, DPT, DT, DPT-Hib, measles, HepB, TT,Td)	Y	N

PART 4. REFERRAL AND COMMUNICATION

10. EMS responds within 60 minutes?	Y	N
11. Functioning landline or phone?	Y	N

PART 5. RECORDS

12. Completion of Road to Health charts –review at least five charts		
• Is the weight plotted correctly?	Y	N
• Is the weight interpreted correctly?	Y	N
• Does nurse explain the findings to mother?	Y	N
• Is there a response if the child is NOT GROWING WELL or is losing weight?	Y	N
• Are immunisations up-to-date?	Y	N
• Is the feeding status recorded - exclusive breast-feeding, introduction to solids, etc?	Y	N
• Is Vitamin A given, if necessary?	Y	N
13.Patient tick register available in each consulting room	Y	N
14.Follow-Up register available and correctly filled in	Y	N

PART 6. DRUGS AND OTHER SUPPLIES

15. Drugs supply management good?					
• Drugs correctly stored (clean and dry)				Y	N
• Drug storage secure·Stock cards in place and up to date				Y	N
16.The following drugs are available:					
Amoxycillin	Y	N	Ciprofloxaxin	Y	N
Cotrimixazole	Y	N	Erythromycin	Y	N
Co-artemether (in malaria areas)	Y	N	Ceftriaxone	Y	N

Diazepan injection	Y	N	Gentian violet or nystatin	Y	N
Paracetamol syrup	Y	N	Oral iron preparation (Ferrous gluconate or ferrous lactate)	N	N
Vitamin A	Y	N	Mebendazole/ Albendazole	Y	N
Salbutamol MDI and Appropriate Spacers	Y	N	Salbutamol solution for nebuliser	Y	N
Adrenaline solution for nebulisers	Y	N	Prednisone tablets	Y	N

17. The following supplies are available:		
ORS packets	Y	N
Sugar and salt	Y	N
IV solution : N Saline	Y	N
Sterile syringes and needles		
Swabs and skin disinfectant	Y	N
Jelcos 24G, 22G	Y	N
IV sets(60drops/ml)	Y	N
NG tubes (5,8,10 FG)	Y	N
Medicine measures and glasses	Y	N
Paediatric nebulizer mask, chamber and tubing	Y	
Oxygen	Y	N
Rapid malaria test kit (for malaria areas)	Y	N
HIV test kits	Y	N
PCR kit	Y	N
TB Skin Test	Y	N

PART 7. STATISTICS

18. Clinical statistics available and used		
• Are the recent clinic statistics available?	Y	N
• Is there evidence that they are being used?	Y	N

PART 8. PATIENT EDUCTION (omit if doing Caretaker interviews)

19. Are mothers/caregivers aware of use of ORS?	Y	N
20. Is nutritional information provided to mother/caregivers?	Y	N
21. Appropriate care of the baby by mother/caregiver?	Y	N
22. Are mothers/caregivers aware of where services are available after hours?	Y	N

PART 9. COMMUNITY INVOLVEMENT

22. Is there an active clinic committee?	Y	N
23. Is there an active HHCC steering committee?	Y	N
24. Do CHW programmes provide services to children?	Y	N

NOTE: When the supervisor/programme manager has finished the review of each facility, the results and action areas are to be summarized in the following table. Leave the copy at the facility and give another copy to the district office.

Results of visit (strengths and problems)	Actions taken	Comment
Case management of sick children and young infants		

FACILITY SUPPORT

Space and equipment		
Clinic and referral services		
Organization of case management tasks		
Quality of records		
Management of drugs, other supplies		

5.5 Diseases prevented by immunisation

Service Description

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

Norms

- All PHC facilities provide immunisations for at least 5 days a week and if the community desires additional periods specifically for child health promotion and prevention.
- Every PHC facility 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 to help solve problems and provide information and skills when necessary.
- Every PHC facility has a senior member of health care personnel trained in EPI who acts as a focal point for EPI programmes.

Standards

References, prints and educational materials

- Copies of the latest editions of EPI (SA) Vaccinators Manual Immunisation That Works.
- Copies of the Cold Chain and Immunisation and Operations Manual.
- Copies of the EPI Disease Surveillance Field Guide.
- Copies of the current Provincial Circulars on particular aspects, e.g. acute flaccid paralysis, Haemophilus influenza type B (Hib surveillance, Adverse Events Following Immunisation (AEFI) investigation and reporting.
- Patient and community information pamphlets in appropriate languages.
- Copies of the EPI Posters and other EPI disease and schedule promotional materials.

Equipment

- Correct needles and syringes according to Vaccinators' Manual.
- A working refrigerator, properly packed, with thermometer and temperature recorded, and
- Back-up refrigerator available.
- Cooler boxes and ice packs available.

Medicines and supplies

- An uninterrupted and monitored cold chain of constantly available vaccines as recommended by EDL.

Competence of health care personnel

Health care personnel are able to:

- Routinely perform correct immunisation practices according to protocol. Vaccines are checked periodically to ensure there are no frozen DPT, HBV, TT, HIB and none out-of-date or indicators showing expiry.
- Provide mothers with correct knowledge of what is needed for the child, what is given and possible side-effects and when to return for the next immunisation.
- Provide education for mothers and antenatal care attendants.
- Follow up suspected patients of measles at home to determine the extent of a possible outbreak.
- Take steps to increase coverage using the Immunisation Monitor Chart (available in the Vaccinators' Manual) to address progress during the year.
- Implement correct disposal of sharps.
- Initiate post-exposure prophylaxis for HIV in patients of needle stick (according to Provincial protocol).
- Ensure all reported and notified AFP, measles, NNT and AEFI patients are reported to EPI Co-ordinator and followed up within 48 hours by district investigation team, of which the nurse in PHC facility is a co-opted member.
- Organise immunisation service as a daily component of comprehensive PHC and to minimise waiting/queuing times.

- Community health committees are given the lay patient definitions of acute flaccid paralysis, measles and neonatal tetanus and urged to report suspected patients immediately.
- The PHC facility has a good relationship with the Environmental Health Officer for assistance in outbreak investigations.
- Ensure that appropriate laboratory specimens are taken for the investigation of all AFP, NNT, measles; and that AEFI investigations are taken or else referred to the nearest hospital where specimens can be taken.
- A 24-hour toll free number for notification (0800 111 408) is on the PHC facility wall.
- All children must be immunized with all vaccines except for BCG in children with symptomatic AIDS.
- PHC facilities arrange mass immunisation or "mopping up" campaigns in their communities as required by the District Manager.
- Remote villages have mobile outreach sessions to provide routine services and to improve coverage where necessary.
- Reduce missed opportunities and ensure that ill children and women in the childbearing age range are immunised as appropriate.

Referrals

- Children with signs and symptoms of the EPI priority diseases (AFP, measles, NNT and AEFI) are referred as in the IMCI Provincial protocols.

Patient education

- All clients attending PHC facilities for immunization services receive the appropriate health education, information and support.

Records

- Patient records and patient notification forms.
- Monthly immunisation statistics.
- Patient investigation forms for flaccid paralysis.
- Patient investigation forms for measles.
- Patient investigation forms for neonatal tetanus.
- Patient investigation forms for adverse events following immunisation.
- Supply of child "road to health" charts.

Community-based services

- Communities participate in campaigns and national health days.
- PHC facility health care personnel follow up suspected patients of measles at home to determine extent of outbreak.

Collaboration

- Health care personnel collaborate with other government departments and sectors to promote immunization and improve coverage.

Checklist: EPI and Disease Surveillance

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

	TICK APPROPRIATE BOX [√]	
1. Is the immunisation service available daily, 5 or 7 days a week (where applicable)?	Y	N
2. Is there a record system to ensure continuity of care?	Y	N
3. Do health care personnel record and trace children who do not come for their routine immunisations?	Y	N
4. Are pamphlets on immunisation and Vitamin A for patients available in the local language?	Y	N
5. Is the AFP toll-free telephone number displayed so notification of a suspected patient can be made telephonically?	Y	N
6. In patients of suspected measles or AFP, do health care personnel know which laboratory specimens to collect and do they follow referral procedures?	Y	N
7. Vaccine stock	Y	N
7.1. Are stock cards kept for each vaccine	Y	N
7.2. Do stock levels correlate with stock in refrigerator?	Y	N
7.3. Are vaccines received regularly and according to amounts ordered?	Y	N
7.4. Is the cold chain maintained when vaccines are removed from refrigerator?	Y	N
7.5. Has the immunisation programme at the PHC facility been stopped since the last supervisory visit?	Y	N
7.6. How many days was it stopped?	#	
7.7. What was the cause of the stoppage?		
7.8. How was the problem solved?		
8. Refrigerator		
8.1. Is the refrigerator in working order?	Y	N
8.2. How many times since the last supervisory visit has it failed?	#	
8.3. What was done to maintain the cold chain?		
8.4. Is the refrigerator defrosted and cleaned regularly?	Y	N
8.5. Is the cold chain maintained during defrosting?	Y	N
8.6. Are vaccines correctly stored and packed in refrigerator?	Y	N
8.7. Are there any expired vaccines?	Y	N
8.8. Is the thermometer in working order?	Y	N
8.9. Is the thermometer correctly placed?	Y	N
8.10. Are refrigerator temperatures recorded daily?	Y	N
8.11. In the last month, has the temperature dropped below 2°C or above 8°C. If yes, discuss the reason for this break in cold chain and remedial action to be taken with health care personnel?	Y	N
8.12. Is there anything else in the refrigerator besides vaccines?	Y	N
8.13. Is there a standby gas supply if the refrigerator uses gas?	Y	N

8.14. Has any of the **Freeze Sensitive** e.g. DPT or TT vaccine in the refrigerator been frozen (to check this, use the shake test on randomly selected vials)?	Y	N
8.15. Has any of the vaccine in stock expired?	Y	N
8.16. Are there any open vials of vaccine in the refrigerator?	Y	N
8.17. Are the open vials dated?	Y	N
8.18. VVM available?	Y	N
9. Is the cold chain maintained in mobiles and consulting rooms	Y	N
9.1. Large cold boxes available, clean and in working order?	Y	N
9.2. Small cold boxes available, clean and in working order?	Y	N
9.3. Ice packs available?	Y	N
9.4. Are the icepacks in the cooler boxes conditioned?	Y	N
10. Is the open vial policy followed	Y	N
10.1. Date and time of opening recorded?	Y	N
10.2. Needles not left in vial?	Y	N
11. RTH card check		
11.1. Are vaccinations appropriate for age?	Y	N
11.2. Are signatures and return dates entered?	Y	N
11.3. Are Vitamin A doses recorded correctly?	Y	N
11.4. Are vaccine batch numbers recorded?	Y	N
12. Vaccination technique		
12.1. Are vaccines withdrawn correctly from vial?	Y	N
12.2. Are the correct needles and syringes used?	Y	N
12.3. Is the injection site correct?	Y	N
13. Information given to caregiver		
13.1. Is the return date indicated?	Y	N
13.2. Is the caregiver aware of side-effects?	Y	N

14. Emergency tray		
14.1. Is the emergency tray properly equipped?	Y	N
14.2. Is the nurse aware of emergency procedure?	Y	N
14.3. Are there guidelines on emergency procedures?	Y	N
15. Are EPI and Vitamin A guidelines available in PHC facility		
15.1. Are EPI statistics and graphs kept up-to-date?	Y	N
15.2. Is the tick register completed properly?	Y	N
15.3. Is the coverage/graph correct and up-to-date?	Y	N
15.4. Are vaccine batch numbers recorded?	Y	N
15.5. Since the last supervisory visits have the PHC supervisors 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
16. Notification		
16.1. Is the notification book available?	Y	N
16.2. Is the list/poster of notifiable diseases available?	Y	N
16.3. Are notified patients reported to the next level, for example, Sub-district co-ordinator, EHP, PHP?	Y	N
16.4. Are disease surveillance forms available?	Y	N
16.5. Are health care personnel aware of protocols to follow in patient of an outbreak?	Y	N
17. Disease Outbreak: Reporting and Management		
17.1. Is there a list of epidemic-prone priority conditions available?	Y	N
17.2. Does the clinic send status reports on suspected outbreaks?	Y	N
17.3. Does the PHC facility have written policies on infection control?	Y	N

17.4. Copies of the current Provincial Circulars on particular aspects, e.g. acute flaccid paralysis, Haemophilus influenza type b (Hib surveillance, Adverse Events management, etc	Y	N
17.5. Is the Sharps disposal equipment adequate?	Y	N

NOTES:

ACTIONS TO BE TAKEN BY PHC FACILITY

Supervisor signature:	
PHC facility manager signature:	
Date:	

5.6 Sexually transmitted infections (STI)

Service Description

The prevention and management of STI is a service available daily at a PHC facility and is a component of services for reproductive health and for control of HIV/AIDS.

Norms

- Every PHC facility has a review of quality of care once a year by a supervisor preferably using the validated DISCA (District STI Quality of Care Assessment) instrument.
- Every PHC facility has at least one member of health care personnel but preferably all professional health care personnel are trained in the management of STI using the latest "Training Manual for the Management of a person with a Sexually Transmitted Infection".
- Every PHC facility has at least one member of health care personnel (but preferably all who have been trained for STI trained as a counsellor for HIV/AIDS/STI.

Standards

- References, prints and educational materials
  - Standard Treatment Guidelines and Essential Drug List, latest edition. Essential drug programme South Africa.
  - Syndromic Patient Management of Sexually Transmitted Infections - guide for decision-makers, health care workers and communicators.
  - The Diagnosis and Management of Sexually Transmitted infections in Southern Africa (latest edition).
  - Supplies of patient information pamphlets on STI in the local languages.
  - Posters on STI and condoms in all the local languages.
  - Wall charts of the 6 protocols of STI management in consultation rooms (must be cleanable with liquid without damage).

Equipment

- A condom dispenser placed in a prominent place where condoms (with pamphlets on how to use these) can be obtained without having to request them.
- Examination light (or torch if no electricity) for every room with a screened examination couch.
- Sterile speculae (speculae and sterilizer).

Medicine supplies

- List of medicines in accordance with the Essential Medicines List and latest management protocols.
- A supply of male/female (where available) condoms with no time period where condoms are out of stock.
- Gloves.
- Dildos – at least one per PHC facility but preferably one per consulting room.

Competence of health care personnel

- PHC facility health care personnel provide STI management daily and have extended hours, or on-call weekend time, if in an urban or peri-urban area.
- PHC facility health care personnel are adolescent-friendly with friendly communication so as to be accessible and acceptable to all patients. Referral to adolescent-friendly sites should be done where necessary.
- Consultation for all patients takes place in private consultation rooms, to ensure confidentiality.
- Health care personnel are able to accurately diagnose and treat STI according to the latest guidelines with relevant partner tracing.
- The history is taken correctly and partner change inquired about (the gender of partners is not assumed).

- Syphilis serology is done on all patients with STI, and during pregnancy (if RPR available at PHC facility this is done there), and some do VDRL.
- All PHC facility health care personnel should receive annual STI updates.
- Pap smears are done on women over 18 years or with a history of vulvae warts.
- Patients are counselled on safe sex and HIV/AIDS is explained to them.
- Treatment is according to the protocol for each syndrome.
- Condom use is demonstrated and condoms provided.
- Partner notification cards in the correct language are given and reasons explained so that at least 60% result in the contact coming for treatment.

Referrals

- All patients are referred to the next level of care when their needs fall beyond the scope of competence.
- Conjunctivitis in the newborn is referred after initial treatment.
- The patient is referred if pregnant and has herpes in the last trimester.
- Pelvic inflammatory disease is referred if patient is sick, has pyrexia and tachycardia, or severe tenderness, or is pregnant.
- A painful unilateral scrotal swelling in a patient aged less than 18 years is referred immediately for a surgical opinion regarding a possible torsion.

Patient education

- All patients receive health education on asymptomatic STI, misconceptions, and rationale of treatment, compliance and return visit.
- Time is given during counselling and for discussion after treatment about the need for contacts to be treated.
- If pregnant then implications for the baby are discussed (congenital syphilis, ophthalmia neonatorum, HIV, chlamydia).
  - The importance of condom use (male and female) is stressed.
  - All female clients receive information about the female condom.
  - All patients should receive safe sex counselling.

Records

- Patient's records are maintained confidentially, according to protocol.
- Laboratory registers with return time for laboratory specimens not greater than 3 days.
- A register is kept of partner's details.

Community based services

- Health care personnel liaise with traditional healers about the signs, symptoms, prevention, referral and care of STI.

Collaboration

- Health care personnel collaborate with different departments such as schools, churches, traditional healers and community organisations implementing health promotion activities leading to the prevention of STI.

Checklist: District STI Quality of Care Assessment (DISCA)

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

Instructions

Please fill out this evaluation by:

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

TICK APPROPRIATE BOX [√]		
1. Accessibility		
1.1. Does this facility offer STI treatment at all times?	Y	N
1.2. Does this facility offer STI treatment as part of PHC facility after-hours services?	Y	N
1.3. How many adult consultation rooms are there in this facility?	#	
1.4. Does this facility use all adult consultation rooms to treat patients with STI?		N
1.5. If no, how many consultation rooms are used for STI care?	#	
1.6. Are female condoms available?	Y	N
1.7. Is every consulting room well-secured against access by unauthorised people during patient consultation?	Y	N
1.8. Please request a patient load book or register:	Y	N
1.9. How many adult patients attended last month?	#	
1.10. How many patients with STI attended last month?	#	

2. Patient Examination					
2.1. Is the following equipment available in all adult consultation rooms:					
2.1.1 Examination couch?	Y	N	Total number in this facility	#	
2.1.2 Examination light?	Y	N	Total number in this facility	#	
2.1.3 Sterile speculae?				Y	N
2.1.4 Sterile gloves?				Y	N
3. Provision of Safe Treatment					
3.1. Are there STI syndromic management guidelines at this facility?				Y	N
3.2. Are there STI syndromic management guidelines in all adult consultation rooms?				Y	N
3.3. Are there individual patient education materials about STI/HIV prevention and treatment available in this facility?				Y	N
3.4. Are these educational materials written in a local language?				Y	N
3.5. Is syphilis RPR testing available in this health facility?				Y	N
3.6. What is the turnaround 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	
3.6.1 Have there been any occasions over the last month where the male condoms ran out?				Y	N
3.6.2 Are STI patients shown how to use condoms in this facility?				Y	N
3.6.3 Is there a dildo available for condom demonstrations in this facility, and if no, what is done to make sure that the patient knows how to use condoms?				Y	N

3.7. Does this facility have a referral guideline for patients who do not respond to treatment or have complications?	Y	N
3.8. Partner notification – observe		
3.8.1 Are partner notification cards/letters available in all adult consulting rooms?	Y	N
4. Ask for the Laboratory Specimen Book or Register		
4.1. How many STI clients had blood specimen collected for RPR (syphilis) test last month?	#	
5. Antenatal screening and STI treatment		
5.1. Does this facility provide antenatal care?	Y	N
5.2. If yes, is syphilis screening done on all pregnant clients who attend antenatal care for the first time?	Y	N
5.3. Are pregnant clients examined and treated for STIs other than syphilis?	Y	N
6. Health care personnel training		
6.1. How many PHC facility personnel are on duty today?	#	
6.2. Of the PHC personnel on duty, how many have undergone formal training on STI syndromic management?	#	
6.3. Of the PHC personnel on duty, how many have undergone training on HIV/AIDS counselling?	#	

STI MEDICINES AND TREATMENT

Visit the pharmacy or medicine storeroom. Ask the pharmacist or nurse in charge of medicines the following:

MEDICINES	IS IT CURRENTLY IN STOCK?		OVER THE LAST MONTH HAS MEDICINE RUN OUT?		STATE THE REASONS FOR MEDICINES RUNNING OUT
Ciprofloxacin 250mg tabs	Y	N	Y	N	
Coftriazone 250mg					
Metronidazole 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 STI client cards, and fill in the information required using the following table:

STI Patient folders	Was the patient diagnosed according to syndromes below?		Specify the syndrome (See codes below)	What type of medicines did the patient receive? State the type, dose and duration	Is the medicine 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 STI (specify)

NOTES:

ACTIONS TO BE TAKEN BY PHC FACILITY

Supervisor signature:	
PHC facility manager signature:	
Date:	

5.7 Comprehensive management and treatment of HIV and AIDS

Service Description

A comprehensive range of services is provided including the identification of possible patients; testing with pre- and post-counselling; the treatment of associated opportunistic infections; referral of appropriate patients; 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 accidental needle prick injury.

Norms

- The District Communicable Disease Control Co-ordinator and the Senior Infection Control Nurse of the district hospital supervise the PHC facility every three months.
- Every three months all PHC facilities receive a visit by a laboratory technologist for quality control.
- At least one professional nurse will attend an HIV/AIDS/STI/TB workshop or other continuing education event on HIV/AIDS each year.

Standards

- Training (References, prints and educational materials)
  - Current HIV/AIDS Strategic Plan for South Africa 2007-2011.
  - National Antiretroviral Treatment Guidelines (2004).
  - Monitoring and Evaluation of the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa – Training manual for Facilitators/Participants (2005).
  - Summary results of the last (1998) National HIV Serological Survey on women attending public health services in South Africa.
  - Management of Occupational Exposure to Human Immunodeficiency Virus (HIV).
  - Guidelines for the management of HIV-infected children (2005).
  - HIV/AIDS PHC Facility Care Guidelines for Adults. Primary AIDS Care (latest edition).
  - Epidemiological Notes - National or Provincial, relating to HIV/AIDS.
  - Strategies to reduce Mother to Child Transmission of HIV and other infections during Pregnancy and Childbirth.
  - HIV and AIDS Guidelines for home-based care.
  - Guidelines for the continuum of care for HIV and AIDS and related diseases (2006).
  - Policy guidelines and recommendations for feeding of infants of HIV positive mothers.
  - HIV and AIDS illustrated booklets and pamphlets in the local language.
  - Posters on HIV/AIDS/STI in the local languages and preferably depicting local culture settings.
  - Guidelines for lay counsellors in all facilities.
  - Policy on cotrimoxazole

Equipment

- Remote PHC facilities have laboratory equipment for RPR and Rapid HIV tests.
- Physical environment conducive for provision of privacy to patients.

Medicines and supplies

- Gloves, protective aprons and goggles, masks and boots.
- Condoms – male and dildo (female condoms if available).
- Post-exposure prophylaxis for occupationally acquired HIV exposure, for example, needle

stick injuries with HIV positive blood in accordance with the recommendations of the Essential Medicine List.

Competence of health care personnel

Knowledge and attitudes

- Health care personnel know the contents of the Guidelines on Management of Occupational Exposure to Human Immunodeficiency Virus.
- Health care personnel relate to patients in a non-discriminatory and non-judgemental manner and maintain strict confidentiality about a patient's HIV status.
- Health care personnel dealing with families of patients with HIV or AIDS are familiar with the principles of confidentiality.
- Health care personnel provide warm, compassionate counselling on a continuous basis, which is sensitive to culture, language and social circumstances of patients.
- Health care personnel are aware of the effects of social factors in relation to HIV transmission in the PHC facility catchment area.
- Health care personnel are aware of the social consequences (orphans, loss of work, family, disruptions to schooling and careers) of AIDS.
- Health care personnel seek to reduce fear and stigma related to HIV and AIDS.
- Health care personnel provide youth-friendly services that help promote improved health-seeking behaviour and encourage adopting of safer sex practices.

Skills

Health care personnel are able to

- Take a complete history including a sexual history and perform a complete physical examination (including PHC facility staging), according to the guidelines.
- Do pre- and post-test counselling after informed consent and collect blood specimens for HIV and/or rapid test.
- Perform, after training, rapid HIV and RPR tests in those remote PHC facilities where this has been set up.
- Promote optimal health and safer sexual practices among all patients.
- Assess and treat common opportunistic infections among those infected with HIV and AIDS.
- Ensure that all HIV positive patients are started on appropriate opportunistic infection prophylaxis, according to National HIV and AIDS Guidelines.
- Initiate directly observed tuberculosis treatment after obtaining positive sputum results or send for X-ray when in doubt; and send sputum for culture, while starting Isoniazide prophylaxis.
- Offer ongoing care to all HIV positive patients.
- Offer education and voluntary HIV testing to all patients with unknown HIV status.
- Counsel patients who have experienced rape and offer HIV testing after informed consent and pre- and post-test counselling, as well as post-exposure prophylaxis.
- Implement infection prevention, control and precautionary measures.
- Use policy guidelines and recommendations for feeding infants of HIV positive mothers, while respecting the mothers' choice after informed counselling.
- Provide education, counselling and supportive care for the HIV positive child and caregiver and facilitate access to social services.
- Collaborate with traditional healers on HIV/AIDS.
- All PHC facility health care personnel (professional and cleaning/laundry) should be immunised against Hepatitis B.

Referral

- Refer all HIV positive patients with low CD4 cell count for ARV assessment, in accordance with the guidelines.
- Refer all complicated patients, especially Herpes zoster, oesophageal candidiasis and severe continued diarrhoea (after trial of symptomatic treatment).
- Refer suspected TB patients with negative sputum for further investigation.

Patient education

- All education addresses ignorance, fear and prejudice regarding patients with HIV/AIDS attending PHC facilities.
- Increase acceptance and use of condoms among the youth and other sexually active populations.
- All patients receive safe sexual practice messages, either individually or as a group.

Records

- Patient records are kept in accordance with the requirements of the National Health Care Act.

Community based services

- The PHC facility has a working relationship with Community Health Committees, political leaders, ward councillors, NGOs and CBOs in the catchment area of the PHC facility.
- HIV positive patients are followed up by health care personnel at the local primary health care facility.
- Health care personnel educate and train family and community groups in home-based care, and seek to de-stigmatise HIV disease in communities through education.
- Health care personnel assist in integrating home-based care services and provide guidelines to community health committees on situation analysis and needs assessment in the community.

Checklist: HIV and AIDS

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

Note: The National Strategic Health Plan 2007–2011 for HIV and STIs to include TB screening.

	TICK APPROPRIATE BOX [√]	
Availability of HIV services	**Daily**	**Special Days**
1. National Guidelines for HIV/AIDS		
1.1. Feeding of infants of HIV positive mothers?	Y	N
1.2. Management of occupational exposure to HIV?	Y	N
1.3. Managing HIV in children?	Y	N
1.4. Prevention and treatment of opportunistic and HIV-related diseases in adults?	Y	N
1.5. Prevention of mother-to-child HIV transmission and management of HIV positive pregnant women?	Y	N
1.6. Counselling and testing guidelines?	Y	N
1.7. Cotrimazole policy?	Y	N
1.8. Tuberculosis (TB)?	Y	N
1.9. HIV/AIDS?	Y	N
1.10. National guideline on home-based care and community-based care?	Y	N
2. Updated protocol/guidelines for PMTCT?	Y	N
3. Protocol for accidental needle prick injury?	Y	N
4. PEP protocol for rape victims?	Y	N

5. IEC activities		
5.1. Is HIV and AIDS or CCMT patient information available, e.g. pamphlets, posters?	Y	N
5.2. Is the information available in local languages?	Y	N
5.3. Are the community and/or patients informed about HIV and AIDS and CCMT while waiting?	Y	N
5.4. Does the facility host and organize special HIV events, such as plays, talks at schools, provision of food parcels?	Y	N
Please specify		
Comments:		
6. Is in-service on HIV and AIDS and CCMT regularly provided to all health care personnel?	Y	N
Comments:		

Support Groups		
7. Are there HIV support groups in the area (e.g. Post-test clubs/support groups)?	Y	N
8. List them		

9. How does the PHC service support these groups?		
Notes:		

10. Voluntary Counselling and Testing		
10.1. Is HIV rapid test and counselling available/offered in this facility?	Y	N
10.2. Are "lay" counsellors used in this PHC facility?	Y	N
10.2.1 How many counsellors are available at this Facility?	#	
10.2.2 Is there a mentorship programme for counsellors?	Y	N
10.3. Number of health care personnel trained in HIV Rapid Testing	#	
10.4. Is pre–counselling done in an area that ensures privacy?	Y	N
10.5. Is post-counselling done in an area that ensures privacy?	Y	N
10.6. Is the client voluntarily agreeing to do testing? (not forced or tricked)?	Y	N
10.6.1 Is testing done in an area that ensures privacy?	Y	N
10.6.2 Does the same counsellor who did the pre-test counselling give the result to the client?	Y	N
10.6.3 Is the client who is found to be HIV positive referred to a support group or mentors?	Y	N
10.7. Is blood specimen taken for CD4 Count for all HIV positive clients?	Y	N
10.7.1 What is the turnaround time (in days) for CD4 count results?	#	
10.8. How many clients were counselled in the last month?	Y	N
10.9. Is there any follow-up on HIV positive clients?	Y	N
10.10. Is VCT done with postnatal women who did not consent to HIV testing during ANC?	Y	N
10.11. Number of health workers trained on VCT per shift.	#	

11. PMTCT		
11.1. Are all pregnant women individually counselled and offered testing for HIV during routine ANC?	Y	N
11.2. Is AZT given to pregnant women who test HIV positive and agree to be on the PMTCT programme? If yes, is AZT dispensed at this PHC facility?	Y Y	N N
11.3. Does the referral hospital refer clients who have received Nevirapine during delivery/labour back to the PHC facility?	Y	N
11.4. Is CD4 Count done for HIV positive pregnant women at this facility?	Y	N
11.5. Are HIV positive pregnant women referred for assessment for ARV therapy?	Y	N
11.6. How many pregnant HIV positive mothers referred for ARV therapy in the past month?	#	
11.7. Are infants Road To Health charts coded?	Y	N
11.8. Is quality of the test kit conducted? Show proof.	Y	N

12. Neonatal And Infant Follow-Up		
12.1. Is there a register for infant follow-up, especially for infants born to HIV positive mothers?	Y	N
12.2. Are records for infant follow-up up-to-date, including treatment to babies born of HIV positive mothers?	Y	N
12.3. Does the PHC facility receive written referrals from hospital for infants born to HIV positive mothers?	Y	N
12.4. Is PCR testing for babies born of HIV positive mothers done at 6 weeks at this facility?	Y	N
12.5. Is AZT dispensed to the patient?	Y	N
12.6. If no, why?		
12.7. List alternative measures to ensure that the patient receives AZT.		

12.8. What is the turnaround time for PCR testing?	Time	
12.9. Is co-trimoxazole initiated at the time of PCR testing?	Y	N
12.10. Are HIV positive infants referred to hospital for ARV therapy?	Y	N
12.11. Are there links with community groups (such as home-based carers) to trace infants for infant follow-up?	Y	N
12.12. What mechanisms exist in the facility to provide community support for infant follow-up? List these.		

13. Home-Based Care		
13.1. Is this facility linked to home-based care services?	Y	N
13.2. How?		
13.3. Does the facility provide and re-stock home care kits for caregivers?	Y	N
13.4. Are problems experienced with replenishing care kits?	Y	N
Comments:		
13.5. Are there volunteer caregivers in the catchment area of the facility?	Y	N
13.6. Do facility health care personnel supervise and support these caregivers?	Y	N
Comments:		

14. Managing the HIV Positive Person		
14.1. Is contraception for HIV positive women promoted?	Y	N
14.2. Is dual protection for contraception emphasized?	Y	N
14.3. Does the PHC facility provide information on "wellness management"?	Y	N
14.4. Cotrimoxazole prophylaxis:		
14.4.1 Is Cotrimoxazole prophylaxis provided?	Y	N
14.4.2 Are the indications for Cotrimoxazole prophylaxis followed?	Y	N
14.4.3 Is there a register to track compliance?	Y	N
14.5. TB and HIV:		
14.5.1 Are all TB patients offered VCT?	Y	N
14.5.2 Are all HIV positive patients offered TB testing?	Y	Y
14.6. Do all STI clients receive individual counselling for HIV?	Y	N
14.7. How many new STI clients tested for HIV in the past month?	#	
14.8. Do health care personnel feel confident to deal with the range of opportunistic infections?	Y	N
14.9. Is there update training required for managing opportunistic infections?	Y	N
Comment:		
14.10. Do appropriate mechanisms exist to refer HIV positive patients for further medical care or social support? Is it functional?	Y	N
Comment:		

15. HIV Occupational Health		
15.1. Is this health facility practicing Universal Precautions?	Y	N
15.1.1 Are gloves routinely used for vein puncture and other invasive procedures?	Y	N
15.1.2 Are sharps correctly disposed of (no recapping) in appropriate containers?	Y	N
15.2. Are health care personnel offered confidential counselling on STI and AIDS-related issues?	Y	N
15.3. Is there sufficient protective clothing available for maternity care, dressings, injections, etc?	Y	N
15.4. Are clear guidelines available indicating the management of occupational injuries (such as needle stick injuries, contact with HIV positive bodily fluids)?	Y	N

15.5. Where is the nearest supply of prophylactic treatment available for personnel?		
Site:		
15.6. Is it possible to access these antiretrovirals in the time prescribed by PEP guidelines?	Y	N

16. Medicines, Equipment and Supplies		
16.1. Do stock-outs of CCMT medicines occur (how often in last three months)?	Y	N
16.1.1 How often?	#	
16.2. Do stock-outs of Rapid Tests or reagents occur?	Y	N
16.2.1 How often in last three months?	#	
♦ How often?	#	
16.3. Is the stock control procedure being followed?	Y	N
16.4. Are there bin cards for test kits?	Y	N
16.5. Are the bin cards correctly completed?	Y	N
16.6. Are test kits stored properly?	Y	N
16.7. Are test kits being used before expiry dates?	Y	N

17. Condoms		
17.1. Are condoms available at the PHC facility today?	Y	N
17.2. Are condoms available in areas easily accessible to all persons visiting the PHC facility and in consulting rooms?	Y	N
17.3. Are condoms stored in a cool and dry place?	Y	N
17.4. Are there any expired condoms in stock?	Y	N
17.5. Are condoms supplied to community depots from this PHC facility?	Y	N
17.6. Does condom stock-out occur? If yes,	Y	N
17.7. How many times in the past three months?	#	

18. Recording		
18.1. Are all HIV Registers correctly completed and kept up-to-date?	Y	N
18.2. Are the patient records retained by the PHC facility correctly completed?	Y	N
18.3. Are patient records at the PHC facility stored in a safe and confidential manner?	Y	N
18.4. Is the PHC report for HIV/AIDS correctly completed?	Y	N
18.5. Is the data / information displayed graphically?	Y	N
18.6. Are there sufficient stocks of stationery for the HIV/AIDS programme?	Y	N

HEALTH CARE PERSONNEL	NUMBER	VCT	PMTCT	PEP	STI	TB
PN						
EN						
ENA						
CHW						
LC						

NOTES:

ACTIONS TO BE TAKEN BY PHC FACILITY

Supervisor signature:	
PHC facility manager signature:	
Date:	

5.8 Tuberculosis

Description of services

Early diagnosis and treatment of active TB is essential in controlling TB and its transmission. Following national protocols, the PHC facility health care personnel should diagnose TB on suspicion using sputum smear microscopy; provide IEC and active screening of families of patients with TB; treat, dispense and follow-up using DOT; and complete the TB register.

Norms

- Achieve a minimum of 85% cure rate of new sputum-positive TB patients.
- Achieve a minimum of 85% smear conversion rate of new sputum-positive patients and 80% smear conversion rate for re-treatment patients.
- Achieve a smear positive rate of less than 10% amongst all TB suspects tested.
- Every PHC facility has at least one health care personnel member who has been trained in TB management.
- Receive a six-monthly assessment of quality of care of the TB service by the District TB Co-ordinator.

Standards

To address 3 categories of activities, namely Diagnosis, Treatment and Public Health responsibilities.

References, prints and educational material

- The latest TB training manual/modules for health facility health care personnel.
- The latest SA National TB Control Practical Guidelines.
- The National TB Control Programme Manual.
- A Training Manual for DOT supporters.
- Flow charts/Algorithms on TB diagnosis.
- The TB/HIV Wheel.
- The latest EDL manual.
- TB posters on walls, and leaflets and pamphlets in local languages for distribution.
- All national and provincial TB programme recording and reporting tools.

Medicines, supplies and equipment

- Uninterrupted supply of TB medicines as per standard guidelines.
- MDR TB medicines only for named patients.
- Sterile syringes, needles and water for injection of streptomycin and PPD.
- Screw-top sputum containers and the National Health Laboratory Services specimen booklet.
- Plastic bags for transportation of sputum specimens including the specimen dispatch list.

Competence of health care personnel

Health care personnel are able to:

- Suspect and identify TB by early symptoms such as cough, loss of weight and tiredness.
- Initiate and follow up treatment of patient using the latest recommended TB management regimens and protocols.
- Educate the community and patients, with the emphasis on correcting misinformation and seeking to prevent the spread of disease.
- Start direct observed treatment (DOT) supported by health facility health care personnel or through identified community structures/volunteers chosen and accepted by the patient.
- Enter all patient information and sputum results on the TB Suspect Register (GW 20/30), TB Register (GW 20/11), the Patient PHC Facility Card (GW 20/12), the Patient Treatment Card (GW 20/15) and Patient Transfer Form (GW 20/14) as and when required.

Referral

- Before being transferred to another health facility the patient receives a completed transfer form and a sufficient supply of medication. Where possible, the facility to which he/she is transferred is notified by telephone or in writing.
- Appropriate referrals to a PHC facility/ hospital linked to the TB programme should be made, such as very ill patients, severe complications of TB, adverse medicine reactions, MDR-TB, children with extensive TB or gross lymph-adenopathy, or those not improving on treatment.

Patient education

- Patients, relatives and communities receive high quality information on TB.
- Supporting information is available in the form of leaflet, pamphlet or poster, in the appropriate languages and is given to the patient to reinforce the main messages.
- Patients are educated about HIV/AIDS/STIs in addition to TB so that they can recognize predisposing conditions and so prevent them. Counselling and testing for HIV should be promoted.

Records and statistics

- All confirmed TB patients to be notified using the standardised reporting tools.
- All registers, recording and reporting forms, monthly and quarterly reports are kept up-to-date and are readily available when needed.

Community and home-based activities

- The PHC facility has good communication skills and knowledge of available community resources in the PHC facility catchment area.
- The PHC facility has an agreement with resulting support from the PHC facility committee about the use of community-based DOT.
- DOT is arranged in the most convenient way possible for the patient.
- The quality of DOT management within the PHC facility and the community-based supporters are monitored and evaluated monthly and quarterly.

Collaboration

- The PHC facility refers patients to the Department of Social Development/Social Welfare when necessary.
- Health care personnel collaborate with NGOs, schools, private practitioners and workplaces in their catchment area to enhance the promotion of TB prevention and care.

Guidelines: How to use the TB Checklist

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

TUBERCULOSIS

GENERAL (A PHC facility should have the following 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	PHC facility health care personnel provide information
Fast Line service available for TB patients currently on treatment*	To ensure that TB patients do not have to spend long periods in queues when fetching medicines/seeking care	PHC facility health care personnel provide information
Protocols and policies available		
The latest SA National TB Control Practical Guidelines	Check availability of prime TB reference document for PHC facility health care personnel.	Supervisor to observe
The latest TB training manual/modules for health facility health care personnel	Check availability of supportive materials for PHC facility health care personnel	Supervisor to observe
The latest National TB Programme Manual	Check availability of supportive materials for PHC facility health care personnel	Supervisor to observe
A Training Manual for DOTS supporters	Check availability of supportive materials for PHC facility health care personnel	Supervisor to observe
Wall flow charts/algorithms on TB diagnosis	Display simplifies the management of TB	Supervisor to observe
The latest EDL manual	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
Is there a focal person who takes responsibility for day-to-day TB management in the PHC facility?	Generally, if one person is responsible for day-to-day management in the PHC facility then there is less confusion	PHC facility manager
Is 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.

* Fast line – a mechanism that ensures that TB patients can rapidly access care without waiting in a queue for extended periods.

PHC Facility Management of Adults with TB (To ensure that the PHC facility is providing the following set of activities)

The role of PHC facility health care personnel:		
Is the National TB Suspect Register (GW20/30) implemented?	Verify that early patient detection is taking place – a vital component of the NTCP	Request to see the TB Suspect Register Check number of suspects identified on monthly PHC return form, verify with the TB Suspect Register
Requesting appropriate sputum investigations for specific categories of patients	PHC facility health care personnel often have difficulties in requesting appropriate investigations for new and re-treatment patients. It is necessary to verify the correctness of sputum requests	TB register – sputum results columns Check "sputum results" columns - blue card
Requesting sputum investigations at the correct times**	Efficient TB programme management requires that sputum investigations are done timeously and for all patients with PTB	TB register – sputum results columns Blue card – sputum results columns
Initiating the correct treatment protocols for newly diagnosed and re-treatment patients	PHC facility health care personnel often have difficulties in initiating appropriate treatment for new and re-treatment 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 that 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 health care personnel provide
Offering HIV Counselling and Testing to all TB patients	The HIV testing of all TB patients needs to be promoted.	Noted on blue card or VCT register
Reviewing the PHC facility progress of each TB patient at least once a month during the treatment period	Regular review of the patient's PHC facility progress is useful as it indicates improvement/problems of the patient. It also serves to enhance the relationship between the PHC facility health care personnel and the patient.	PHC facility health care personnel PHC facility notes in patient blue card
Managing contacts according to TB Programme guidelines	Contact management is not always optimal. It is necessary to ensure that health care personnel knows who the contacts are and that they are taking steps to trace contacts.	PHC facility health care personnel Contact list on blue card completed

**Duration of treatment calculated from the point in time when patient started treatment.

PHC Facility Management of Children with TB

Are PHC facility health care personnel doing the following:

Actively searching for the child contacts of all TB patients?	It is important to ensure that the PHC facility health care personnel is taking steps to trace and initiate contact treatment for children under five.	PHC facility health care personnel Ask to be provided with the blue card of each contact and check details on card.
Using Mantoux test in children under five?	It is important to ensure that only children under five years are diagnosed with TB using Mantoux test as the only diagnostic method. It is important to ensure that the Mantoux test is used appropriately in children.	TB register (look at disease coding column and compare with patient age and diagnostic criteria used). Check details in blue card
Correctly reading Mantoux test results?	Mantoux test results need to be interpreted properly before deciding whether they are positive or not. Health care personnel should record the size of indurations and it is necessary to ensure that the diagnosis is based on guidelines (especially patient age) according to the NTCP protocols	Knowledge of PHC facility health care personnel patients' cards.
Initiating the correct treatment for children?	Ensure that children receive the appropriate treatment regimes according to contact or disease status.	TB Register Blue Cards

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

Does the PHC facility have the contact details of their laboratory?	Open communication with the laboratory is critical to enable health care personnel to follow up specimen results and address any other related problems. The laboratory contact numbers should be displayed and readily accessible for all health facility health care personnel	PHC facility health care personnel Ask to see number
Are the correct/approved sputum jars available?	It is important to verify the availability of the appropriate sputum jars – preferably wide-necked with screw tops.	Ask to see sputum jars
Are the correct/approved laboratory request forms available? Are laboratory request forms completed correctly?	Useful NTCP monitoring information can be obtained from the laboratory providing that PHC facility health care personnel complete request forms properly. The correct completion of these forms need to be verified.	Ask to see the approved NHLS laboratory request book Ask the health care personnel to complete a form for an imaginary patient. Ask laboratory health care personnel how request forms are being completed Check comments on laboratory reports
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 how the specimen is labeled and sealed Check laboratory comments on lab reports (e.g. saliva, insufficient)

Did the PHC facility have stock-outs of sputum jars in the last month?	This allows the opportunity to explore the reasons for stock-outs if they do occur and to make plans to prevent such occurrences.	PHC facility health care personnel Stock Cards Laboratory health care personnel
Are the results of all the sputum specimens sent to the laboratory returned to the PHC facility? Does this occur within 48 hours of sputum specimen being sent off?	Late or non-return of sputum results affects the ability of the PHC facility nurse to manage TB patients optimally.	PHC facility health care personnel Specimen register
Does sputum transportation to laboratory occur daily, Monday to Friday?	The regularity of transport to the PHC facility should be assessed. Irregular or poor transport affects the confidence of both PHC facility health care personnel and patients.	PHC facility health care personnel
Is there an up-to-date specimen dispatch list?	The dispatch list is a record of all specimens sent to the laboratory. This assists health care personnel to keep track of the specimens sent and follow up on results if problems arise	PHC facility health care personnel Ask to see the list
Does the PHC facility use a cooler box to transport sputum to the laboratory?	This ensures that sputum specimens are protected from exposure to direct sunlight and high temperatures during transportation to the laboratory. A cooler box should be dedicated to sputum specimens only.	PHC facility health care personnel
Are specimen plastic bags available?	Each sputum specimen should be individually packed in a plastic bag during transportation to the laboratory to prevent spillage / leaks	PHC facility health care personnel Ask to see plastic bags Check laboratory reports on specimen spillages/leaks

Medicines

Do TB medicine stock-outs ever occur? If yes, which medicines? Did any patient go without treatment during this period?	This allows the opportunity to explore the reasons for stock-outs if they do occur and to make plans to prevent such occurrences. Listing the affected medicines may help to assess whether there are problems at medical depot	PHC facility health care personnel Medicine stock cards Stock levels

Treatment support systems: (A variety of treatment support systems exist at health facility level – these include PHC facility-based DOT, community-based DOT and self-supervision by patients. It is important to understand what treatment support system each PHC facility provides and how the PHC facility is performing in providing treatment. A PHC facility may provide one or more forms of treatment support; therefore the PHC supervisor should enquire about the presence or not of each form of support. An up-to-date database of active DOT supporters will give an idea on how the DOT system is structured/managed at the PHC facility

How does the PHC facility provide treatment to TB patients?		
Daily facility-based DOT	To determine whether this form of treatment is provided from the PHC facility	PHC facility Health care personnel
Number of TB patients currently on daily PHC facility-based DOTS:	To determine how many patients are on PHC facility-based DOT.	TB Register Blue Cards Data base of DOT supporters Daily/monthly DOT form
How many of these patients have missed more than two consecutive days of treatment during the last month?	One needs to get an idea of how well the PHC facility is performing in ensuring that these patients take their TB medicines. It is also important to ensure that a system exists to recall patients and continue with treatment	Blue cards of patients on PHC facility-based DOT Daily DOT form
What has been done to improve the adherence of patients who are not regular?	If the PHC facility is experiencing problems with PHC facility-based DOT clients it is important to determine what is being done to solve these problems	PHC facility health care personnel
Through a network of community-based treatment supporters (community-based DOT):	To determine whether this form of treatment is provided from the PHC facility	PHC facility Health care personnel Data base of DOT supporters
Number of patients currently supported by treatment supporters	To determine how many patients are on community- based DOTS.	TB Register Blue Cards Data base
Does the PHC facility keep a record of the performance of the treatment supporters?	PHC facility health care personnel should be aware of how treatment supporters are performing.	PHC facility record / tool
Do health facility health care personnel meet at least once a month with treatment supporters? Are PHC facility health care personnel able to visit treatment supporters in the field for supervision and support?	There should be a good relationship and interaction between treatment supporters and PHC facility health care personnel. It is important to enquire whether interaction does take place, for support and mentoring	PHC facility health care personnel Treatment supporters PHC facility record of such meetings
Patients taking treatment on own responsibility (also called self-supervision):	It must be noted that patients do have a right to choose where to take their treatment. It is important to determine whether this form of treatment is provided by the health facility and how the health care personnel are managing this process.	PHC facility Health care personnel Blue cards
How often does the patient collect treatment?	Knowing the frequency with which a patient collects treatment is important as it does give an indication of the adherence of the patient. A patient who collects treatment weekly and is regular in doing so is probably taking the medicines whilst this may not necessarily be the case for persons collecting medicines monthly. It is also easier to detect adherence problems in patients who collect their medicines weekly than it is for those who collect medicines monthly.	Blue cards

Does the PHC facility monitor the intervals at which the patient should collect treatment?	It is important to know whether PHC facility health care personnel have a system whereby they can detect patients who do not come back for treatment.	Blue card Other forms of attendance register.
Does the PHC facility have any form of outreach service for TB patients?	It is important to determine what efforts the PHC facility is making to deal with TB patients who have either problems in obtaining TB medicines or who have adherence problems. Outreach services might be in the form of sending messages to the patient, linkages with community health workers and PHC facility committees/traditional leaders, linkages with support groups, providing nutritional support and sending PHC facility health care personnel out to support patients.	PHC facility health care personnel Database/record of outreach activities/services available at the PHC facility

TB recording: (Proper TB recording supports the proper management of the NTCP)

Is the TB register correctly completed and up-to-date?	All TB documentation should be accurately and promptly completed. 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 PHC facility-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 cards (retained) 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
Is there an internal quality assurance system in place?	It is important to verify that TB data entered into the PHC monthly returns are correct. Health care personnel 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. Weekly quality assurance meetings will assist health care personnel to understand the TB programme activities and enable them to complete all the necessary documentation with less difficulty.	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 PHC facility health care personnel experience problems with the preparation of monthly/quarterly statistics?	PHC facility health care personnel may experience problems in completing quarterly statistical reports. It is necessary to ensure that PHC facility health care personnel feel competent to do this and, to the extent that it is possible, to verify the correctness of reports.	PHC facility health care personnel 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.	PHC facility health care personnel
Do health care personnel know their TB indicators?	Understanding of TB indicators assist health care personnel with monitoring their own progress and identification of problems	PHC facility health care personnel DHIS

Patient Transfers (referred, moved) (Large numbers of patients are lost to follow-up during transfer/referral from hospital to PHC facility, PHC facility to hospital and between PHC facilities. It is important to ensure that PHC facilities are doing all they can to minimise this loss of patients during transfers).

Does the PHC facility have a mechanism to ensure that patients who transfer/move/are referred 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 – reply slip
Does the PHC facility report to the referring institution that a referred patient has arrived at her/his stated destination?	It is important that institutions to which patients are referred report the arrival of that patient to the referring institution.	Referral register – reply slip
Does the PHC facility complete the referral documentation (transfer out forms) correctly and completely when referring a TB patient? Is there a system to get feedback on transferred patients?	Poorly completed referral documentation is a great source of frustration to health care personnel that receive a referred patient. PHC facility health care personnel should complete the TB referral form properly and this should be verified.	Review of referral forms where possible.
	Lack of information on patients who transfer out of the district/ province has a negative effect on treatment outcomes. The PHC facility health care personnel should try and establish mechanisms to get feedback on the outcomes of these patients	Review of referral forms where possible. PHC facility health care personnel

Checklist: TB

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

TICK APPROPRIATE BOX [√]			
1. Availability of services	Daily	Special days	
1.1. Fast Line service available for TB patients currently on treatment?	Y	N	
2. Protocols and policies available:			
2.1. The latest SA National TB Control Practical Guidelines?	Y	N	
2.2. The latest National TB/HIV Guidelines?	Y	N	
2.3. A Training Manual for DOTS supporters?	Y	N	
2.4. Flow charts/Algorithms on TB diagnosis?	Y	N	
2.5. The TB/HIV Wheel?	Y	N	
2.6. The latest EDL manual?	Y	N	
2.7. TB posters on walls, leaflets and pamphlets in local languages for distribution?	Y	N	
2.8. Is there a focal person responsible for TB management in the PHC facility?	Y	N	
2.9. Are TB patients notified and notification forms submitted to the appropriate office?	Y	N	

PHC Facility Management of Adults with TB

3. Are PHC facility health care personnel doing the following:		
3.1. Is the National TB Suspect Register (GW 20/30) implemented?	Y	N
3.2. Is there a list of patients' names due for collection of sputum during conversion phase?	Y	N
4. Requesting appropriate sputum investigations for specific categories of patients:		
4.1. Sputum direct for new TB suspects/all patients currently on treatment?	Y	N
4.2. Sputum culture and susceptibility for TB re-treatments/patients who fail to convert on treatment?	Y	N
4.3. Requesting sputum investigations at the correct times?	Y	N
4.4. During the last week of initial phase and conversion phase?	Y	N
4.5. At 2/3 months on treatment?	Y	N
4.6. At 5 months (new patients) and 7 months (re-treatment patients) on treatment?	Y	N
5. Initiating the correct treatment protocols for:		
5.1. Newly diagnosed patients?	Y	N
5.2. Re-treatment patients?	Y	N
6. Providing the following information to new TB patients:		
6.1. The importance of treatment adherence?	Y	N
6.2. The need for a treatment supporter?	Y	N
6.3. What to do if side-effects occur, they run out of medicines, or need to leave for another area beyond the PHC facility catchment area?	Y	N
6.4. Reviewing the PHC facility progress of each TB patient at least once a month during the treatment period?	Y	N
6.5. Referring TB patients for appropriate care when necessary?	Y	N
6.6. Managing contacts according to TB Programme guidelines?	Y	N
6.7. Offering HIV Counselling and Testing to all diagnosed TB clients?	Y	N

PHC Facility Management of Children With TB

7. Are PHC facility health care personnel doing the following:		
7.1. Identifying children with suspected TB?	Y	N
7.2. Actively searching for the child contacts of all TB patients?	Y	N

7.3. Using Mantoux testing in children under five?	Y	N
7.4. Correctly reading Mantoux test results?	Y	N
8. Initiating the correct treatment for children according to the protocols:		
8.1. Contacts?	Y	N
8.2. Children with active disease?	Y	N
8.3. Referring children with suspected TB when necessary?	Y	N
9. Equipment availability		
9.1. Adult/foot scale?	Y	N
9.2. Baby scale?	Y	N

Sputum Management

10. Does the PHC facility have the contact details of their laboratory?	Y	N
11. Are the correct/approved sputum jars available?	Y	N
12. Are the correct/approved laboratory request forms available?	Y	N
13. Were stock-outs of sputum jars experienced in the last month?	Y	N
14. Is the sputum collection correctly done?	Y	N
15. Are laboratory request forms completed correctly?	Y	N
16. Does sputum transportation to the laboratory occur daily, Monday to Friday?	Y	N
17. Is there an up-to-date specimen dispatch list?	Y	N
18. Does the PHC facility use a cooler box reserved for transportation of sputum specimens?	Y	N
19. Are specimen plastic bags available?	Y	
20. Are the results of all sputum investigations returned to the PHC facility?	Y	N
21. Does this occur within 48 hours of the sputum being sent away?	Y	N

Medicines

22. Did TB medicine stock-outs occur in the last month?	Y	N
23. If yes, which medicines?		
24. Did any patient go without TB treatment because of this?	Y	N
25. Expired medicines?		

Treatment Support Systems

26. Does the PHC facility have an up-to-date database of active DOT supporters?	Y	N
27. How does the PHC facility provide treatment to TB patients: -	Y	N
27.1. Number of TB patients currently on daily health facility- based DOT	#	
27.2. How many of these patients have missed more than two consecutive days of treatment during the last month	#	
27.3. How many are still not back on treatment	#	
27.4. Are tracing mechanisms in place?	Y	N
28. What has been done to improve the adherence of patients who are not regular? Explain.		
29. Information from a network of community based treatment supporters (e.g. DOTS):		
29.1. Number of patients currently supported by treatment supporters	#	
29.2. Does the PHC facility keep a record of the performance of the treatment supporters?	Y	N
29.3. Do PHC facility health care personnel meet at least once a month with treatment supporters?	Y	N
29.4. Are PHC facility health care personnel able to visit treatment supporters in the field for supervision and support?	Y	N

Patients taking treatment on own responsibility:					
30. How often does the patient collect treatment	Weekly	2 weekly	Monthly		
31. Does the PHC facility monitor the intervals at which the patient should collect treatment?				Y	N
32. Does the PHC facility have any form of outreach service for TB patients:				Y	N
33. To provide medicines to patients who have a difficulty in reaching the PHC facility?				Y	N
34. To trace patients who have apparently defaulted?				Y	N
35. Is there a support group for TB patients?				Y	N
36. Does the PHC facility provide nutritional support to TB patients?				Y	N

TB Recording

37. Is the TB register correctly completed and up-to-date?	Y	N
38. Are all fields correctly completed?	Y	N
39. Is the information valid and accurate?	Y	N
40. Are the blue PHC facility-retained patient records fully completed and up-to-date?	Y	N
41. Are the green patient-retained cards of TB patients correctly completed and up-to-date?	Y	N
42. Is there an internal TB quality assurance system in place?	Y	N
43. Are results/problems discussed at least monthly?	Y	N
44. Do PHC facility health care personnel experience problems with the preparation of monthly/quarterly statistics?	Y	N
45. Do the health facility health care personnel know their TB indicators?	Y	N
46. Are stock-outs of TB stationery ever experienced?	Y	N

Transferred Patients (moved/referred)

47. Does the PHC facility have a mechanism to ensure that patients who are transferred/moved/referred out have reached their intended destination?	Y	N
48. Does the PHC facility report to the referring institution that a patient who has been transferred /moved/referred in has reached her/his destination?	Y	N
49. Does the PHC facility complete the referral documentation (transfer out forms) correctly and completely when referring a TB patient	Y	N
50. Number of XDR patients	#	
51. Is there a system to get feedback on transferred out patients?	Y	N

TB Indicators

52. % of TB suspects detected	
53. % of smear positive clients detected	
54. % of smear positive patients put on treatment	
55. Smear Conversion Rates at two months	
56. Cure Rates	
57. Treatment Interruption Rates within two months	
58. % of patients that die when in the intensive phase	
59. Sputum Turnaround Time	
60. Proportion of TB patients Counselled and Tested for HIV	

Social Mobilization

61. Number of health talks conducted in the last month	
62. Number of outreach activities undertaken by the facility in the last month	
63. Number of NGOs/CBOs attached to PHC facility	
64. Treatment interruption rate in the continuous phase	
65. Re-treatment rate	
66. Number of treatments completed	
67. % of patients in the initial phase	

NOTES:

ACTIONS TO BE TAKEN BY PHC FACILITY

Supervisor signature:	
PHC facility manager signature:	
Date:	

5.9 Mental health and substance abuse

Service Description

Mental health and substance abuse services form part of integrated comprehensive Primary Health Care. The service seeks to improve the mental health and social well-being of individuals and communities. Promotion of community mental health is included in PHC facility- and community-based IEC. Preventive measures for mental disability are included in all services such as antenatal, infant, child, reproductive health and curative care. By preventing and managing substance abuse in the PHC facility, the service aims to reduce substance abuse among groups at risk and also to reduce alcohol-related motor vehicle morbidity and mortality. Prevention and management of substance abuse also has relevance for tuberculosis, STDs and HIV/AIDS, mental illness, family violence and educational attainment.

Norms

All PHC facilities have regular visits (for patient care, training, supervision and support) from dedicated mental health or psychiatric nurses from health centres, hospitals or mobile teams based in the district.

All PHC facilities have access (by referral or by periodic PHC facility visits) to specialist mental health expertise (psychiatrists, psychologists, occupational therapists) and social workers from district or regional level at least once a month.

In every PHC facility there is a personnel member who has had continuing education in psychiatry or mental health (including community aspects) in the last year.

In every PHC facility there is at least one person trained in counselling and the management of victims of violence and rape.

The following will apply in terms of substance abuse:

1. Reduce school attendees admitting to drinking alcohol and smoking tobacco.
2. Reduce the use of illegal substances including cocaine, mandrax, methamphetamine, heroin and marijuana.
3. Reduce the consumption of alcohol and other drugs among women and especially pregnant women.
4. Identify, manage or refer high-risk users.

Standards

References, prints and educational materials

- Mental Health Care Act No. 17 of 2002 and its General Regulations.
- Mental health policy document for provinces.
- Admission procedures and relevant forms under current Mental Health Act.
- List of designated mental health facilities.
- List of facilities that conduct 72-hour assessments in the province.
- List of members of the Mental Health Review Board for the district.
- Child and Adolescent Mental Health Policy Guidelines.
- Rights and duties relating to mental health care users.
- List of visiting psychiatric personnel at nearest health centre, district hospital, psychiatric specialist hospital or outreach service.
- Mental health and substance abuse assessment guidelines as well as clinical management protocols for common mental disorders, including, but not limited to, major depression, anxiety disorders, suicide, substance abuse and acute psychosis.
- Psycho-social rehabilitation checklist for community work.

- Checklist for daily living skills for rehabilitated patients.
- Emergency medication protocol in line with the current Essential Drug List for Primary Health Care.
- 24-hour access to telephone or radio to psychiatric unit or district hospital or nearest mental health hospital.
- Posters and pamphlets on mental health, severe psychiatric conditions, available services in a local language.
- Health learning materials on alcohol, cannabis, mandrax and other drugs in local languages.

Equipment

Standard equipment for PHC facilities.

Medicines and supplies

- Emergency and routine medication provided according to protocol and EDL.
- Monitoring of blood levels from patients on specific treatment has been conducted, for example, patients on Lithium, Clozapine, Tegretol.
- Psychotropic drugs available at the PHC facility.

Competence of health personnel

Recognising mental illness

- PHC facility personnel consider risk factors for mental health within their catchment area: poverty, social power, unemployment, ill-health, homelessness, migrancy, immigrants, isolated persons, HIV positive persons. PHC facility personnel are trained in conducting a bio-psychosocial assessment.
- Personnel identify and provide appropriate interventions for patients with depression, anxiety, stress-related problems, domestic violence, substance abuse and special needs of women (childbearing, abortion, sterilisation, disability, malignancy). PHC facility personnel are trained on the different categories of mental health care users (voluntary, assisted, involuntary mental health care users as well as State patients and mentally ill prisoners).
- PHC facility personnel recognise the expression and signs of emotional distress and mental illness early (especially in young patients or in relapse of a psychiatric condition).
- Personnel are trained on monitoring adherence to chronic medication, State patients' leave of absence, conditions for conditional discharge and conditions for involuntary outpatient care.
- PHC facility personnel participate in the promotion of healthy lifestyle among PHC facility attendees and the community.
- Patients needing detoxification for substance abuse withdrawal symptoms have entry to PHC facility care via NGOs, teachers, employers, traditional healers and/or police; are referred rapidly to general hospitals with detoxification facilities; and have a social worker to arrange follow-up and social reintegration on discharge.

Organising services

- Personnel organise the PHC facility to have specific clinic times set aside for booked interviews.
- Personnel provide prompt help from, or at, the PHC facility if a patient's condition in the community deteriorates.
- Personnel ensure time is allocated for home visits to patients who have returned from mental hospital.
- Personnel ensure there is no segregation or stigmatisation at the PHC facility of patients who have to use other services, for example, family planning, antenatal care.
- Personnel arrange access to a consistent member of personnel for each consultation.

Managing care

- Specially trained personnel are able to:
  - Maintain relationships with patients that are just, caring and based on the principles of human rights.

- Perform an adequate medical examination which:-
  - Identifies the general mental state, for example, psychotic or depressed.
  - Identifies the severity and level of crisis.
  - Rules out organic illness.
  - Records temperature and blood glucose level.
- Take a history that includes previous service use such as admission to hospital.
- Take a family history and evaluate support.
- Develop a sustained therapeutic relationship with patients and their families.
- Know and implement standard treatment guidelines especially the section on delirium with acute confusion and aggression, acute psychosis and depression.
- General nurses are able to:
  - Detect and provide services for severe psychiatric conditions as a component of comprehensive Primary Health Care.
  - Make appropriate and informed referrals to other levels of care.
  - Provide basic psychiatric care and assess urgency and severity of symptoms.
  - Provide individual community maintenance and care for stable long-term patients who have severe psychiatric conditions and have been discharged from hospital.
  - Provide each stable long-term user with individualised comprehensive care which includes:
  - An ongoing assessment of mental state, functional ability and social circumstances.
  - Familiarity with the internationally recognised diagnostic system:
    - An ability to detect and monitor distress and relapse.
    - An ability to provide basic counselling and support to patient and family.
- A basic knowledge of the criteria and pathways for referral for disability grants.
  - Knowing community referral and support organisations.
  - The follow-up of all cases returned to community after hospitalisation and keeping a register.
  - An ability to use records to facilitate continuity of care, such that:-
  - The condition of patients in the community is monitored and poor compliance, functional deterioration, substance abuse and family conflict or community ridicule are identified.
  - The onset of mental deterioration in HIV positive patients is recognised.
  - The prescription of sedation for aggressive or violent patients only as appropriate when other measures fail.
  - Coping with disturbed, intoxicated, aggressive suicidal behaviour without resorting to the use of undue physical restraint.
  - PHC facility personnel provide patient and caregiver satisfaction with assistance in alleviating family burden, achieving social integration, improving quality of life and general functioning while improving symptoms.
  - PHC facility personnel conduct consultations in privacy and in a confidential way and informed consent is obtained for communication to others.

Referral

- Referral pathways to other levels or types of care are known and expedited.
- Resource directory is available which provides information on community-based facilities for disabilities under the auspices of the Department of Social Development.

Patient education

- Patients, relatives and the community receive high quality information on mental health and mental illness.
- Patients and their supporters are given individualised education when their situation is reviewed.
- Patients and their supporters are educated on how to recognise predisposing factors and conditions to prevent relapse.
- PHC facility personnel use education in the family and community to address ignorance, fear and prejudice regarding patients with severe psychiatric conditions attending the PHC facility.
- Record the number of health talks conducted in the last month.
- Record the number of outreach activities undertaken by the facility in the last month.
- Record the number of Non Government Organisations or Community Based Organisations attached to the PHC facility.

Records

- Records are kept according to protocol with emphasis on confidentiality and accuracy.
- A register of psychiatric patients in the community is maintained.
- Personnel record mental health indicators on:-
  - The number and mix of cases.
  - The frequency of contact.
- Personnel analyse indicators and develop appropriate action.

Community and home-based activity

- Personnel participate in community awareness programmes for mental health according to the national and international calendar.
- Personnel participate in the training of family and carers of patients to plan an active role in their rehabilitation.
- Personnel encourage patient and caregiver support groups in communities.
- Personnel keep the addresses and phone numbers of people assisting with mental health and social problems (e.g. women's shelters, community self-help groups).

Collaboration

- Personnel respect and, where appropriate, seek collaborative association with local traditional healers.
- Personnel collaborate with all community services such as crisis counselling (lifeline, priests with counselling skills) and mental health groups, especially those for youth.
- Personnel collaborate with the hospital for planning discharges to the community.
- Personnel collaborate with other sectors like education, correctional services, labour and welfare as well as other relevant NGOs and CBOs to improve mental health.

Collaboration with community-based residential and day care mental health facilities that refer mental health care users to the facility for follow-up care.

Checklist: Mental Health and Substance Abuse

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

	TICK APPROPRIATE BOX [√]	
1. Has an update on Mental Health/illness being provided for personnel in the last 12 months?	Y	N
2. Are Policies and Guidelines on mental health as well as the Act available?	Y	N
3. Are services available daily for:		
3.1. Known psychiatric patients?	Y	N
3.2. People in crisis?	Y	N
3.3. People requiring counselling?	Y	N
3.4. Mental health care users as referred to the Primary Health Care facility from other facilities/programmes	Y	N
4. Are records of attendance of psychiatric patients kept to enable follow-up of defaulters?	Y	N
5. Does a psychiatric team visit this facility to consult and attend to referred patients?	Y	N
6. How often?	Weekly #	Monthly #
7. Does the PHC facility have a mechanism for evaluating the service?	Y	N
8. Is there collaboration with other stakeholders?	Y	N
9. Is the Mental Health Care Act No. 17 of 2002 and its General Regulations available?	Y	N
10. List of designated mental health facilities in the province?	Y	N
11. List of facilities that conduct 72-hour assessments in the province?	Y	N
12. List of members of the Mental Health Review Board?	Y	N
13. Child and Adolescent Mental Health Policy Guidelines?	Y	N
14. Resource Directory on Disability which provides community-based facilities for those with disabilities?	Y	N

Promotion of Mental Health and Prevention of Mental Illness		
15. Are personnel actively involved in promoting mental health, through education on:		
15.1. Substance abuse?	Y	N
15.2. Stress management?	Y	N
15.3. Parenting education?	Y	N
15.4. Life skills education?	Y	N
15.5. Early signs and symptoms of mental disorder?	Y	N
15.6. Correct use of medication?	Y	N
15.7. Healthy lifestyle?	Y	N
15.8. Violence and rape?	Y	N
15.9. Suicide?	Y	N
15.10. Awareness campaigns?	Y	N
15.11. Child and Adolescent Mental Health assessment?	Y	N

Early Detection		
16. Are CHWs given information regularly about mental illness?	Y	N
17. Are CHWs involved in the follow-up of defaulters?	Y	N
18. Are the practitioners trained to detect early signs of mental illness?	Y	N
19. Is crisis intervention counseling available at this PHC facility?	Y	N
20. Could a client in crisis receive continuity of care from the same practitioner?	Y	N
21. Are people with symptoms of mental illness given a full physical examination and history, including neurological system, blood glucose, signs of substance abuse?	Y	N

Referral System

22. Are written referral protocols accordingly to the Mental Health Act (17/2002) available?	Y	N
23. Is in-depth individual/family counseling available?	Y	N
24. Is there a private office for such counselling?	Y	N
25. Is feedback received on mental health users who are granted leave of absence?	Y	N
26. Are there procedures to manage readmission of mental health users who absconded from hospitals, once they are found?	Y	N
27. Does the PHC facility report to the referring institution that a patient has been transferred/moved/or referred for outpatient care?	Y	N
28. Are there procedures on captured mental health users who absconded from hospitals?	Y	N
29. Does the PHC facility report to the referring institution on whether a patient who has been transferred/moved/referred in resumed outpatient care?	Y	N
30. Are patients referred for psychosocial rehabilitation?	Y	N
31. Is there a psychosocial rehabilitation group available for all mental health care users in the district?	Y	N
32. Are patients on medication referred for six-monthly reviews for assessment and renewal of prescription?	Y	N
33. Is feedback received informing the PHC facility of their role in continuation of care?	Y	N
34. Is feedback received concerning patients discharged from hospital?	Y	N
35. Have there been any problems regarding emergency admission for patients?	Y	N
35.1. If yes, how have these been solved (or not)?		

Treatment

36. Is medication available to patients who require medication not on PHC EDL?	Y	N
37. Does this PHC facility take routine blood from patients requiring monitoring, such as patients on Lithium, Clozapine, Tegretol?	Y	N
38. Are results received within seven days?	Y	N
39. Are the blood results seen by the doctor and treatment reviewed accordingly?	Y	N
40. Is emergency treatment of major side effects available?	Y	N
41. Are there "standing orders" on the administration of psychiatric drugs for psychiatric emergencies?	Y	N
42. Is emergency treatment for acute psychosis available using EDL?	Y	N
43. Are patients and their families educated about the side-effects of the medication?	Y	N
44. Are complaints from patients managed by the nursing personnel?	Y	N
45. Is privacy for patients maintained?	Y	N
46. Is it possible for a psychiatric patient to see the same health worker, to provide continuity of care?	Y	N
47. Are there support groups for patients and their families?	Y	N
48. Are home visits conducted?	Y	N

Records

49. Is there a register of psychiatric patients with the required information available?	Y	N
50. Is the register maintained confidentially?	Y	N
51. How many psychiatric patients does this PHC facility attend to?	#	
52. Are the mental health indicators recorded?	Y	N
53. What is the frequency of contact with patient?		
54. What is the average contact time each patient has with a health worker during the PHC facility visit (minutes)?	#	
55. Is there an individual patient file?	Y	N

56. Are there PHC facility activity statistics that correspond to the MDS?	Y	N
57. Is there a medicine control register?	Y	N
58. Is there a system of tracing defaulters and how to manage them?	Y	N
59. Is a system for periodical reports for outpatient involuntary mental health care users and State patients on conditional discharges in place?	Y	N
60. Is there a system of transmitting statistics on mental health care users through to the Province?	Y	N

NOTES:

ACTIONS TO BE TAKEN BY PHC FACILITY

Supervisor signature:	
PHC facility manager signature:	
Date:	

5.10 School health services

Basic considerations

The School Health Service is expected to provide services that promote good health by acting in a co-ordinating role, and making use of the skills and capacity in different sectors of society, including the community, the learners themselves, educators and NGOs.

Standards set for the School Health Service need to take into account the diverse situation of schools, the current state of school health services, and the changing philosophy introduced by the education sector, including outcomes-based education and inclusive education. The introduction of the philosophy of inclusive education means that children with barriers to learning will be included in ordinary schools and that the schools and communities will have to be developed to provide acceptable services for these children. Teachers generally do not have the capacity to deal with children who experience barriers to learning, and the school health services can play a role in enabling teachers to identify and integrate these children into the classroom. School Health personnel may not have the capacity to implement their new role so a transformation/training programme is required. New resources for school health promotion need to be developed and funded. The School Health Teams are becoming an integral part of the primary health team and are intra-sectoral (i.e. they work with other sections of the Health Department).

These recommended standards are based on the assumption that the Primary Health Service is built on the Sub-district approach to service delivery.

Service description

The school health service is a health promotion service dealing with the individual in the context of the family and community and within the school environment. The service encourages the school to develop and implement school policies that promote and sustain health, improve the physical and social environment within which children learn and develop, and improve children's capacity to become, and stay, healthy.

Norms

1. Each sub-district has a minimum of one School Health Promoting Team.
2. Every PHC facility will be able to access a specially trained nurse on school health within the district.
3. District School Health Promoting Teams are supported at provincial level with an appropriate, effective transformation training programme. The development of standardised resource packs and the training occurs during those times of the year when schools are closed.
4. Screening Programmes are provided to give adequate coverage to identify all children at risk of barriers to learning, and are not limited to certain age groups.
5. The School Health Promoting Service creates a positive learning environment, by identifying barriers to learning, and developing ways to remove these barriers in a community-inclusive way.
6. School Health Promotion Programmes promote acceptance and celebration of diversity among individuals through a learner-centred approach.
7. An accessible, healthy physical and social environment in which children can learn is promoted.

Standards

References, prints and educational material

- A standardised questionnaire for use by teachers to screen for the presence of factors causing barriers to learning in the individual ("School Readiness Screening Pilot: April – July 1997; "School and Youth Health Directorate"; and a questionnaire developed by an Intersectoral team in the Ladysmith Region of KwaZulu-Natal).
- A standardised questionnaire for use by school health promoting teams to assist in detecting barriers to learning in the environment of the learner (for example, the draft of "The Index - an

instrument to assess Health Promoting Schools in South Africa").

- A resource register for the district for use by School Health Promotion Teams and Educators, by which available health services can be identified, and how they can be accessed, to be compiled by each district and regularly updated.
- Health promoting educational materials in the local language, accessible to people with disabilities, including films, videos, posters, booklets, visual aids and audiotapes.

Equipment

- As for mobile teams.
- Projector, video recorder, slide projector, white boards and audiotapes.
- Access to administrative support, including typing services, telephone and fax, photocopying services, stationery and appropriate transport for the environment.

Medicines, supplies and assistive devices

- Access to medication for control of specific disease conditions identified at district level, such as prevention of blindness from trachoma, treatment of scabies outbreak.
- Assistive devices for daily living for people with disabilities (such devices, if required to access education, are supplied by the Department of Education).

Competencies

The School Health Promoting Team is able to:

- Function as an effective and efficient team.
- Promote the whole person and lifestyle skills development of pupils and educators.
- Identify resource people and involve them to promote the transformation.
- Promote community participation and the participation of all stakeholders in programmes, for example, Participatory Learning and Action (PLA) skills.
- Plan and implement health promoting programmes.
- Apply and interpret the screening questionnaires for individuals and schools and transfer these skills to the teachers.
- Identify gaps in the service and barriers to learning.
- Promote healthy nutrition, mental health and reproductive health.
- Provide counseling for substance abuse and to victims of violence, including rape.
- Identify and seek to reduce stress.
- Promote healthy sexuality and deal with the results of unhealthy sexual behaviours.

Patient education

- Address health risk behaviours with the provision of behaviour-specific knowledge and opportunities to practice knowledge and skills.

Referral

- Refer to nearest PHC facility service, the students that require more intense PHC facility assessment and management.

Records

- An information system at all levels of the service, which informs the different sectors to make effective use of existing services, identifies gaps in the service and monitors the progress toward the development of Health Promoting Schools.

Community-based activities

- Promote the development of child-to-child programmes as an important resource.
- Work with school governing bodies to promote activities in the community, such as reading circles, cultural activities, and sporting activities.

Collaboration

- PHC facility personnel collaborate with, and involve officials from, the departments of health, welfare, education and agriculture, as well as educators, learners, parents, community leaders, CBOs and NGOs.
- School Health Promoting Teams are intra- and inter-sectoral.

Checklist: School Health Services

School services team:		Date:	
District and subdistrict:		District code:	
Supervisor/programme manager name:	Please print name	Signature:	

Note: School Health Teams should include:

- School Health Nurses
- Nurse Assistant
- Enrolled Nurse
- Health Promoter

All school health records, e.g. Consent forms, Statistical data, number of schools per team are available.

REMARKS:

1. Area covered	Name and level of school	Partially covered	Phase 1	Phase 2	Phase 3

Health facility/facilities linked with:

2. Training Needs:	
2.1. Professional Nurse	
2.2. Nurse Assistant	
2.3. Enrolled Nurse	
2.4. Health Promoter	

3. Norms:			
3.1. School Health Nurse	Phase 1: 5 000 learners	Phase 2: 5 000 learners	Phase 3: 5 000 learners
3.2. Health Promoter	Phase 1: 20 to 25 000 learners	Phase 2: 15 000 learners	Phase 3: 10 500 learners

4. Policies and Guidelines		
4.1. Latest School Health Policy & Guidelines available?	Y	N
4.2. Latest Guidelines: Environmental Health Officer engaged in School Health Services available?	Y	N
4.3. Other (Specify)		

5. Equipment and Transport	Number Available	Calibrated/ Maintained	Need	Remarks
5.1. Audiometer				
5.2. Vision Eyes: Plus lens and wheel of vision				

5.3. Scales (measure Body Mass Index (BMI))				
5.4. Measuring tapes (Height measures)				
5.5. Snellen chart: E - Chart				
5.6. Snellen chart: Alphabet Chart				
5.7. Stethoscopes				
5.8. Baumanometer				
5.9. Different baumanometer size cuffs available (small/medium/large cuffs)				
5.10. Diagnostic set				
5.11. Transport - available daily				
5.12. Official Stamp available				
5.13. Other (Specify)				

6. Communication and Reporting Lines

6.1. Name of Supervisor:				
6.2. Reporting to: - Name and title				
6.3. Attendance Register completed	Y		N	
6.4. At which PHC facility/facilities do the School Health personnel work during the holiday period?				
6.5. List of responsibilities and duties performed during holiday period, i.e. at 6.4 above				
6.6. Record (summary) of all activities performed during the holiday period				
Reports submitted to:				

7. Planning		
7.1. Contact details of Department of Education (District Office)	Y	N
7.2. List of schools in the area, with full contact details	Y	N
7.3. System to obtain information for 10th day enrolment	Y	N
7.3.1 Obtain from school	Y	N
7.3.2 Obtain from Deparatment of Education	Y	N
7.4. 10th day enrolment available	Y	N
7.5. Year Plan available (subject to change)	Y	N
7.6. School Holiday programme available	Y	N
7.7. Calibration of audiometers (Annual process VA 2)	Y	N
7.8. List of stationery available	Y	N
7.9. Stock-outs of stationery experienced	Y	N

8. Health Records and Statistics		
8.1. School Health Record (Check accuracy and completeness of 10 records)	Y	N
8.1.1 Vision recorded (R) & (L) 6/6	Y	N
8.1.2 Hearing chart (R) & (L) - decibels ticked	Y	N
8.1.3 Orthropometric: weight & height recorded	Y	N
8.1.4 Oral health: caries, gums	Y	N
8.1.5 Physical examination	Y	N
8.1.6 Counselling	Y	N
8.1.7 Networking, liaison and communication with parents	Y	N
8.1.8 Problem identification and child abuse	Y	N
8.1.9 Referrals	Y	N
8.2. Referral forms (Check accuracy and completeness of 10 records)	Y	N
8.3. Other (specify)	Y	N
8.4. Daily statistical collection tool – Available and filled in daily	Y	N
8.5. Monthly statistical report – Available and completed fully and correctly	Y	N
8.6. Quarterly report – Available and completed fully and correctly	Y	N
8.7. Flow of data: - Explain Y N	Y	N
8.8. Is data used for planning and decision-making?	Y	N

9. Referrals		
9.1. Knowledge of/or access to Referral Criteria	Y	N
9.2. Knowledge of Resources	Y	N
9.3. System in place to follow-up referrals	Y	N
9.4. System to follow-up referral to Optometrist for spectacles	Y	N
9.5. Referrals received from Optometrist.	Y	N
9.6. System to follow-up detected defects	Y	N

10. Collaboration		
10.1. Collaboration with other Departments	Y	N
10.2. Education	Y	N
10.3. Social Services	Y	N
10.4. SA Police & Correctional Services	Y	N
10.5. NPOs, NGOs, SANCA	Y	N
10.6. Rehabilitation teams	Y	N
10.7. Other	Y	N

11. Health Education		
11.1. Record of Health Education given (indicate topic)	Y	N
11.2. Plans according to Health Calendar & Needs	Y	N
11.3. Liaise with Health Promoting Schools	Y	N
12. ENVIRONMENTAL HEALTH SERVICES		
12.1. Environmental Health Services available at schools	Y	N
12.2. Frequency of inspections	Y	N
12.3. Liaise with EHP	Y	N

NOTES:

ACTIONS TO BE TAKEN BY PHC FACILITY

Supervisor signature:	
PHC facility manager signature:	
Date:	

5.11 Oral health

Service description

The Basic Primary Oral Health Care Services at PHC facility level should as a minimum consist of promotive and preventive oral health services (oral health education, tooth-brushing programmes, fluoride mouth-rinsing programmes, fissure sealant applications, topical fluoride application); and basic treatment services (an oral examination, bitewing radiographs, scaling and polishing of teeth and simple fillings of 1-3 tooth surfaces, including Atraumatic Restorative Treatment (ART)) and emergency relief of pain and sepsis (including dental extractions).

Norms

- Expose at least 50% of primary schools to organized school preventive programmes.
- 2. Everybody in the catchment area is covered by basic treatment services.

Standards

References, prints and educational materials

- National Oral Health Policy/Strategy.
- National Norms, Standards and Practice Guidelines for Primary Oral Health Care.
- Provincial Operational Oral Health Policy/ Strategy.
- Oral Health Promotion Framework.
- Oral health education material in appropriate languages.

Equipment

- Dental unit complete with chair, light, delivery unit with hand pieces, suction and compressor
- Aseptic trolley
- Dental Autoclave
- Amalgamator
- Dental X-ray unit
- Intra-oral X-ray film processor
- X-ray view box
- Lead apron
- Ultrasonic scaler
- Dental operating stool (2)
- Dental hand instruments (refer to the National Norms, Standards and Practice Guidelines for Primary Oral Health Care)
- Portable dental equipment and/or mobile dental units where fixed facilities are not available.
- Composite Curing Light
- Washer disinfector

Medicines and supplies (for details of material required, refer to 1.2 above)

- Medicine according to the EDL
- Local anaesthetic materials
- Exodontia and oral surgery procedure materials
- Prophylaxis materials
- Conservative procedure materials

Competence of health personnel

- The dental assistant is competent to do patient administration, surgery cleanliness and infection control, oral health education, as well as chair-side assisting.
- The oral hygienist is competent to conduct oral health education, oral examination, apply fissure sealants, topical fluorides, scaling and polishing and taking of intra-oral x-rays.
- The dental therapist is able to carry out oral hygienist competencies as well as tooth extractions and simple 1 to 3 surfaces filling of teeth.

Referrals

- All patients whose needs fall beyond the scope of services provided at the PHC facility are referred to the next level of care.

Patient Education

- All patients receive oral health education.

Records

- Patients' records.
- Patient register.

Community Based Services

- Oral Health Promotion should be integrated into PHC oral health promotion
- School oral health programmes consist of oral health education, tooth-brushing, fissure sealant application and Atraumatic Restorative Treatment (ART).

Collaboration

- Collaboration with other departments: Education, Water Affairs, and Forestry and other programmes within health such as Child Health, Health Promotion, Environmental Health, Nutrition, Communications.

Checklist: Oral Health

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

1. Availability of services	Daily	Special days
1.1. Emergency Services available	Y	N
1.2. Daily check and control of emergency tray and oxygen apparatus	Y	N
1.3. Protocols and policies available:		
1.3.1 National Oral Health strategy/policy?	Y	N
1.3.2 Provincial Operational Oral Health Strategy?	Y	N
1.3.3 National Norms, Standards and Practice Guidelines for Primary Oral Health Care?	Y	N
1.3.4 National Oral Health Policy?	Y	N
1.3.5 National Oral Health Strategy?	Y	N
1.3.6 Commuted Overtime Protocol?	Y	N
1.3.7 Referral System?	Y	N
1.3.8 Application forms for Dental Services?	Y	N
1.3.9 Patients' Rights Charter displayed?	Y	N
1.3.10 Complaints Procedure displayed?	Y	N
1.3.11 Batho Pele principles displayed?	Y	N
1.3.12 Oral Health education materials such as posters, pamphlets?	Y	N

PHC Facility Oral Management of Adults

2. Are oral health personnel doing the following:		
2.1. Consultation?	Y	N
2.2. Extraction:	Y	N
2.2.1 Simple?	Y	N
2.2.2 Surgical?	Y	N
2.3. Restorations?		
2.4. Amalgam?	Y	N
2.5. Composite?	Y	N
2.6. Prosthetics?		
2.7. Acrylic dentures?	Y	N
2.8. Scaling and polishing?	Y	N
2.9. Taking of intra-oral X-rays?	Y	N

PHC Facility Oral Management of Children

3. Are oral health personnel doing the following:		
3.1. Consultations?	Y	N
3.2. Extractions?	Y	N
3.3. Atraumatic Restorative Technique?	Y	N
3.4. Composite or Amalgam Restorations?	Y	N
3.5. Taking of Intra-oral X-rays?	Y	N
4. Orthodontic appliances		
4.1. Fixed	Y	N
4.2. Removable	Y	N
4.3. Local anaesthesia	Y	N

5. Equipment Availability and Functionality		
5.1. Dental Chair & Light	Y	N
5.2. Suction system	Y	N
5.3. Compressor	Y	N
5.4. Autoclave	Y	N
5.5. Amalgamator	Y	N
5.6. Curing White Light	Y	N
5.7. Ultrasonic scaler	Y	N
5.8. X-Ray unit	Y	N
5.9. Dental operator chairs	Y	N

6. MEDICINES		
6.1. Tablets, capsules and injectables:	Y	N
6.1.1 Amoxycillin 250 mg capsules	Y	N
6.1.2 Amoxycillin 500mg capsules	Y	N
6.1.3 Phenoxymethyl penicillin 250mg tablets	Y	N
6.1.4 Erythromycin 250 mg tablets	Y	N
6.1.5 Ibuprofen 200mg tablets	Y	N
6.1.6 Paracetamol 500mg tablets	Y	N
6.1.7 Metronidazole 200mg tablets	Y	N
6.1.8 Factor VIII and IX	Y	N
6.2. Syrups	Y	N
6.2.1 Amoxycillin 100ml 125mg/5ml	Y	N
6.2.2 Amoxycillin 100ml 250mg/5ml	Y	N
6.2.3 Phenoxymethyl penicillin 100ml 250mg/5ml	Y	N
6.2.4 Erythromycin 100ml 125mg/5ml	Y	N
6.2.5 Metronidiazole 50ml 200mg/5ml	Y	N
6.2.6 Metronidiazole 100ml 200mg/5ml	Y	N
6.2.7 Paracetamol 50ml 120mg/5ml	Y	N
6.2.8 Chlorhexidene mouthwash 0.2% 50ml	Y	N

7. Patient Transfers		
7.1. Does the PHC facility have a mechanism to ensure that transferred out patients have reached their intended destination?	Y	N
7.2. Does the PHC facility report to the referring institution that the referred patient has reached his/ her destination?	Y	N

8. Personnel Management		
8.1. Attendance Register completed	Y	N
8.2. Leave forms submitted	Y	N
8.3. Personnel meetings held	Y	N
8.4. Telephone available	Y	N
8.5. Transport available	Y	N
8.6. Dosimeter used	Y	N

9. PHC Facility Management		
9.1. X-ray register checked	Y	N
9.2. Daily statistics	Y	N
9.3. Monthly statistics	Y	N
9.4. Repairs & maintenance records kept	Y	N
9.5. Sharps disposal correct	Y	N
9.6. Mercury disposal correct	Y	N
9.7. Infection control maintained	Y	N

10. Community Based Services		
10.1. Is oral health promotion integrated into PHC facility health promotion?	Y	N
10.2. Are there any school oral health programmes in place?	Y	N

5.12 Victims of abuse and violence

Service description

The service requires co-operation between the health sector, the police and the Department of Justice. It provides counselling and referral of victims, STD prophylaxis and HIV testing, emergency contraception, care of injuries, medico-legal advice and documentation of evidence.

Norms

Every PHC facility has established working relationships with the nearest South African Police Service facility, as well as social welfare service by having visits from them at least twice a year. Personnel of every PHC facility have received training in the identification and management of sexual, domestic and gender-related violence. The training includes gender sensitivity and counselling skills.

Standards

References, prints and educational materials

- All relevant guidelines/protocols related to women's health issues.
- A suitable library of references and journals on sexual offences, domestic and gender violence.
- The PHC facility has a list of names, addresses and telephone numbers of the nearest accredited health care practitioners, police and social workers who would be involved in dealing with these patients.
- The PHC facility has a list of names and addresses of NGOs or other organisations (e.g. CBOs), which undertake appropriate counselling (e.g. FAMSA, ATIC) for violence, child abuse and sexual offences.

Equipment

- There is a room available at short notice for private, confidential consultations.

Medicines and supplies

- Emergency contraceptive pills.

Competence of health personnel

- The identified/assigned PHC facility personnel fast-track in a confidential manner any rape victim to a private room for appropriate counselling and examination.
- The personnel always include a question on gender violence when taking the history from women with depression, headaches, stomach pains or a known abusive partner.
- The personnel include sensitive probing of the domestic situation in taking histories of children with failure to thrive, recurrent episodes of trauma or behavioural problems.
- All patients of sexually transmitted disease in children are managed as patients of sexual offence or abuse.
- When a person presenting at a PHC facility alleges to have been raped or sexually assaulted, the allegation is assumed to be true and the victim is made to feel confident they are believed and are treated correctly and with dignity.
- A detailed medical history is recorded on the patient record card and a brief verbal history of the alleged incident is taken and noted – with an indication that these are not a full account. These notes are kept for 3 years.
- Personnel explain that referral is necessary to an accredited health practitioner and arrangements are made expeditiously. While awaiting referral, emergency medical treatment is given with the consent of the victim, such as prophylactic treatment against STD and post-coital contraception.
- The victim is given information on the follow-up service and the possibilities of HIV infection and what to discuss with the accredited health practitioner at the hospital or health centre.
- The personnel, even though non-accredited, are not prohibited from dealing with rape victims but must keep patient records.

- Victims are not allowed to wash before being seen by an accredited health practitioner.
- A female health worker attends to women who have been raped or abused and if this is not possible (for example, a male district surgeon comes to the PHC facility) then another woman must be present during the examination.
- The victim is given brief information about the legal process and the right to lay a charge.
- If the victim now indicates a desire to lay charges, the police are called to the PHC facility.
- PHC facility personnel inquire if charges will be, or have been, laid with the SA Police Service.

Checklist: Victims of Abuse and Violence (Forensic and Medico Legal Services)

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

	TICK APPROPRIATE BOX [√]			
1. Service Availability at PHC Facility				
1.1. When are services available?	Daily i.e. 8hours	12hours	24hours	N/A
1.2. Have personnel received training in the management of:				
1.2.1 Rape and sexual abuse?			Y	N
1.2.2 General child abuse?			Y	N
1.2.3 Assault?			Y	N
1.2.4 Gender violence and sensitivity?			Y	N
1.2.5 Driving under the influence of drugs and alcohol?			Y	N
1.2.6 Mental status evaluation?			Y	N
1.2.7 Age estimation?			Y	N
1.2.8 Disability grant evaluation?			Y	N
1.3. If No – which category of personnel needs training?			Doctors	Nurses
1.4. Is there a facility to refer clients to?			Y	N
1.5. Is the referral system effective?			Y	N
1.6. Is there a Fast Line service available?			Y	N

2. Service Quality		
2.1. Does the PHC have a victim-friendly service area/room?	Y	N
2.2. Is the consultation area for persons under arrest well-secured?	Y	N
2.3. Are showering/washing facilities available?	Y	N
2.4. Are clients attended to in a supportive, friendly manner?	Y	N
2.5. Are there change-of-clothing packs available?	Y	N
2.6. Is there always a female health worker/professional nurse present during the examination?	Y	N

3. Counselling and Referrals		
3.1. Is there a list of local names, addresses and contact numbers of NGOs and other organizations which undertake appropriate counselling, and is this available to the client?	Y	N
3.2. Is there a list of names, addresses and contact numbers of the nearest accredited health care practitioners, police stations and social workers who would be involved in dealing with these patients?	Y	N
3.3. Are there guidelines on information that is expected to be covered by personnel during counselling sessions?	Y	N
3.4. Is there information on medical issues such as HIV, AIDS, STI, post-sexual contraception prophylaxis?	Y	N
3.5. Is there information on legal issues such as Family Violence Act, Child Care Act?	Y	N

4. Documents and Equipment: Is the Following Equipment Available?		
4.1. Light source	Y	N
4.2. Patient scales	Y	N
4.3. Measuring tape	Y	N
4.4. Stethoscope (adult & paediatric diaphragm)	Y	N
4.5. Blood pressure apparatus	Y	N
4.6. Reflex (patella) hammer	Y	N
4.7. Crime kits	Y	N
4.8. Sterile vaginal speculae (different sizes)	Y	N
4.9. Disposable gloves (different sizes)	Y	N
4.10. Long straight artery forceps	Y	N
4.11. Disposable wooden tongue depressors	Y	N
4.12. Small kidney dish	Y	N
4.13. Swab holding forceps with sterile swabs	Y	N
4.14. Mosquito forceps (curved)	Y	N
4.15. KY jelly	Y	N
4.16. Specimen gFass slides (with labels)	Y	N
4.17. Specimen cover-slips	Y	N
4.18. Tubes for blood samples	Y	N
4.19. Needles and syringes for blood samples	Y	N
4.20. Pus swabs	Y	N
4.21. Urine specimen bottles	Y	N
4.22. Adhesive labels	Y	N
4.23. Nail clipper or scissors	Y	N
4.24. Disposable underwear	Y	N
4.25. Sanitary pads/tampons (different sizes)	Y	N
4.26. 10cc sterile normal saline water	Y	N
4.27. Reliable pregnancy test strips	Y	N
4.28. Rapid HIV test kit	Y	N
4.29. Diagnostic set, including auto scope with removable truncated ear canal piece, five times magnification	Y	N

5. Are the following documents available?		
5.1. Policy and Protocols on PHC facility forensic & Medico Legal Services	Y	N

6. Are the following forms available?		
6.1. SAP 308	Y	N
6.2. SAP 308 a	Y	N
6.3. Amended 308(a) (Road block)	Y	N
6.4. Injury Report	Y	N
6.5. J88	Y	N
6.6. Drunken Driver Report	Y	N
6.7. Mental Status Evaluation	Y	N
6.8. Age Estimation	Y	N
6.9. Confirmation of Gender	Y	N
6.10. Notification of Child Abuse and Malnutrition	Y	N
6.11. Referral letter for trauma counselling	Y	N
6.12. Referral letter for HIV testing and counselling	Y	N
6.13. Court subpoena	Y	N
6.14. Consent form for HIV test	Y	N

7. Medicine and Supplies: Are the following EDL drugs available?		
7.1. Ciprofloxacin 500mg	Y	N
7.2. Doxycline 100mg	Y	N
7.3. Metronidazole 250mg	Y	N
7.4. Erythromycin 250mg tabs	Y	N

7.5. Benzathine Penicillin 2,4mg injection	Y	N
7.6. Erythromycin Suspension	Y	N
7.7. Metronidazole Suspension	Y	N
7.8. Cephtriaxone injection	Y	N
7.9. E Gen-C/Ovral	Y	N
7.10. Antiretroviral treatment tablets/capsules	Y	N

8. History and Initial Visit

8.1. Is the history recorded according to protocols?	Y	N
8.2. Is the gynaecological examination performed according to medico-legal protocols?	Y	N
8.3. Has the height and weight been recorded?	Y	N
8.4. Has a pregnancy test been performed?	Y	N
8.5. Has the relevant information and patient numbers from the J88 form been recorded on the patient file?	Y	N

9. Registers and Records

9.1. Are the following registers available and kept as prescribed by sections 12, 13, 14, 15, 16, 17 of the National Health Act, 2003 (Act 61 of 2003)?	Available		Completed Correctly	
9.1.1 Rape Register?	Y	N	Y	N
9.1.2 Child Abuse Register?	Y	N	Y	N
9.1.3 Drunken Driving Register?	Y	N	Y	N
9.1.4 Assault Register?	Y	N	Y	N

NOTES:

ACTIONS TO BE TAKEN BY PHC FACILITY

Supervisor signature:	
PHC facility manager signature:	
Date:	

5.13 Chronic diseases and geriatric care

Norms and standards

Referrals

- All patients are referred to the next level of care when their diagnosis and needs fall beyond the scope of competence as recommended by National protocols.
- All Health care personnel must have updated contact details of relevant experts in the area for advice.
- Health Care Providers/doctors keep detailed information on the frequency of follow-up visits - 1-3 monthly, 6-monthly and annually, for detailed examination.
- Patients suspected of having Diabetes Mellitus are referred to hospital for diagnosis.

Patient education

- All patients and caretakers are supported and their capacity developed regarding self-care, self-monitoring, compliance, prevention of complications and management of the disease.
- Education activities are sensitive to the cultural and economic realities of the patient and home.

Records

- Patient register of chronic conditions (Chronic Diseases Management Register), and treatment record.
- Patients' cards.
- Home-based care records.

Community-based services

- Health care personnel work with any district NGO and CBO dealing with chronic conditions.
- The Chronic Diseases Management Register is regularly analysed. The register will identify defaulters; will provide total number of disease-specific patients in the health facility to facilitate annual budgeting; will inform the health education/information policy; will inform disease management policies; and will identify trends in the community.
- Health education and information on modifiable risk factors, early recognition of symptoms and regular check-ups to be provided to the patients and communities.
- Educational activities are culturally and linguistically appropriate.
- PHC facility health care personnel approach the catchment area populations through community health committees, traditional leaders, NGOs, CBOs, youth groups and the church to reduce common risk factors operating in the community.
- Health care personnel facilitate the establishment and sustainability of active support groups.

Checklist: Chronic Care and Geriatric Care

PHC facility name:		**Date:**	
Name of clinic manager in print		**Signature:**	
Supervisor	Please print name	**Signature:**	

TICK APPROPRIATE BOX [√]

GUIDELINES

Availability

1. Are the following guidelines available?		
1.1. Non-Communicable Diseases – A Strategic Vision?	Y	N
1.2. Management of Epilepsy in Adults?	Y	N
1.3. National programme for control and management of hypertension at primary level?	Y	N
1.4. National programme for control and management of diabetes Type 2 at primary level?	Y	N
1.5. Management of asthma in adults at primary level?	Y	N
1.6. Prevention and management of overweight and obesity?	Y	N
1.7. Guidelines on primary prevention of chronic diseases of lifestyle?	Y	N
1.8. Management and control of eye conditions at primary level?	Y	N
1.9. Guidelines for cataract surgery in South Africa?	Y	N
1.10. Prevention of blindness?	Y	N
1.11. Refractive Errors Screening for 60 years and older?	Y	N
1.12. Palliative care in adults?	Y	N
1.13. Testing for prostate cancer?	Y	N

2. Health information material		
2.1. Information on female breast cancer for primary level health care providers	Y	N
2.2. Posters, pamphlets, videos, tapes	Y	N
2.3. Cervical Cancer Screening Programme	Y	N
2.4. Testicular cancer patient information	Y	N
2.5. Prostate cancer patient information	Y	N
2.6. Prevention of cancer and early warning signs of cancer patient brochures	Y	N
2.7. Good health practices - patient brochures	Y	N

Long-term/chronic care

3. Services required		
3.1. Does the PHC facility have a system to detect defaulting patients?	Y	N
3.2. Does the PHC facility have a system to follow up defaulting patients?	Y	N
3.3. Does the PHC facility arrange special times for the follow-up of chronic patients?	Y	N
3.4. Are there dedicated professional nurse/s attending to chronic patients	Y	N
3.4.1 When they come to the clinic patients should be, as far as possible, assigned to the same health care professional at each visit, is this the case?	Y	N
3.5. Is there a Fast Lane so that chronic patients do not wait in long queues?	Y	N
3.6. Waiting time: How long do NCD patients wait on average?		

3.7. Are there dedicated clinic services for chronic patients When? (Days and times) ..... Diabetes: ..... Hypertension: ..... Asthma: ..... Epilepsy:	Y	N
3.8. Is a chronic disease register available?	Y	N
3.9. Does the register indicate the following:		
3.9.1 Disease control?	Y	N
3.9.2 Adherence to treatment regimen?	Y	N
3.9.3 Disease progression?	Y	N
3.9.4 Complications?	Y	N
3.9.5 Defaulters?	Y	N
3.10. Are there any Support Groups for chronic patients and their families in the clinic or community?	Y	N
3.11. When do they meet?	Y	N
3.12. What do they do?	Y	N
3.13. What health education is provided?	Y	N
3.14. Are patients trained in self-care and disease management?	Y	N
3.15. If there are no Support Groups available, please state reasons:		
3.16. Are HbA1c tests performed as per the guideline?	Y	N
3.17. Are there doctors working/visiting in this clinic?	Y	N
3.18. If not, how are patients' consultations and six-monthly reviews handled/done?		

4. Referral system for chronic patients:		
4.1. Is there a referral form?	Y	N
4.2. Is there a specific 'upward' referral system?	Y	N
4.3. If **yes**, is it functional?	Y	N
4.4. Is there a specific 'downward' referral system?	Y	N
4.5. If **yes**, is it functional?	Y	N
4.6. Are patients referred according to the protocols/ guidelines?	Y	N
4.7. If **no**, how is the patient movement (up/downward) managed?		
4.8. Is there a transport plan linked to the referral system in place?	Y	N

5. Equipment					
5.1. Is the following equipment available / in good working order?		**YES**	**NO**	**NUMBER**	**WORKING ORDER**
5.1.1 Baumanometers					
5.1.2 Other BP machines					
5.1.3 Cuff sizes	Large				
	Medium				
	Small				
5.1.4 Stethoscopes					
5.1.5 Peak-flow meters					
5.1.6 Glucometers					
5.1.7 Glucostix / urine strips					
5.1.8 Ophthalmoscope					

5.1.9 Snellens Chart				
5.1.10 Adult scale and tape measure				
5.1.11 O_2 + Nebuliser				
5.1.12 Cholesterol machine				

5.2. Are there any patients with individual monitoring equipment?	Y	N
5.2.1 What has been provided?		
5.2.2 Glucometer	Y	N
5.2.3 Peak flow meter	Y	Y

6. Medication

6.1. Is all the medication for people with non-communicable chronic diseases available all the time according to the guidelines?	Y	N
6.2. Have you experienced any 'out of stock' chronic medication in the past 3 months?	Y	N
6.3. If yes state names		
6.4. Reasons for stock out		
6.5. How often does the health facility receive medicine deliveries?		
6.6. From where do the deliveries come?		
6.7. Who monitors medication availability, storage? (pharmacist, pharmacist assistants, drug co-ordinators)		

7. Human Resources and Development

7.1. Dedicated professionals must be suitably trained, carefully selected and not rotated.		
7.2. How often does the training of health care professionals happen in this Clinic?		
7.3. How often does training on priority chronic diseases take place?		
7.4. How is this training conducted (in-service/formal or external)?		
7.5. Is a training register available (recording previous training done)?	Y	N

8. Surveillance

8.1. What surveillance systems do you have in place for NCDs and associated risk factors to determine:
8.1.1 Magnitude?
8.1.2 Success of interventions?
8.1.3 Cost?
8.1.4 Impact?

NOTES:

ACTIONS TO BE TAKEN BY PHC FACILITY

Supervisor signature:	
PHC facility manager signature:	
Date:	

5.14 Rehabilitation services

Basic considerations

Rehabilitation services are an integral part of the services provided at the primary level. This reflects the reorientation of rehabilitation from mainly institution-based services to community-oriented and community-based services. Communities, and particularly people with disabilities, should be involved in designing, implementing and monitoring services for people with disabilities. A disability service should preferably not be viewed narrowly as a therapy service provided only by a certain category of staff. All health personnel, in co-operation with all other sectors and the communities/people themselves, are responsible for making society inclusive of all people, including people with disabilities.

The PHC facility is the first point where people with disabilities, their family members or caregivers meet health staff. PHC facilities therefore need to become creative in their approach to the problems experienced by these patients.

Service description

The purpose of rehabilitation at PHC facility level is to provide a service to prevent disabling conditions; to detect disabilities early so to prevent complications and the worsening of the effects of a disability on a person's functional ability; to treat disabling and potentially disabling conditions; and to provide access to rehabilitative services for people with disabilities, making them appropriate and acceptable.

The pivotal person at the PHC facility, through whom people with disabilities will access the rehabilitation service, is the PHC Nurse. The Therapy Assistant (Community) is the person providing the rehabilitation service at this level, in consultation with the visiting Therapist. The visiting generalist doctor is important in providing access to treatment of potentially disabling conditions, which would otherwise be difficult for people to access on a regular and affordable basis.

Specific rehabilitative services include a basic assessment of people with disabilities such as stroke, spinal injury, cerebral palsy, developmental delay, blindness, communication problems, arthritis, amputations, backache, followed by an appropriate treatment programme, in consultation with the disabled person and her/his family. Consumable assistive devices, such as continence devices, rubber ferrules and other aids to daily living are prescribed, provided and people trained in their use. Management of continence problems of patients with spinal cord injury, spina bifida, mental retardation, traumatic conditions and the elderly includes the supply of continence devices and devising continence programmes.

Patients are also assessed for disability and care dependency grant applications.

Norms

1. Improve access to comprehensive health services for the disabled. (National: Year 2000 Goals, Objectives and Indicators.)
2. Have a responsive and area-specific disability information system in place, which will feed into the general information system of the district and PHC facility.
3. Institute a functional referral system between the community–PHC facility–district hospital, as well as other relevant sectors.
4. Institute a system of obtaining, repairing and maintaining essential assistive devices for rehabilitation at PHC facility level.

Standards

References, prints and educational materials

- A register of all local, regional, provincial and national resources for referral for rehabilitation, education and training.

- OT reference pack.
- "Disabled Village Children" by David Werner, as a reference book

Equipment

(Standard facility equipment)

Medicines and supplies

- Consumables such as auxiliary rubbers, rubber ferrules and cane tips.
- Ready-made packs on order per specified patient:

Competence of health staff

PHC Facility Staff are able to:

- Use standardised questionnaire for the detection of hearing loss.
- Identify and refer patients requiring rehabilitation.

The Therapy Assistant is able to:

- Teach prevention of pressure sores and pressure sore care.
- Identify and implement techniques in a walking re-education programme.
- Construct simple aids for daily living from locally available materials, and teach the patient how to make and use them.
- Teach mobility and daily living skills to a blind person.
- Identify articulation, language and fluency disorders.
- Plan, implement and monitor language stimulation programmes.
- Use augmentative and alternative communication methods with appropriate patients, construction of simple communication boards, and teach the family how to use them.
- Plan, implement and monitor basic programmes for the rehabilitation of people with neurogenic disorders of communication.
- Counsel the family and teachers of a person with hearing impairment on simple measures to improve communication.
- Have knowledge of available resources for rehabilitation.
- Construct, and instruct in the making of, corner chairs with table, standing frames and walkers out of Appropriate Paper Technology.
- Construct and instruct in the making of toys out of locally available waste materials and plan, implement and monitor play and stimulation activities to facilitate development.
- Teach basic maintenance of wheelchairs, hearing aids, callipers and crutches.
- Teach an exercise programme for the prevention and treatment of backache.
- Instruct on back care and joint protection principles to decrease pain and maintain the range of movement in the treatment of back pain and other conditions involving joints.

Visiting Therapists are able to:

- Design treatment/rehabilitation programmes for people with stroke, spinal injury, spina bifida, cerebral palsy, barriers to learning, sports injuries, backache, arthritis, amputations and blindness, to be implemented by the therapy assistant or family members of the person with a disability.
- Assess people with disabilities on the need for Specialised Assistive Devices, and prescribe and order these from the District, Regional or Tertiary Hospital.
- Assess patients with burn scar tissue, and prescribe and order pressure garments.
- Assess scholars with barriers to learning
- Guide doctors in assessment of degree of disability for applications for disability and care dependency grants.
- Design and direct needs-driven awareness raising, education and prevention programmes.

- Assess the need for surgical release of contractures and other corrective procedures.
- Supervise and arrange the continuing education of community therapy assistants.

The visiting PHC doctor is able to:

- Assess continence problems and advise suitable continence management in consultation with the therapist or therapy assistant, patient and family.
- Manage spasms related to spinal injury with drug treatment and/or detection and treatment of stress factors.
- Assess persons for disability grants and care dependency grants.
- Use a Schiotz Tonometer.
- Diagnose disabilities as early as possible, and develop a system of referral (National Year 2000 Goals, Objectives and Indicators).
- PHC facilities are accessible to wheelchairs and trolleys and have toilet facilities for people in wheelchairs.
- People with disabilities are given preference when queuing for services and, where feasible, appointments are given to patients to reduce waiting times.

Referral

- From district hospital to PHC facility:
  - All patients with newly acquired disabilities, who have completed the acute phase of their rehabilitation for follow-up by the therapy assistant.
  - All newly detected patients with disabilities, who have been assessed by a therapist, doctor or specialist, for follow-up and rehabilitation at the nearest PHC facility.
- In the PHC facility to the rehabilitation service:
  - All children detected with a developmental delay for assessment.
  - Patients with healed burns that cover a joint surface for the prevention of contractures and treatment of scarring.
  - Patients with disabilities for alleviation programmes and rehabilitation.
  - All patients with chronic deforming arthritis.
- Referral of patients to doctor or multidisciplinary team:
  - Patients with spinal cord injury with troublesome spasms.
  - Patients with continence problems for institution of an adequate continence programme.
- From PHC facility for specialist assessment or treatment:
  - Patients with physical disabilities amenable to corrective surgery, assuming that a therapy follow-up service is available.
  - Patients with chronic disabling rheumatoid arthritis for assessment and monitoring.
- From PHC facility to hospital:
  - Patients requiring intensive daily rehabilitative therapy.
  - Patients with extensive bedsores.
  - Patients in need of more assistive devices not available at district level.
  - Complicated burns (facial, perineal, burns involving a joint or over 10% of body surface).
  - Patients with spinal injury and sudden increase in spasms, temperature and high blood pressure.
- From PHC facility to other sectors:
  - Children with sensory loss to LSEN schools.
  - Patients with disabilities who are capable of working, to Department of Labour for employment opportunities.

- Patients with disabilities for training in suitable occupational skills.
- Patients with disabilities who are not suited to the open labour market, to community groups for disabled people, self-help groups, or protected workshops.
- Any other sectors which are deemed useful for the development of social and economic independence of the disabled person, such as training centres for the blind.
- Peer support groups.
- Patients with disability who are not adequately cared for in the community to the Department of Social Development.
- Severely disabled children who are not accepted at schools, to community day care centres.

Patient education

- Prevention of bedsores in debilitated patients and patients with sensory loss.

Records

- Data collected at PHC facilities to be used for development of a district database on disability for use in programme planning.
- Patient information recorded using the SOAP format.
- Initial assessment and follow-up forms standardised for the district, and kept in the chronic file of the patient at the PHC facility.
- A summary note of the diagnosis, referral and treatment is in the patient-held record.
- The visiting therapist ensures that data and information, and records are accurately and consistently maintained.
- Data fields for clients referred for rehabilitation are included in the PHC facility register.

Community and home-based activity

- Refer patients to community monitoring programmes, mobilise community support, where indicated by the patients' social circumstances to ensure compliance with treatment.
- Needs analysis for rehabilitation in the community, to plan appropriate and effective intervention programmes.
- Home visits to patients to gain insight into their social situation.
- Devise home-based rehabilitation programmes for people requiring extended rehabilitation, in collaboration with the disabled person, her/his family, and/or community.
- Maintain contact with clients through follow-up visits.
- Identify and mobilise community resources for groups and peer support, skills training and income generation.
- Supervise, advise and assist community therapy assistants.
- Recommend and assist with implementation of adaptations to client's homes, communities, work areas, or schools.

Collaboration

- Develop a responsive disability information system and database in consultation with PHC Nurse, Generalist Doctor, Disabled People's Organisations and Community.

Checklist: Rehabilitation At Primary Care Facilities

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

TICK APPROPRIATE BOX [√]

1. General

1.1.	Is the facility physically accessible to people with disabilities (deaf, blind, other)?	Y	N
1.2.	Are toilets at this facility accessible to people with special needs (deaf, blind, other)?	Y	N
1.3.	Is there a list of referral agents, to ensure appropriate referral?	Y	N
1.4.	Does a rehabilitation therapist/assistant visit the PHC facility?	Y	N
1.5.	When was the last visit?		
1.6.	Assistive Devices		
1.6.1	Is there a system for the maintenance and repair of assistive devices?	Y	N
1.6.2	Do personnel at the PHC facility know basic sign language to assist deaf people?	Y	N

2. Prevention of Disabilities

2.1.	Is immunisation offered daily at this facility?	Y	N
2.2.	Are the developmental milestones of children routinely assessed?	Y	N
2.3.	Are people with chronic conditions offered regular monitoring of their condition, and referral when needed?	Y	N
2.4.	Are people with chronic conditions referred when necessary?	Y	N
2.5.	Is there an active health education programme?	Y	N
2.6.	Does the programme address rehabilitation?	Y	N
2.7.	Are other community-based health practitioners trained in assisting emergency delivery?	Y	N
2.8.	Have all personnel had training/updating on resuscitation in the past 24 months?	Y	N

3. Services

3.1.	Is there an appointment system available for people with chronic diseases?	Y	N
3.2.	Is there a Fast Lane queue available for people with chronic diseases?		
3.3.	Are all services available to disabled people (including counselling)?	Y	N

4. Community Outreach

4.1.	Are disabled people and their families encouraged to form support groups?	Y	N
4.2.	Is there a list of support groups/organizations available?	Y	N

5. Continuity of Service

5.1.	Are rehabilitative workers/therapists available within easy distance?	Y	N
5.2.	Does a team visit the facility?	Y	N
5.3.	Are PHC facility personnel given feedback on referrals and their role of continuity in the client's care?	Y	N

6. Early Detection

6.1.	Are there guidelines for the prevention of hearing impairments due to otitis media at PHC facility level?	Y	N
6.2.	Do personnel know where to refer patients if hearing loss is suspected?	Y	N

NOTES:

ACTIONS TO BE TAKEN BY PHC FACILITY

Supervisor signature:	
PHC facility manager signature:	
Date:	

5.16 Health promotion

Service description

Health promotion is a service that ensures the public is well-informed of issues related to health and healthy life styles. Information on health issues is available to the public in many different communication media, such as IEC material, campaigns, and health talks. HP is integrated into the PHC programme and should not be seen as an individual programme.

Priorities

The main priorities that health promotion focuses on are:

- The prevention of illness and promotion of health
- Changing negative health behaviours, such tobacco use, alcohol and drug abuse, into positive health behaviours
- Promoting different HP techniques (not merely health education) to ensure that health messages are communicated to service users, for example, competitions, group discussions, debates, exercise programmes
- Promotion of proper nutrition
- Promotion of safe sex.

Standards

For a successful health promotion, the PHC should obtain its directive from sources such as:

- An HP policy including all other related policies, for example, a 'no smoking' policy with applicable regulations
- A health calendar
- The needs and requests of the community
- A year planner.

Checklist: Health Promotion (HP)

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

1. Health Facility Catchment Area Profile	**#**
1.1. How many Municipal Wards are in the PHC facility's catchment area?	
1.2. How many villages / sections are in a ward?	
1.3. How many of these Wards were covered by HP activities in the past quarter?	
1.4. How many primary schools fall into the PHC facility's catchment area?	
1.5. How many secondary schools fall into the PHC facility's catchment area?	
1.6. Are there traditional leaders in a ward?	

2. Health Promotion Documents tick appropriate box [√]		
2.1. Does the facility have the following HP documents available:		
2.1.1 A health calendar?	Y	N
2.1.2 A year planner?	Y	N
2.1.3 HP policy?	Y	N
2.1.4 A no smoking policy?	Y	N
2.1.5 "No Smoking" signs visible to all PHC facility visitors?	Y	N

3. Communication		
3.1. Is HP integrated into the PHC service of the facility rather than being a stand-alone, vertical programme?	Y	N
3.2. Is a monthly meeting held that includes HP on the agenda?	Y	N
3.3. At these meetings, are plans drawn up for meeting health needs and/or overcoming problems in the community around the PHC facility?	Y	N
3.4. When planning HP interventions, are trends in health indicators as well as available data taken into account?	Y	N
3.5. Is there evidence of *ad hoc* meetings held to plan urgent HP activities as health problems arise?	Y	N
3.6. Is there evidence that the HP co-ordinator for the area or sub-district visits the facility monthly?	Y	N
3.7. Are the following displayed in a visible area of the PHC facility:	Y	N
3.7.1 HP talks?	Y	N
3.7.2 Projects?	Y	N
3.7.3 Campaigns?	Y	N
3.7.4 Support Groups?	Y	N
3.7.5 DOTS?	Y	N
3.8. Is a monthly HP report submitted to the District co-ordinator?	Y	N
3.9. Are health talks and other HP programmes evaluated?	Y	N
3.10. List the subjects of health talks given at the facility in the last month to meet the needs of groups of people		

4. Community Projects		
4.1. Over and above PHC facilities, are there HP projects at the following venues:		
4.1.1 In schools?	Y	N
4.1.2 In workplaces?	Y	N

4.1.3 At community gatherings and meetings?	Y	N
4.2. Is there a health-promoting school in the community catchment area of the PHC facility?	Y	N
4.3. Are there support groups developed at, or from, the PHC facility for:	Y	N
4.3.1 People with non-communicable diseases?	Y	N
4.3.2 HIV/AIDS infected and affected persons?	Y	N
4.3.3 Persons with mental illness?	Y	N
4.3.4 Persons with disability?	Y	N
4.3.5 The elderly?	Y	N
4.3.6 Victims/survivors of domestic violence?	Y	N
4.4. Is there a vegetable garden at the PHC facility?	Y	N

5. Interventions

List the interventions/campaigns/projects held in the last month and the programme that they targeted

Intervention/campaign/project	Programme e.g. MCWH, TB, Mental Health

6. The Requirements for Client Education

6.1. Is there audiovisual equipment in the PHC facility?	Y	N
6.2. If "no", is it available to be borrowed from elsewhere when needed?	Y	N
6.3. Are there posters and other visual aids available for health education?	Y	N
6.4. Are posters and exhibitions:		
6.4.1 Neat in appearance?	Y	N
6.4.2 Changed regularly?	Y	N
6.4.3 Linked to the health calendar?	Y	N
6.4.4 Grouped according to a specific topic?	Y	N
6.4.5 In local languages?	Y	N
6.5. Are there sufficient quantities of IEC materials available?	Y	N
6.6. Is health education done according to:		
6.6.1 The health calendar?	Y	N
6.6.2 The needs and requests of the community?	Y	N
6.7. Are exhibition boards available in the sub-district for the display of materials?	Y	N
6.8. Is there a notice board available to display forthcoming events and requirements of the service users?	Y	N

EVALUATOR TO SELECT 5 SERVICE USERS AND ASK THE FOLLOWING QUESTIONS:

NO.	WHAT WAS THE TOPIC OF THE LAST HEALTH TALK ATTENDED?	WHAT WAS THE MAIN LESSON LEARNED?	WHAT USE HAS BEEN MADE OF IT?	HAS THE HEALTH WORKER (HW) EXPLAINED YOUR CONDITION ?	HAS THE HW EXPLAINED TREATMENT TO THE PATIENT?
1					
2					
3					
4					
5					

7. Health Promotion Priorities

7.1. Are all health care workers informed about:

7.1.1 Their HP role in prevention of illness and promotion of health?	Y	N
7.1.2 Their role in changing negative health behaviours into positive health behaviours?	Y	N
7.1.3 Different HP techniques (not merely health education) to ensure that health messages are communicated to service users? (For example: competitions, group discussions, debates, exercise programmes etc).	Y	N
7.1.4 Focus on "Healthy Lifestyles" is a national priority for health promotion.	Y	N
7.1.5 Are campaigns for the following carried out at the PHC facility's catchment area on at least a quarterly basis?	Y	N
7.1.6 Balanced nutrition	Y	N
7.1.7 Physical activity programmes (as part of "Vuka – South Africa!")	Y	N
7.1.8 Anti-tobacco (including snuff)	Y	N
7.1.9 Safe use of alcohol and other medicines	Y	N
7.1.10 Safe sex	Y	N

NOTES:

ACTIONS TO BE TAKEN BY PHC FACILITY

Supervisor signature:	
PHC facility manager signature:	
Date:	

Checklist: Medicine Supply Management

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

	TICK APPROPRIATE BOX [√]	
1. Infrastructure		
1.1. Are medicines kept in the storeroom, consulting room or both? Specify:	Y	N
1.2. Is the temperature in the storeroom kept below 25°C?	Y	N
1.3. Are working surfaces and shelves where medicines are kept finished with a smooth impermeable material?	Y	N
1.4. Are there separate facilities for washing hands and cleaning equipment?	Y	N
1.5. Are there tablet counting trays?	Y	N
1.6. Are they cleaned after every use?	Y	N
1.7. Is the access to the medicine storeroom controlled for unauthorized persons?	Y	N
1.8. Are waste containers available (in line with the IPC policy)?	Y	N
1.9. Please respond to the following:		
1.9.1 The medicine store is large enough to keep all supplies	Y	N
1.9.2 The medicine store is kept locked at all times when not in use	Y	N
1.9.3 There are no cracks, holes or sign of water damage in the medicine store	Y	N
1.9.4 There is a ceiling in the medicine store which is in good condition	Y	N
1.9.5 The medicine store is appropriately air-conditioned	Y	N
1.9.6 The windows are painted in white (or have curtains) and are secured with grilles	Y	N
1.9.7 There are no signs of pest infestations in the medicine store (i.e. cockroaches, rats)	Y	N
1.9.8 The medicine store is tidy; shelves are dusted, the floor is swept, and walls are clean	Y	N
1.9.9 Supplies are stored neatly on shelves or in boxes	Y	N
1.9.10 There are no supplies in direct contact with the floor (boxes are kept on pallets)	Y	N
2. Selection		
2.1. Are medicines prescribed by generic name?	Y	N
2.2. Are medicines adequately labelled?	Y	N
2.3. Are medicines prescribed from the essential medicines list?	Y	N
2.4. Is the essential drug list/formulary available to practitioners?	Y	N
3. Procurement - Stock cards/Ordering Supplies		
3.1. Does the facility have an SOP for procurement of medicine stock?	Y	N
3.2. Is it signed and dated?	Y	N
3.3. Is it known how to calculate the Average Monthly Consumption (AMC) – ask a member of staff to calculate it then Check Formula	Y	N
3.4. Is possible stock-out period taken into consideration when calculating the AMC?	Y	N
3.5. Do the personnel calculate the Maximum Stock by multiplying the AMC by the Maximum Stock Factor?	Y	N
3.6. Has the Maximum Stock been calculated for each item in the store?	Y	N

3.7. Is the Maximum Stock recorded on each item's stock card (in pencil)?	Y	N
3.8. When was the last time that the Maximum Stock was reviewed? Indicate:		
3.9. Is a standard requisition form used?	Y	N
3.10. Are all orders placed in writing using the prescribed forms?	Y	N
3.11. Is the requisition book kept at the facility?	Y	N
3.12. Is all information on the requisition form accurate and clearly written?	Y	N
3.13. How often does the facility place an order? Explain:		
3.14. What is the PHC facility's average lead-time?		
3.15. What is the PHC facility's reorder factor? Explain:		

4. Distribution

4.1. How are stock-outs addressed when they occur? Explain:		
4.2. What is the average length of time of stock-out for critical items (tracer medicines)? Indicate:		
4.3. How are stock oversupplies handled when they occur? Explain:		
4.4. Are quantities received checked against quantities ordered?	Y	N
4.5. Are safety stock levels determined and adjusted accordingly?	Y	N
4.6. Does the PHC receive feedback regarding the status of orders (expected delivery dates for orders placed, dues out from depot, expected delivery dates for dues out items, etc.)?	Y	N
4.7. Does the PHC know whom to contact in case of emergencies (stock-out)?	Y	N

5. Storage

5.1. Are supplies systematically classified on the shelves (that is, by dosage forms or therapeutic class)?	Y	N
5.2. Are generic names used with every medicine?	Y	N
5.3. Are tablets and other dry medicines (e.g. ORS) stored in airtight containers?	Y	N
5.4. Are the liquids, ointments and injectables stored on the middle shelves?	Y	N
5.5. Are supplies such as surgical items, condoms and bandages stored on the bottom shelves?	Y	N
5.6. Are items grouped in amounts that are easy to count?	Y	N
5.7. Are there any expired medicines in the store?	Y	N
5.8. Are medicines utilized in terms of first-expiry-first-out principle (FEFO)?	Y	N
5.9. Are supplies with no expiry or manufacture date stored in the order received (FIFO)?	Y	N
5.10. Are supplies with a manufacture date only stored in chronological order?	Y	N
5.11. Are there any damaged containers or packages on the shelves?	Y	N
5.12. Are there any overstocked, or obsolete items on the shelves?	Y	N
5.13. Is the disposal of medicines recorded in a separate register that includes the date, time, witness, value, quantities and reason(s)?	Y	N
5.14. Are narcotics and psychotropic medicines stored in a separate double-locked storage space?	Y	N
5.15. Are items checked regularly for potential deterioration (i.e. bad odour or discoloured tablets)?	Y	N
5.16. Are temperature-sensitive items stored in a refrigerator?	Y	N
5.17. Is the refrigerator is in proper working condition?	Y	N
5.18. Is there any food belonging to health care personnel in the refrigerator?	Y	N
5.19. Is a temperature record available and up-to-date?	Y	N

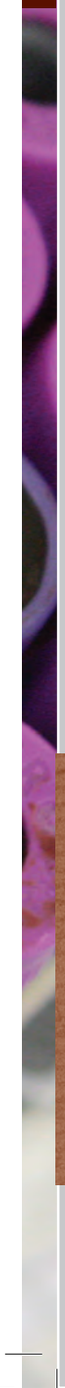
6. Use		
6.1. Does the labelling of medicines meet the legal requirements? (Supervisor to take 3 random samples of prescriptions issued to 3-5 patients. Tick from the list: Name of patient, name of medicine, strength and quantity, instructions on how to take the medicine, name of facility, expiry date and batch number)	Y	N
6.2. Is the person dispensing the medicines licensed and/or registered?	Y	N
7. Quality Control/ Patient Care		
7.1. The health care worker checks for poor quality items, such as:		
7.1.1 Discolouration of medicines?	Y	N
7.1.2 Sediments in medicines?	Y	N
7.1.3 Broken and/or leaking containers?	Y	N
7.1.4 Spoiled labels on medicine containers?	Y	N
7.1.5 Unsealed and/or unlabelled medicine containers?	Y	N
7.1.6 Expired medicines on shelves?	Y	N
7.2. What is the average consultation time for a PHC nurse?		
7.3. What is the average consultation time for a PHC doctor?		

NOTES:

ACTIONS TO BE TAKEN BY PHC FACILITY

Supervisor signature:	
PHC facility manager signature:	
Date:	


VACUTAINER
BRAND



Section 6

DHIS Information System for PHC Facilities

DHIS INFORMATION SYSTEM FOR PHC FACILITIES

6.1 Introduction to DHIS information system for PHC facilities

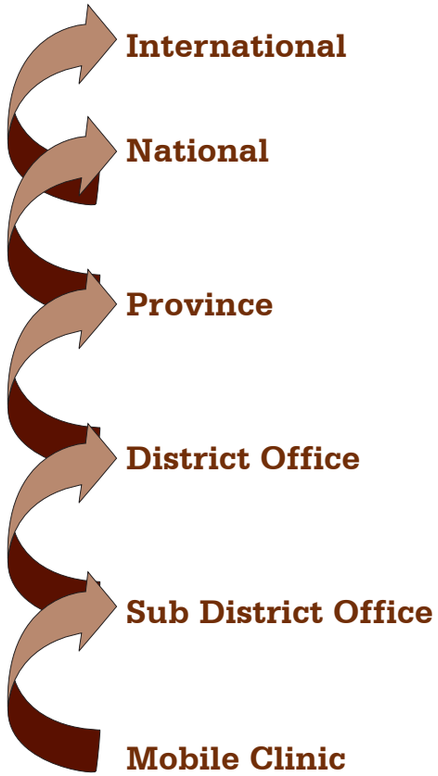
The purpose of health information is to inform management decisions aimed at strengthening health care systems to improve health status.

All PHC facilities must submit monthly data to the district information department. The data is entered into the District Health Information System (DHIS). The DHIS is the computer software that analyses this data. The system is able to detect numbers that lie outside the normal range (described as the minimum and maximum of each data field) and runs validity checks on certain figures. 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.

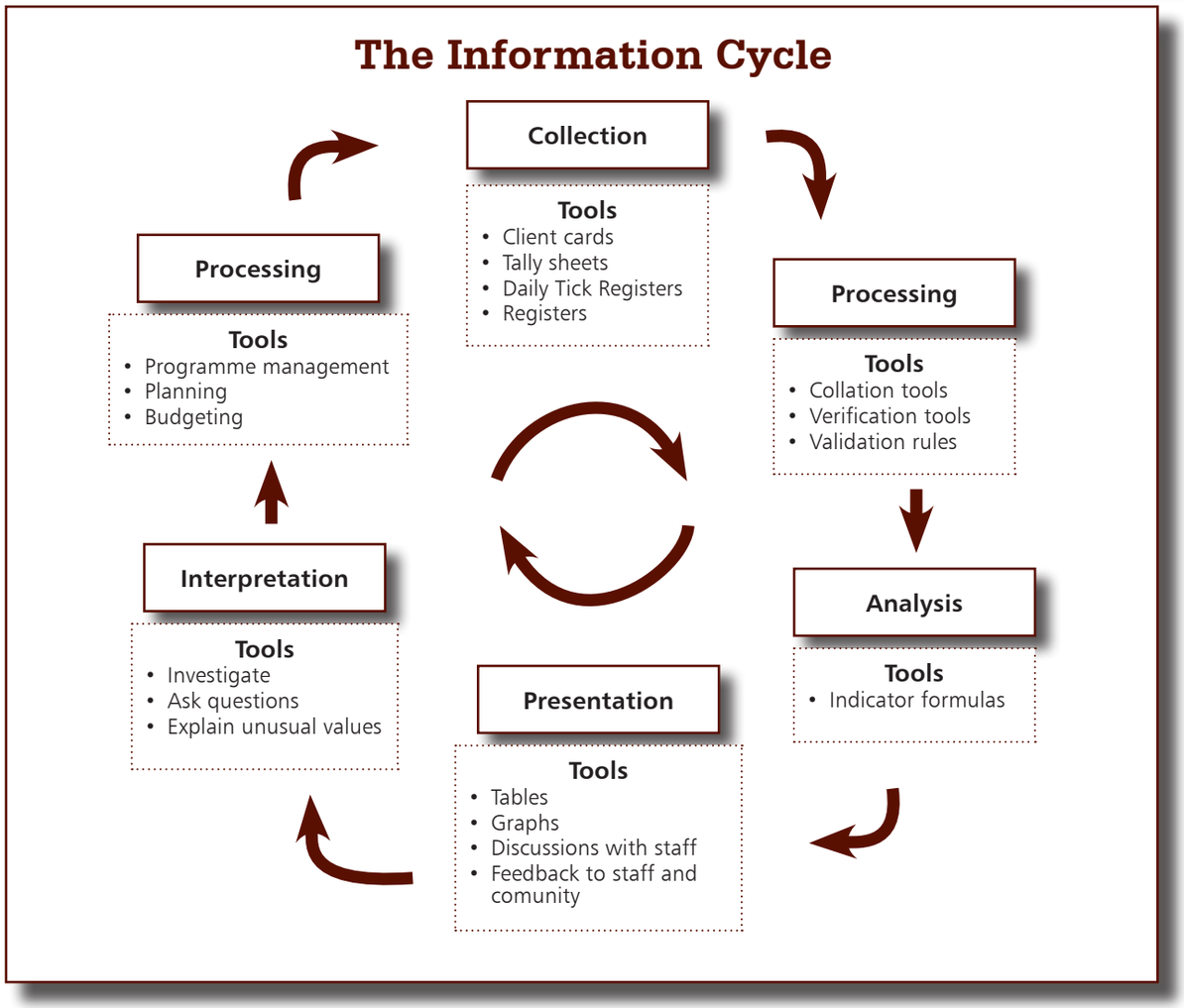
It is important to note that a large percentage of PHC facilities do not capture their data in the facilities and that paper-based systems should be in place to ensure quality of data generated at facility level before it is submitted to the next level for capturing.

It is important to realize that the quality of data provided by the PHC facilities is the most critical factor in the information system. If the monthly reports from the PHC facilities are incorrect, the entire system is misled and the information will not be accurate.

Data Flow:



Feedback at every stage. At the facility it is suggested that data is handled according to the **Information Cycle** in the following way:



Data Collection: The facility manager must ensure that all the necessary data elements are collected and that each staff member understands the definition of the data elements that are being collected. There should be standardised definitions of data elements. The formal definitions are not always understood by all the health workers who are involved in the data collection process. The latest

list of definitions needs to be distributed to all health workers and the appropriate in-service training must take place with all staff. Any additional data elements and indicators need to be accompanied with the relevant definitions.

Supervisors should check and support facilities to ensure that each staff member has a copy of the data element definitions, that data collection tools are standardised, easy to read and that up-to-date tools are available at all times.

It is important that staff understand the definitions of each data element and record it correctly. **A COPY OF THE PHC NATIONAL INDICATOR DATA SET IS ATTACHED AS ANNEXURE A**.

Data Processing: This is the most important stage in the information cycle and a very important responsibility of the facility manager to ensure that the data that is being submitted is of good quality.

At the end of each month the data is collated from the various registers and entered onto the form used for submission to the next level. The data for the month needs to be checked for mistakes, missing values and inconsistencies. The next step is to compare the new data with the data submitted for the past few months and look for inconsistencies, gaps and outliers.

The facility manager must verify that the data is collected from all the service points in the facility for every day of the month from all the staff members in the facility. Collation (counting of totals from data collection tools to get a monthly total) should not be left until the end of the month, but preferably be done daily or weekly to prevent inaccurate calculations that may occur if people are under pressure to produce a report in time. Administrative and/or support staff can take responsibility for these time-consuming tasks at regular daily/weekly intervals so that professional staff do not have to spend 2 or 3 days at month end compiling reports.

Data must be validated with a set of validation rules. These validation rules are set up in the DHIS system, but most PHC facilities do not capture data in the DHIS at facility level. The validation should therefore be done "manually", applying a few critical rules to the data to verify that all the values are correct and make sense. The validation rules are explained in detail in Section 7.3.

The following are common problems to identify:

ERROR	EXAMPLE
Missing data (gaps)	Data items missing for whole months. Blank data items. A zero should be entered if a facility that is equipped to provide a service does not have any clients for that time period
Duplication	Same set of values entered for two consecutive months
Imaginary data/ preferential end data	When data collection tools are not used regularly, staff just fill in a likely looking number
Unlikely values for a variable	A male being pregnant
Contradictions between variables (values outside the normal range)	A total of 7 live births weighing less than 2500g is reported in a facility while only 3 babies were delivered
Calculation errors	Mistakes in adding
Typing error	Data is wrongly entered into the computer
Entering data in the wrong field	Condoms distributed instead of intra-uterine devices, e.g. transposing numbers or data in fields

The signature of the person approving the data implies that the data has been checked and determined to be correct.

Data Analysis: Analysis should not only be done at district and higher levels, but analysis should happen at facility level where the data is generated. Analysis will involve the use of indicators that allow one to measure performance or progress towards targets or changes in disease patterns. Analyzed data tells us what impact our service delivery has on the health status of the population we serve.

There are four main types of indicators.

TYPE OF INDICATOR	DESCRIPTION	EXAMPLE
Count indicator	Number of events without a denominator	Total PHC headcounts
Proportion indicator	Numerator is contained in denominator	Proportion of children under 5 years weighed: Numerator: Children weighed x 100 Denominator: Headcount under 5 years
Rate indicator	Frequency of the event in specified time in given population. Often expressed per 1,000, 10,000 or 100,000 population, but also as percentages	Incidence of new cases of STI: Numerator: STI new cases x 1000 Denominator: Catchment population 15 years and older
Ratio indicator	Numerator is not included in denominator	Ratio of males to females accessing VCT services Females accessing VCT services (e.g.100) Males accessing VCT services (e.g.25) = 1 male for every 4 females accessing VCT services

Note: A copy of the PHC National Indicator Dataset attached as Annexure A

Data presentation and dissemination (feedback): The process of sharing information or distributing information or knowledge to potential users is also important for the facility. Supervisors are to ensure that display of information in the form of graphs of key indicators is done on a monthly basis. The graphs should be prominently displayed to inform patients and also the community. Data should be compared with the previous month's data to inform the current decisions and promote quality assurance. PHC supervisors should test the knowledge of facility staff on their own data by asking them, for example, about trends in their data and the coverage rates for their catchment population.

Feedback should be given to facility staff and information should be discussed at facility meetings (as a standard item on the agenda). Decisions based on the information should be recorded in the minutes of the meetings. Feedback from districts and programme managers should also be shared with all staff members.

Interpretation: This is a very important step in the data handling cycle where unusual fluctuations or trends picked up in the validation and analysis of the data should be investigated.

This is an essential part of Quality Suppervision (see chapter 2).

People generating the data are most often in the best position to explain why there are unusual fluctuations and to make sense of the data. Supervisors should ask staff members to provide explanations and explore possible reasons for variations and ensure values are correct.

The most important action in the interpretation step is to give an explanation in the "Comments" column of the monthly report. These comments are being captured in the DHIS with the values and will inform all levels of data users about reasons for the unusual values. If no explanation is given, data might not be trusted and action on important changes in the health status or service delivery might not be taken.

Use of Information: This is the process of using information for decisions for planning and monitoring of services The PHC facility should use data to analyse performance and guide local planning and decision-making. If, for example, the cervical cancer screening coverage is low, a monthly target (based on catchment population) should be determined and strategies developed to increase the number of pap smears taken. This could include, for example, targeting more family planning clients, making health promotion talks more inclusive, distributing leaflets, or displaying posters.

The PHC supervisor should check evidence of information use with every visit and use it for problem solving. **It is very important that the supervisor ensures that the monthly data submitted to the district information office is correct and the decisions taken (for example, adding or transferring resources) are based on the evidence of good quality data**. Support from programme managers should be called in if necessary, for example, if there is a high incidence of diarrhoea or communicable diseases.

6.2 PHC monthly data collection tool

The following table is a list of routine data elements with which the performance of the PHC facility is reported on. In order to collect correct data, one should use the correct formula to calculate the indicator value, i.e. numerator/denominator = routine data element (see Annexure A as well as item 7.3: Data validation rule). **Motivations for all outliers should be noted on the comment column**.

> NB! The table below is the mandatory, routine PHC data to be collected. With time, however, there may be additional or fewer routine data elements. The change or update will be communicated by NDoH as and when the need arises.

Provinces that prefer to have additional local data collection may do so using a separate, locally developed tool.

NAME OF THE PHC FACILITY (INCLUDE CODE)	
MAGISTERIAL	
HEALTH DISTRICT	
HEALTH SUB-DISTRICT	
MONTH AND YEAR FOR COLLECTION	
DATE OF SUBMISSION	
COMPILED BY	
VERIFIED AND CORRECTED BY (supervisor in block letters & sign):	

ROUTINE DATA ELEMENT	INDICATOR VALUE	COMMENT ON DEVIATION
Headcount PHC		
PHC headcount under 6 months		
PHC headcount 6 months to 5 years		
PHC headcount under 5 years		
PHC headcount 5 years and older		
PHC headcount seen between 7 pm and 7 am		
Professional nurse clinical workdays		
Enrolled nurse clinical workdays		
Nursing assistant clinical workdays		
Pharmacy staff clinical workdays		
PHC patients seen by doctor in this facility – referred from nurse		
PHC patients seen by doctor in this facility – not referred from nurse		
Doctor clinical workdays		
Campaign headcount under 5 years		
Campaign headcount 5 years and older		
Child Health		
Child under 6 months weighed		
Child 6 months to 5 years weighed		
Children under 5 years weighed (record only once per month)		
Of those weighed, children under 5 years not gaining weight this month		
Underweight for age under 5 years – new patients		
Severe malnutrition patients under 5 years – new ambulatory		
Diarrhoea patients without dehydration under 5 years – new ambulatory		
Diarrhoea patients with dehydration under 5 years – new ambulatory		
Pneumonia patients under 5 years – new ambulatory		
HIV tests done on children under 5 years		
HIV positive children under 5 years – new patients		
Nutrition		
Child under 6 months on breast-feeding		
New child under 6 months on PEM		
Babies born to women with HIV on Nevirapine and PEM		
Babies born to women with HIV on Nevirapine and PEM on register		
Children under 6 months on PEM in register		
New children 6 months to 5 years on PEM		
Children 6 months to 5 years on PEM on register		
TB patients on PEM		
TB patients on PEM on register		
New antenatal patients on PEM		
Antenatal patients on PEM on register		
HIV positive patients on PEM – new		
HIV positive patients on PEM register		

Vitamin A supplement to 6-11 months infants		
Vitamin A supplement to 12-59 months children		
Vitamin A supplement to women within 8 weeks after delivery		
Immunisation		
BCG doses to children under 1 year		
OPV doses at birth		
DPT-Hib 1st doses to children under 1 year		
DPT-Hib 3rd doses to children under 1 year		
OPV 1st doses to children under 1 year		
OPV 3rd doses to children under 1 year		
HepB 1st doses to children under 1 year		
HepB 3rd doses to children under 1 year		
Measles 1st doses to children under 1 year		
Immunised fully under 1 year – new patients		
Measles 2nd doses to children over 1 year		
DT doses at 5 years		
DT doses at 12 years		
Maternal Health		
Antenatal 1st (booking) visits before 20 weeks		

Antenatal 1st (booking) visits 20 weeks or later		
Antenatal follow-up visits		
Tet Tox 2nd/ Booster doses to pregnant women		
Deliveries in facility		
Normal deliveries in facility		
Total births in the facility		
Live births in the facility		
Live births in the facility under 2500g		
Still births in the facility		
Live births outside health facility (excluding BBAs)		
Postnatal visits		
Reproductive Health		
Medroxyprogesterone injections		
Norethisterone enanthate injections		
Oral pill cycles (packets)		
IUCDs inserted		
Cervical smear 30 years and older screening for cervical cancer		
Cervical smear 30 years and older screening for diagnostic purpose		
Sterilisations – female		
Sterilisation – male		
STI		
Male condoms distributed		
Female condoms distributed		

STIs treated using the syndromic approach – new episode		
STI treated new episode – ART patient		
Male Urethritis Syndrome patients treated – new episode		
STI partner notification slips issued		
STI partners treated – new		
VCT		
HIV pre-test clients counselled (excluding antenatal)		
HIV pre-test counselled (excluding antenatal) medically referred		
HIV clients tested (excluding antenatal)		
HIV test positive – new patients (excluding antenatal)		
PMTCT		
Antenatal clients tested for syphilis		
Antenatal clients tested positive for syphilis – new patients		
Antenatal clients tested for HIV		
Antenatal clients tested HIV positive – new patients		
Nevirapine dose to women at antenatal or labour		
Live births to women with HIV		
Nevirapine doses to babies born to women with HIV		
Nevirapine dose dispensed to HIV pregnant women		
HIV 1st test of baby born to HIV positive women		

HIV 1st test positive of baby born to HIV positive women		
HIV/AIDS		
Blood drawn for CD4		
CD4 tests with turnaround time of more than 6 days		
Referrals to ART service point for ART assessment – new		
Registered ART patients		
Registered ART patients on any adult regimen		
Scheduled dose issued (within 3 days) ART any regimen		
Scheduled dose defaulted (>3 days) ART any regimen		
Sexual assault patients – new		
Sexual assault patients given ARV prophylaxis – new		
Occupational HIV exposure – new patients		
Occupational HIV exposure patients given ARV prophylaxis – new		
HIV positive new patients screened for TB		
HIV positive new patients with confirmed TB		
HIV positive new patients started on INH prevention therapy		
HIV positive new patients started on Cotrimoxazole prophylaxis		
HIV positive patients with PPD or Mantoux done		

TB		
Suspected TB patients with sputum sent		
Suspected TB patients smear positive		
Suspected TB patients smear positive-treatment start		
Sputum results received within 48 hours		
All sputum samples sent		
TB patients under treatment (on register)		
TB patients pre-test counselled for HIV		
TB patients tested for HIV		
TB patients tested positive for HIV		
TB HIV positive new patients started on Co-trimoxazole prophylaxis		
TB HIV positive patients referred for ART assessment		
TB HIV positive patients started on ART – new		
Chronic Conditions		
Hypertension patients put on treatment – new		
Hypertension follow-up visits		
Hypertension clients on register		
Diabetes Mellitus patients put on treatment – new		
Diabetes Mellitus follow-up visits		
Diabetes Mellitus clients on register		
Asthma visits under 18 years		
Asthma visits 18 years and older		
MENTAL HEALTH		
Mental health visits		
New mental health visits		
Mental health clients in register at the end of month		
Mental health clients in register not receiving treatment		
Patients counselled for psychological trauma		
Oral Health		
Dental visits		
Tooth extractions		
Tooth restorations		
Rehabilitation Services		
Wheelchair issued – new		
Hearing aid issued – new		
Walking aid issued – new		
Drug Stock-Out		
ACE inhibitor stock-out		
Adrenalin stock-out		
Amoxicillin 125mg/5ml suspension (75ml) stock-out		
Amoxicillin capsules stock-out		
Any ARV drug stock-out		
Any nutrition supplement stock-out		
Any TB drug stock-out		
Ceftriaxone stock-out		
Co-Trimoxazole 480mg stock-out		

Co-Trimoxazole syrup stock-out		
DTP-Hib vaccine stock-out		
Ibuprofen stock-out		
Insulin stock-out		
Male condom stock-out		
Morphine stock-out		
Norethisterone enant or Medroxyprogesterone injection stock-out		
Paracetamol 500mg stock-out		
Rapid HIV test stock-out		
Salbutamol inhaler stock-out		
Drug Management		
Prescriptions issued		
Items dispensed		
Vaccine fridge missing or not working		

Finance		
Income-patient fees		
Expenditure total		
Expenditure on staff		
Expenditure on drugs		
Expenditure on maintenance		
Management And Supervision		
Number of meetings of clinic committee/hospital board during reporting period (minutes available)		
Supervisor visit this month (excludes programme managers)		
Complaints received from patients or their relatives		
Patient complaints outstanding for more than 60 days		
Inpatient incidents – new		
Infections acquired in hospital – new		

6. 3 Data quality – validation rules

It is the responsibility of the PHC supervisor to "sign off" the monthly data report before it is sent for capturing into the DHIS information system. Signin off must be done either on-site or off-site. The validation rules described in this section should be a guide to check the quality of the data. PHC supervisors should apply these basic validation rules to the data in the monthly report as a minimum quality check before the data is signed off (to confirm validity of the report). If there is a deviation from any of these rules, the reasons for such deviation should be investigated. If the data is correct and there are special circumstances or an explanation for the deviation, these should be included in the Comments column of the report.

VALIDATION RULE	VALIDATION RULE DESCRIPTION	POSSIBLE DEVIATIONS
PHC headcount under 5 years plus PHC headcount 5 years and older must be equal to PHC headcount total	Under 5 years plus above 5 years headcount must be equal to the total headcount	
Doctor or Nurse clinical work days must be less or equal to the available work days	The actual **clinical workdays** reported here cannot exceed the total available workdays and should not be less than 70% of the available workdays without an explanation in the comments column. The available workdays are not routinely collected, but should be calculated as: workdays this month x number of nurses or doctors. For example, if 5 professional nurses and 20 workdays this month, the available work days =100 Do not report work hours here. Clinical workdays means the proportion of available workdays spent on direct patient contact. There should be a space on the daily collection tools to record this for every clinician according to the options below: 1 hour, 2 hours, 3 hours } 0.25 workday 4 hours, 5 hours, 6 hours } 0.5 workday 7 hours, 8 hours } 1 workday 9 hours, 10 hours } 1.25 workdays 11 hours, 12 hours } 1.5 workdays	Not more than 30% of the available work days should be lost to meetings, training, leave etc. If more than 30% a reason should be provided; for example, Doctor on 10 days sick leave in this month Facilities that are open 24 hours should calculate work days in 8 hours; therefore 3 workdays in every 24 hours. The work load in these facilities is usually lower than facilities that are open for "working hours" because these facilities often handle emergencies and maternity cases only after hours
Child under 5 years weighed must be less or equal to headcount under 5 years	Children < 5 years weighed cannot be more than headcounts < 5 years. All children should be weighed once a month	Children visiting the clinic more than once a month
9 Month Measles should be more or less equal to fully immunised less than 1 year	9 Month Measles injection is usually the completion of the primary immunisation schedule = fully immunised < 1 year	Children that still need to catch up any/all of the DTP/Hib, HepB or polio immunisations at 9 months
ANC clients tested for Syphilis must be equal to, or more than, first ANC visits	All antenatal clients should be tested for syphilis at the 1st ANC visit	Some ANC clients will be tested more than once in pregnancy. Very seldom will the client come for the booking visit with blood results from private GP

Antenatal client tested for HIV should be equal or less than first Antenatal clients	Ideally all antenatal clients should be tested for HIV early in their pregnancy, ideally at the first antenatal clinic visit	Some antenatal clients might come back at a later stage for HIV testing which might result in slightly higher HIV tests than 1st antenatal visits in the same month
Antenatal client tested positive for HIV must be less than Antenatal clients tested	HIV positive ANC clients can not be more than the HIV test done on ANC clients. Report only once at the event of HIV positive result. Do not report all HIV pos ANC clients here	
Nevirapine prophylaxis to women during labour should be equal or less than HIV positive Antenatal clients	All HIV positive antenatal clients should receive Nevirapine prophylaxis during labour. Nevirapine dose to HIV positive women cannot be more than the HIV positive ANC clients	Due to the "time lag" between the HIV positive test of antenatal clients and delivery there might be month to month variations where more Nevirapine doses were issued than HIV positive ANC clients in the same facility
Nevirapine prophylaxis to baby born to HIV positive women must be less or equal to Live births to women with HIV	All HIV exposed babies should receive Nevirapine within 72 hours of birth. There cannot be more Nevirapine doses than Live births to HIV positive women	Women without known HIV status at delivery that are getting HIV tests post-delivery within 72 hours and test positive, should also be counted as Live births to women with HIV
HIV tests done should be either more, equal or less than Clients pre-test counselled	Ideally all patients counselled should be tested, so the two figures should be more or less the same. Post-test counselling or follow-up counselling after an HIV positive result should not be counted as pre-test counselling as this will inflate the denominator and result in low percentages for HIV testing rate	Clients pre-test counselled and refuse testing. Clients that come back more than once for counselling before they agree to be tested
HIV positive tests should be equal or less than the HIV tests done	HIV positive tests cannot be more than the HIV tests done. Report only once at the event of HIV positive result. Do not report all HIV positive clients here	
Suspected TB case smear positive must be less or equal to sputum sent	Suspect TB patients are the number of patients from whom sputum was taken and sent to the laboratory. The PHC facility should be regularly suspecting TB in any adult with chronic cough. Normally, one would expect at least 1-2% of the adult headcount to require a sputum exam. If fewer sputa are sent, the PHC facility is not adequately seeking new TB patients. There cannot be more suspect cases positive than TB sputum samples sent	
Suspected TB case smear positive – treatment start should be less or equal to TB suspect smear positive	There cannot be more suspect cases starting on treatment than TB suspect smear positive. Do not include already diagnosed PTB clients referred to your clinic to start TB treatment as suspected case smear positive treatment start	
STI contact slips issued should be more or less equal or more than the STI new cases seen	All STI cases should receive slips to notify sexual partners /contacts to come for treatment	Clients with more than one contact. Clients who refuse to take contact slips
Occupational HIV exposure given ART should be less or equal than occupational HIV exposure new cases	ART given can be a little less as the HIV positive clients do not receive ART Rx	.
Rape case given ART must be less or equal to Rape case new	ART given can be a little less as the HIV positive clients do not receive ART Rx	

Checklist: Information Management

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

The information management checklist should be used by the supervisor before signing off on 'routine data' i.e. item 6.2. Comments and recommendations should be discussed with the PHC facility manager and a copy of item 6.4 (CHECKLIST: INFORMATION SYSTEM) should remain in the PHC facility for further reference. It is imperative that the supervisor compares the applicable registers or tally sheets with the monthly report.

TICK APPROPRIATE BOX [✓]		
1. Data Collection		
1.1. Is the PHC facility using a daily Tick register/Tally sheet for recording clients?	Y	N
1.2. Are all children under five weighed?	Y	N
1.3. Are children not gaining weight recorded?	Y	N
1.4. Are the immunizations recorded?	Y	N
1.5. Are those fully immunized recorded and consistent with Measles 1 dose?	Y	N
1.6. Have pregnant women been given Tetanus Toxoid?	Y	N
1.7. Have partner notification slips been issued, such as for STIs?	Y	N
1.8. Are condoms issued recorded?	Y	N
1.9. Are the data being collated on a regular basis, preferably daily or at least weekly?	Y	N
2. Monthly PHC Report		
2.1. Are the Monthly Reports submitted on time at the end of the month?	Y	N
2.2. Are copies of the reports kept in the PHC facility?	Y	N
2.3. Are there any gaps/unfilled spaces in the forms?	Y	N
2.4. Have comments been made against the gaps?	Y	N
2.5. Has the PHC supervisor signed off the monthly report?	Y	N
2.6. Is the PHC report discussed and recorded in the monthly staff meetings?	Y	N

3. Data Analysis/Interpretation		
3.1. Do they have a map of the catchment area?	Y	N
3.2. Do they have population of the area served?	Y	N
3.3. Are indicators calculated?	Y	N
3.4. Do they have graphs displayed on the wall?	Y	N
3.5. Are the graphs updated?	Y	N
3.6. Are the following graphs available? - Immunization Coverage	Y	N
3.6.1 Children Not Gaining Weight	Y	N
3.6.2 Diarrhoeal Incidence	Y	N
3.6.3 Pneumonia incidence	Y	N
3.7. Are any other additional graphs displayed?	Y	N
3.8. Are there any trends and variations noted on the graphs?	Y	N
3.9. Emanating from this information is there any Quality Improvement Project undertaken?	Y	N
3.10. Are the graphs discussed with the PHC facility supervisor and staff?	Y	N
4. Feedback		
4.1. Do they receive written feedback from the supervisor?	Y	N
4.2. Is the information shared with the community through the PHC facility Committee?	Y	N
4.3. Does the facility submit DHIS reports monthly to the clinic supervisor?	Y	N
4.4. Did the health information officer visit the PHC facility in the last quarter?	Y	N

NOTES:

ACTIONS TO BE TAKEN BY PHC FACILITY

Supervisor signature:	
PHC facility manager signature:	
Date:	

Section 7

PHC Facility Committee (Clinic/CHC Committee)

PHC Facility Committee (Clinic/CHC Committee)

7.1 PHC facility committee's participation and contribution to primary health care

- 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 PHC facility nurses? What is the relationship between CHWs and the committee and do they co-operate?
- Are there community development projects in which nurses are involved; 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 the Departments of Water and Environmental Affairs, Agriculture, Forestry and Fisheries, Social Development and Human Settlements?
- Are support services provided by communities to PHC facilities, such as the supply of water, assistance with transport, or providing security personnel for PHC facilities?
- Are changes in PHC facility services or new policies shared and explained to the community?
- Are new personnel introduced to the community?

THREE TOOLS FOR INCREASING THE CONTRIBUTION OF THE PHC FACILITY COMMITTEE TO IMPROVE PHC

7.2 Checklist 1: Roles and activities of PHC committees

In meetings held with the existing facility committee, the latter expressed a desire for guidance on their role and a checklist was therefore designed by the EQUITY Project. The checklist includes the following key points: the committee should discuss each point with the PHC facility 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.

Checklist 1: The Roles and Activities of PHC Facility Committee

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

COMPOSITION OF THE PHC COMMITTEE MEMBERS PER AGE & GENDER	AGE	WOMEN	MEN
	16 - 25		
	26 - 45		
	46- 65		
	66 +		
	Chairperson		

Community structures represented (such as, among others, traditional health practitioners)	
Frequency of committee meetings	
Does the person in-charge of the PHC attend the board meetings?	

ROLE OF THE PHC COMMITTEE/CLINIC COMMITTEE IN PHC

	[✓] TICK APPROPRIATE BOX	
1. Does the PHC committee:		
1.1. Facilitate working together of existing **community-based health activities** (e.g. NGO, CBO, Health, other Sectors such as Education, and private enterprises)?	Y	N
1.2. Identify felt needs for more health/work such as recruiting volunteers for DOTS?	Y	N
1.3. Guide the health facility on how to be more accessible and meet more of community felt needs, for example, possible changes in PHC facility hours?	Y	N
1.4. Initiate health and environment-related projects and activities with community participation, such as periodic cleaning campaigns?	Y	N
1.5. Attend periodic meetings with facility personnel to discuss issues of concern?	Y	N
1.6. Initiate and support nutrition projects (such as in schools and for the elderly)?	Y	N
1.7. Provide a channel for the flow of health information from the PHC facility to the community?	Y	N
1.8. Advocate for positive behaviour change to improve and promote health in the community?	Y	N
1.9. Liaise with health groups, NGOs and other committees, e.g. District Council, Hospital Board, District Health Forum?	Y	N
1.10. Identify underserved groups in the community that have difficult access to health facility services?	Y	N
1.11. Notify the health facility personnel on outbreaks of disease or unusual conditions (e.g. dysentery)?	Y	N

1.12. Work with other government sectors to improve environment (inter-sectoral collaboration) for example, the Department of Water and Forestry, Agriculture?	Y	N
1.13. Manage minor repairs and maintenance	Y	N
1.14. Manage or supervise CHW (administrative supervision)	Y	N
1.15. Manage or supervise CHW (administrative supervision)	Y	N
1.16. Contribute to directly observed treatment of TB, follow-up of chronic patients?	Y	N
1.17. Provide certain types of non-professional support to local health facilities such as grounds improvements (landscape)?	Y	N
1.18. 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 PHC facility)?	Y	N
1.19. Assist with repairs and maintenance follow-ups	Y	N

NOTES:

ACTIONS TO BE TAKEN BY PHC FACILITY

Supervisor signature:	
PHC facility manager signature:	
Date:	

7.3 Checklist 2: Rapid situation analysis by PHC facility committee

This checklist is intended for use during the discussions between the community and the facility personnel leading to community action to address identified problems. These discussions should include an analysis of what was found, the reasons for the findings, and then 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: Rapid Situation Analysis by PHC Facility Committee

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

Note: This rapid situation analysis should be participatory with all members of the committee taking an active part, assisted where necessary by the PHC facility personnel.

NAMES OF VILLAGES SERVED BY THE HEALTH FACILITY:	TOTAL NUMBER	DISTANCE IN KM AND/OR MINUTES WALKING	ESTIMATED POPULATION
Facility Committee to assist with indicating other/alternative health services in the catchment map?	Y	N	

1. Does the clinic committee monitor and promote operation/ functionality of the health facility?	Y	N
2. Does the health facility provide:		
2.1. Health education (include other applicable audiovisual aids where necessary)	Y	N
2.2. Services as indicated in the service package	Y	N

Attitude of PHC facility personnel (give example) .....

.....

.....

Attitude of community members to health care facility and the personnel (give examples).....

.....

.....

Comment on cleanliness of the PHC facility .....

.....

.....

Is there a copy of the supervisor/programme manager's checklist? .....

Services needed but not offered at the PHC facility: .....

.....

.....

.....

.....

1. Tools to monitor implementation of service standards by the facility personnel:		
1.1. Is there a complaints box at the PHC facility?	Y	N
1.2. Are complaints dealt with promptly and appropriately?	Y	N
1.3. Is a poster of the National Patients Rights Charter available and displayed?	Y	N
1.4. Are the health care providers known (i.e. do they wear uniforms and nametags or identity cards)?	Y	N
1.5. Is counselling available on reproductive health, HIV and AIDS?	Y	N
1.6. Are privacy and confidentiality maintained?	Y	N

Community Health Workers' Monitoring Tool

Note: Where there are community health workers, complete the following section

NAMES OF VILLAGES SERVED BY CHWS:	# OF CHWS	TRAINED BY

1. TITLE FOR THIS TABLE?		
1.1. Have CHWs been selected by the community	Y	N
1.2. Are they accepted by the community? Explain:	Y	N
1.3. Is consultation with CHW after hours possible?	Y	N
1.4. Are they remunerated through the community?	Y	N
1.5. Give details of remuneration or incentives:		
1.6. Does the PHC facility personnel give regular support to CHWs?	Y	N
1.7. Give details of what this support includes:		

1.8. Key activities of CHWs:
1.9. Achievements of CHWs

7.4 Checklist 3: For PHC facility committee to assess community-based health care for different life stages in the community

At each stage of life, critical experts of health determine present and future well-being. The checklist identifies important aspects of health in the community at each life stage: pregnancy, delivery, infancy, preschool, school, adolescent, adult and elderly. 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 the uterus 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 person during childbirth. In order to ensure quality and depth, it is suggested that one or two stages be covered in each meeting. It is further suggested that in each life stage, only one or two items be prioritised for action by the committee. Prioritisation should be based on the urgency of the problem, the number of people affected, the serious consequences for health if the problem is not addressed, the committee's ability to tackle the problem with existing resources, and sustainability of action.

Checklist 3: For PHC Facility Committee to Assess Community-Based Health Care for Different Life Stages in the Community

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

1. Pregnant Women

1.1.	Are pregnant women provided with information on warning signs of serious complication (headache, per vaginum bleeding)?	Y	N
1.2.	Are they provided with education on breast-feeding and foods needed in pregnancy?	Y	N
1.3.	Do Community Health Workers (CHWs) refer pregnant women to PHC facility and keep a list of expected births?	Y	N
1.4.	Do traditional health practitioners refer pregnant women to PHC facility for blood tests and injections (Tetanus Toxoid)?	Y	N
1.5.	Does the community have arrangements for emergency transport of women in labour and about to deliver?	Y	N

2. Delivery

2.1.	Do traditional leaders, traditional healers, CHWs and mothers report home deliveries to nearest PHC facility?	Y	N
2.2.	Do health workers visit women who delivered at home?	Y	N
2.3.	Are traditional birth attendants able to get training at PHC facility if they have been delivering many babies?	Y	N
2.4.	Is there a breast-feeding support group in the community?	Y	N
2.5.	Are stillbirths or deaths of baby shortly after delivery reported to PHC facility?	Y	N
2.6.	If any abnormal babies are born, are they recognised quickly and referred to PHC facility?	Y	N

3. Infancy

3.1.	Are immunization campaigns done with community involvement and well-publicised?	Y	N
3.2.	Have Health Surveys on Nutrition or other health matters been done with community involvement?	Y	N
3.3.	Do the health committee or CHW check on immunization cards of infants in village/area and refer those not up-to-date to PHC facility?	Y	N
3.4.	Has the community been educated about polio, measles and neonatal tetanus and the need for reporting and immunization?	Y	N
3.5.	Does a nurse from the PHC facility visit homes of mothers with newborn twins or very small newborn babies?	Y	N
3.6.	Is there some system for care of orphans or fostering of children from families where parents have died?	Y	N
3.7.	Has the PHC facility arranged some training for mothers with disabled children?	Y	N
3.8.	Does a team from the PHC facility, health centre or hospital visit the families with disabled children?	Y	N
3.9.	Does the community collect mothers with infants under 2 every month for weighing and promoting good growth?	Y	N

4. Preschool Age

4.1.	Do the health committee and environmental health officer or PHC facility nurse inspect preschools?	Y	N
4.2.	Are homes where orphans live visited periodically?	Y	N

4.3. Are there community-feeding projects in preschools and for preschool-age children?	Y	N
4.4. In the last year, has there been a round of immunizations for measles and polio?	Y	N
4.5. Are all disabled children referred periodically to the PHC facility for review?	Y	N
4.6. Do all preschools have a community parents committee that consider health aspects?	Y	N

5. School Age

5.1. Does the community or a group encourage packed lunches for schools in order to improve nutrition and school performance, or are there school feeding programmes?	Y	N
5.2. Are school inspections of environment (e.g. toilets, water) done by community parents committee together with a nurse and environmental health officer?	Y	N
5.3. Do school nurses screen school children and discuss findings with parents?	Y	N
5.4. Do the teachers in this community attend health workshops?	Y	N
5.5. Do the environmental health officers check buildings and grounds of schools and report to the committee?	Y	N
5.6. Are there adequate sports facilities and coaching for both boys and girls of school age to decrease sports injuries?	Y	N
5.7. Does the committee discuss the problems of children in the street and those living in the street?	Y	N
5.8. Has life skills education been introduced in all schools?	Y	N
5.9. Are there community-feeding projects in preschools and for preschool-age children?	Y	N
5.10. In the last year has there been a round of immunization for measles and polio?	Y	N
5.11. Are all disabled children referred periodically to the PHC facility for review?	Y	N
5.12. Do all preschools have a community parents committee that consider health aspects?	Y	N

6. Adolescent

6.1. Has the community arranged for mature approachable women or women teachers to act as focal points where sexually harassed schoolgirls can go for help and support?	Y	N
6.2. Are there peer group health educators for schools and out-of-school youth?	Y	N
6.3. Can adolescents in the community easily obtain contraceptives and condoms at the PHC facility?	Y	N
6.4. Are there youth group activities for recreation and health (for male and female)?	Y	N
6.5. Are the following available to youth: health education on smoking, drugs, alcohol and safe sex, and dangers of STI\HIV\AIDS?	Y	N
6.6. Do adolescents (girls and boys) receive nutritional guidance?	Y	N
6.7. Does the environmental health officer check on sport and play facilities to ensure safety?	Y	N
6.8. Is there a community-based mental health programme?	Y	N
6.9. Has circumcision been made a safe procedure in the community?	Y	N

7. Adults

7.1. Has there been health worker participation in community-based planning, such as for water points, toilets, the siting of PHC facilities, telephones?	Y	N
7.2. Does the community have members trained in early TB diagnosis and daily Direct Observed Treatment (DOTS)?	Y	N
7.3. Does the community have group information sessions for men and women related to health?	Y	N
7.4. Are there Non-Governmental or Community-Based Organisation activities for health and welfare in the community?	Y	N
7.5. Do nurses help with the reintegration of the mentally ill into their families after discharge from mental hospitals?	Y	N
7.6. Have the committee and community members done their own health surveys?	Y	N
7.7. Has the committee participated with health personnel to investigate outbreaks of disease (e.g. dysentery)?	Y	N

7.8. Is there a committee concerned with violence\dispute\conflict resolution?	Y	N
7.9. Is the health in occupational situations, such as factories, plantations, workshops, bus\taxi ranks, and bars\hotels monitored?	Y	N
7.10. Has there been community education for adults on TB, HIV, AIDS, STI and condom use?	Y	N
7.11. Are the mentally ill returning from hospital visited by health personnel (and committee members if relevant)?	Y	N
7.12. Does the community arrange for rapid emergency transport for patients in case of accidents, violence or maternity emergencies?	Y	N
7.13. Does the environmental health officer (EHO) check new buildings, rubbish collection and toilets in the villages?	Y	N
7.14. Does the EHO also advise on keeping pigs and on inspection of home-slaughtered animals?	Y	N
7.15. Can an adult who is HIV positive get confidential counselling from the PHC facility or lay counsellor?	Y	N
7.16. Has the committee taken steps to decrease the stigma of mental illness, epilepsy, AIDS and TB?	Y	N
8. Elderly		
8.1. Does the CHW keep a register of chronic disease (high blood pressure, diabetes, asthma, mental illness)?	Y	N
8.2. Does the committee arrange for home visits of the chronically ill?	Y	N
8.3. Has the community some arrangements in place for care of the elderly?	Y	
8.4. Are old people or disabled people in the community assisted in getting pensions or grants processed?	Y	N
8.5. Are arrangements made with community workers or nurses to help with terminal care of the extremely ill?	Y	N
8.6. Are there community volunteers who help with the aged and bedridden?	Y	N

NOTES:

ACTION TO BE TAKEN BY PHC FACILITY

Supervisor signature:	
PHC facility manager signature:	
Date:	

7.5 Checklist: For Use by PHC Facility Managers

PHC facility name:		**Date:**	
District and subdistrict:		**District code:**	
Supervisor/programme manager name:	Please print name	**Signature:**	

TICK APPROPRIATE BOX [✓] **Date last revised / checked**

1. General facility environment		
1.1. Appropriate signage available/visibly displayed?	Y	N
1.2. Clean (free from litter and weeds)?	Y	N
1.3. Easy access for people with disabilities (wide doors, ramps, lighting)?	Y	N
1.4. Functional and up-to-date fire extinguishers in place?	Y	N
1.5. Regular disaster drills conducted?	Y	N
1.6. Security available 24 hours a day?	Y	N
2. PHC internal environment		
2.1. Floors clean?	Y	N
2.2. Walls clean?	Y	N
2.3. Windows functioning properly?	Y	N
2.4. Clean linen available?	Y	N
2.5. Waste properly disposed of?	Y	N
2.6. Curtains and screens clean and well-functioning?	Y	N
3. Security room		
3.1. Is it well-secured against unauthorized entry?	Y	N
3.2. Clean and well-maintained?	Y	N
4. General leadership and planning		
4.1. Vision/Mission Statement developed and displayed visibly?	Y	N
4.2. Core values for team developed and displayed?	Y	N
4.3. Operational plan and/or business plan for year is available?	Y	N

5. Personnel		
5.1. Is every staff member clearly identified (such as through uniform, identity cards)?	Y	N
5.2. Did all personnel undergo an orientation programme?	Y	N
5.3. Personnel establishment for all personnel categories known; vacancies discussed with supervisor?	Y	N
5.4. Generic job descriptions per personnel category are available?	Y	N
5.5. Individual personnel Performance and Development Plan (PMDS) available and signed?	Y	N
5.6. Duty roster for all personnel available and displayed?	Y	N
5.7. Personnel attendance register in use?	Y	N
5.8. Delegation list/roster used?	Y	N
5.9. Duties not carried out due to lack of identified skills?	Y	N
5.10. For each personnel member: Record of meetings, workshops, and training attended?	Y	N
5.11. Are personnel given equal opportunity to participate in relevant workshops, meetings and training?	Y	N
5.12. Personnel meetings held regularly as per facility policy?	Y	N
5.13. In-service training activities taking place?	Y	N
5.14. Disciplinary procedures documented and copied to supervisor?	Y	N
6. Finance		
6.1. Budget for main categories of current year available and known?	Y	N
6.2. Monthly recording of expenditure in each category?	Y	N
6.3. Are balances calculated?	Y	N

6.4. If no, is any action taken?	Y	N
6.5. Has transfer of funds between line items been requested, if necessary (as permitted in youth setting)?	Y	N

7. Transport/communication

7.1. Weekly or monthly plan for transport needs?	Y	N
7.2. Plans submitted to supervisor or transport co-ordinator?	Y	N
7.3. Telephone/two way radio – in working order (line in PHC facility, card phone)?	Y	N
7.4. Used for official purposes only?	Y	N
7.5. Supervisor informed of problems?	Y	N

8. Visits to facility by supervisor

8.1. Visited monthly?	Y	N
8.2. Visit schedule to the facility available in advance?	Y	N
8.3. Visits schedule displayed?	Y	N
8.4. Record of visit available in the facility?	Y	N

9. Visits to facility by programme manager/co-ordinator

9.1. Visit schedule to facility available in advance?	Y	N
9.2. Visits schedule displayed?	Y	N
9.3. Record of visits available in the facility?	Y	N
9.4. Visited quarterly?	Y	N

10. Quality of Care

10.1. Patient/Client Consideration		
10.1.1 Patient charter displayed (in local languages)?	Y	N
10.1.2 Clear list of services available (with times) and displayed?	Y	N
10.1.3 Every patient/client welcomed in the facility?	Y	N
10.1.4 Customer care mechanisms (complaints, compliments, suggestions)?	Y	N
10.1.5 Patients'/clients' waiting times monitored regularly?	Y	N
10.1.6 Auditory and visual privacy during consultation maintained?	Y	N
10.1.7 Is facility physically accessible to people with disabilities?	Y	N
10.1.8 Is facility youth-friendly?	Y	N
10.2. Service Organization		
10.2.1 Supermarket approach practised?	Y	N
10.2.2 Patients with similar diseases/conditions **encouraged** (not required) to come as a group (to facilitate group education, support groups)?	Y	N
10.2.3 Efforts made to spread work over entire day (see description)?	Y	N
10.2.4 Audiovisual health information available in waiting area (in local language)?	Y	N
10.2.5 Arrangements for visiting doctors/other specialist services available?	Y	N
10.3. Referral system		
10.3.1 Letter sent with patient/client to referral level?	Y	N
10.3.2 Reply letter (back – referral) sent with patient/client?	Y	N
10.3.3 Special medicines for continuity of care (not in the EDL) sent to facility?	Y	N
10.4. Outreach programmes from higher level facilities implemented?	Y	N
10.5. Outreach programmes to lower level facilities implemented?	Y	N
10.6. Hand-washing done as per IPC policy?	Y	N
10.7. Waste (sharps, medical & household) managed as per IPC policy?	Y	N
10.8. Post-HIV exposure prophylaxis available?	Y	N
10.9. Standard Treatment Guidelines (STGs) followed?	Y	N
10.10. Medicines (TTO) properly labelled (name, strength, frequency, route; duration)?	Y	N
10.11. Patients provided with verbal and written instructions?	Y	N

11. Equipment

11.1. Essential equipment for PHC in place (stethoscope, baumanometer, thermometer, scale (adult & baby), oxygen with masks & cannulae)?	Y	N
11.2. Inventory up-to-date?	Y	N

11.3. Broken equipment labelled and recorded, with problem stated?	Y	N
11.4. Equipment due for routine maintenance identified?	Y	N
11.5. List of building (infrastructure) repairs needed (doors, windows, water)?	Y	
11.6. Discussed with supervisor and/or PHC facility committee?	Y	
11.7. Vaccine refrigerator available and functional?	Y	N

12. Medicines and supplies

12.1. Secure place for all stocks, under appropriate conditions?	Y	N
12.2. Stock cards used and up-to-date?	Y	N
12.3. Vaccine refrigerator temperature recorded twice daily?	Y	N
12.4. Orders for supplies placed regularly (according to average monthly consumption) and on time?	Y	N
12.5. Verify orders received against order placed?	Y	N
12.6. Discrepancies discussed with the supplier and supervisor?	Y	N
12.7. Monthly stock-outs recorded and discussed with supervisor?	Y	N
12.8. Stock organised according to FEFO (first expiry, first out)?	Y	N
12.9. No expired stock?	Y	N
12.10. Prescription carried out according to EDL?	Y	N
12.11. Prescription not in line with EDL discussed with supervisor?	Y	N

13. Information and documentation

13.1. References and resources:		
13.1.1 Up-to-date printed material on each national programme available for use by personnel (protocols, treatment guidelines)?	Y	N
13.1.2 Norms/standards for PHC facility services accessible to providers?	Y	N
13.1.3 Resource materials/references available?	Y	N
13.1.4 Flow charts on wall/desk (STI, IMCI, TB)?	Y	N
13.1.5 List of circulars, documents received (personnel signatures to confirm that they have read them) with date?	Y	N
13.2. Recording and reporting		
13.2.1 Facility-kept records?	Y	N
13.2.2 If facility-kept records system used: retrieval time, % lost analysed?	Y	N
13.2.3 Patient-kept records used (where applicable)?	Y	N
13.2.4 Stationery (new cards) available?	Y	N
13.2.5 Patient visit and services recorded (using tick register or other method)?	Y	N
13.2.6 Continuity records kept, up-to-date, follow-up done (e.g. registers for chronic diseases)?	Y	N
13.2.7 Laboratory specimen register kept?	Y	N
13.2.8 Missing laboratory results followed up?	Y	N
13.2.9 Medico-legal forms available (notifications, statutory responsibilities)?	Y	N
13.2.10 Notifiable diseases		
♦ Newly diagnosed diseases reported immediately?	Y	N
♦ "Nil" reports submitted weekly?	Y	N
13.2.11 Births, deaths: timely reports on correct form?	Y	N
13.2.12 Monthly PHC data: accurate, on time, filed/sent?	Y	N
13.3. Managing PHC facilities using information (as a terms of reference)		
13.3.1 Monthly data verified, discussed, graphically displayed with /by facility personnel?	Y	N
13.3.2 Monthly data and action discussed with facility committee?	Y	N
13.3.3 Operational plans (business plan) reviewed and updated regularly?	Y	N
13.3.4 Operational plans (business plans) as informed by data, in line with District, Provincial and National health plans?	Y	N
13.3.5 Catchment area map available, including location of mobile stops, DOTS supporters, CHWs and other outreach activities?	Y	N

NOTES:

ACTION TO BE TAKEN BY PHC FACILITY

Supervisor signature:	
PHC facility manager signature:	
Date:	

Annex A

PHC Data Definitions and Rationale

- Indicator name
- Numerator
- Denominator
- Indicator
- Routine Data Elements
- Data Element
- Guide for use and Context

	Indicator name	Numerator	Denominator	Indicator	Routine Data Elements	Data Element	Guide for use and Context
1	Utilisation rate - PHC	PHC total headcount	Total population	The rate at which PHC services are utilised by the catchment population, represented as the average number of visits per person per year in the catchment population. The denominator is usually Census-derived population estimates. USE: To determine overall utilisation patterns, in particular relevant for the move towards equity in the health sector. COMMENTS Utilisation may depend on many things like accessibility, acceptance and appropriateness of services, as well as the legacy of apartheid with its gross inequities in resources and personnel.	PHC headcount under 5 years	All individual patients not yet reached five years (60 months) of age attending the facility during the reporting period (usually month) for Primary Health Care. Each patient is counted once for each day they appear at the facility, regardless of the number of services utilised during the visit.	Include any child given individual service(s) during e.g. a home or crèche visit. CONTEXT: Workload indicators and monitoring of facility utilisation and accessibility.
					PHC headcount 5 years and older	All individual patients five years (60 months) and older attending the facility during the reporting period (usually month) for Primary Health Care. Each patient is counted once for each day they appear at the facility, regardless of the number of services utilised during the visit.	Only the mother is counted with regard to a delivery. DOTS visits to the facility (NOT DOTS in community/workplace/ home) are included in total headcount.
2	Utilisation rate under 5 years - PHC	PHC headcount under 5 years	Population under 5 years	The rate at which PHC services are utilised by clients 5 years and older in the catchment population, represented as the average number of PHC visits per year per person 5 years or older in the catchment population. The denominator is usually Census-derived population estimates. USE To determine overall utilisation patterns, in particular relevant for the move towards equity in the health sector. COMMENTS Utilisation may depend on many things like accessibility, acceptance and appropriateness of services.	PHC headcount under 5 years	All individual patients not yet reached five years (60 months) of age attending the facility during the reporting period (usually month) for Primary Health Care. Each patient is counted once for each day they appear at the facility, regardless of the number of services utilised during the visit.	Include any child given individual service(s) during e.g. a home or crèche visit. CONTEXT: Workload indicators and monitoring of facility utilisation and accessibility.
3	Utilisation rate 5 years and older - PHC	PHC headcount 5 years and older	Population 5 years and older	The rate at which PHC services are utilised by children under 5 years in the catchment population, represented as the average number of PHC visits per child under 5 per years in the target population. The denominator is usually Census-derived population estimates. USE To determine overall utilisation patterns, in particular relevant for the move towards equity in the health sector. COMMENTS Utilisation may depend on many things like accessibility, acceptancey and appropriateness of services.	PHC headcount 5 years and older	All individual patients five years (60 months) and older attending the facility during the reporting period (usually month) for Primary Health Care. Each patient is counted once for each day they appear at the facility, regardless of the number of services utilised during the visit.	Only the mother is counted with regard to a delivery. DOTS visits to the facility (NOT DOTS in community/workplace/ home) are included in total headcount.

4	Proportion of PHC headcount seen between 7pm and 7am	PHC headcount seen between 7pm and 7am	PHC total headcount	The percentage of all PHC visits that are seen between 7pm in the evening and 7am in the morning, often referred to as `after hours`.	PHC headcount seen between 7pm and 7am	All individual patients attending the facility between 7pm (19.00) and 7am (07.00) for Primary Health Care (this includes Emergency care as well as deliveries) during the reporting period. Each patient is counted once for each day they appear regardless of the number of services utilised during the visit.	This period is often loosely referred to as `after hours`, but that term is not clear. Note that only patients seen after 19.00 and before 07.00 in the morning should be counted.
					PHC headcount under 5 years	All individual patients not yet reached five years (60 months) of age attending the facility during the reporting period (usually month) for Primary Health Care. Each patient is counted once for each day they appear at the facility, regardless of the number of services utilised during the visit.	Include any child given individual service(s) during e.g. a home or crèche visit. CONTEXT: Workload indicators and monitoring of facility utilisation and accessibility.
					PHC headcount 5 years and older	All individual patients five years (60 months) and older attending the facility during the reporting period (usually month) for Primary Health Care. Each patient is counted once for each day they appear at the facility, regardless of the number of services utilised during the visit.	Only the mother is counted with regard to a delivery. DOTS visits to the facility (NOT DOTS in community/workplace/ home) are included in total headcount.
5	Child under 5 years case load - PHC	PHC headcount under 5 years	PHC total headcount	Children under 5 years headcount as a percentage of PHC total headcount. USE Using more detailed studies on requirements for child care (time, services, equipment), this indicator can be used both to allocate resources and to `weigh` workload figures between facilities and health districts. COMMENTS This indicator must not be confused with `Child Utilisation Rate`, which indicates extent of children utilising the facility (or to what extent services are reaching children in the area).	PHC headcount under 5 years	All individual patients not yet reached five years (60 months) of age attending the facility during the reporting period (usually month) for Primary Health Care. Each patient is counted once for each day they appear at the facility, regardless of the number of services utilised during the visit.	Include any child given individual service(s) during e.g. a home or crèche visit. CONTEXT: Workload indicators and monitoring of facility utilisation and accessibility.
					PHC headcount 5 years and older	All individual patients five years (60 months) and older attending the facility during the reporting period (usually month) for Primary Health Care. Each patient is counted once for each day they appear at the facility, regardless of the number of services utilised during the visit.	Only the mother is counted with regard to a delivery. DOTS visits to the facility (NOT DOTS in community/workplace/home) are included in total headcount.
6	Professional Nurse clinical work load - PHC	PHC total headcount	Professional Nurse clinical workdays	The average number of patients seen per Professional Nurse per clinical workday. PHC total headcount is used as a proxy numerator. Nurse work loads are relevant for analysing utilisation patterns, efficiency, need for more/less staff, more training, etc.	PHC headcount under 5 years	All individual patients not yet reached five years (60 months) of age attending the facility during the reporting period (usually month) for Primary Health Care. Each patient is counted once for each day they appear at the facility, regardless of the number of services utilised during the visit.	Include any child given individual service(s) during e.g. a home or crèche visit. CONTEXT: Workload indicators and monitoring of facility utilisation and accessibility.
					PHC headcount 5 years and older	All individual patients five years (60 months) and older attending the facility during the reporting period (usually month) for Primary Health Care. Each patient is counted once for each day they appear at the facility, regardless of the number of services utilised during the visit.	Only the mother is counted with regard to a delivery. DOTS visits to the facility (NOT DOTS in community/workplace/home) are included in total headcount.
					Professional Nurse clinical workdays	The number of actual workdays by Professional Nurses, irrespective of rank, used to perform clinical services in the facility during the reporting period (usually month). One actual work day is normally equivalent to an 8-hour shift (40 hours).	Do not confuse this data element with `Clinical days open during month` since the two would only be equal when there is only ONE nurse in the facility. Only days PRIMARILY used to handle patients are included, NOT days primarily used for e.g. training courses, meetings and other administrative issues.

7	Enrolled Nurse clinical work load - PHC	PHC total headcount	Enrolled Nurse clinical workdays	The average number of patients seen per enrolled nurse per clinical workday. PHC total headcount is used as a proxy numerator. Nurse work loads are relevant for analysing utilisation patterns, efficiency, need for more/less staff, more training, etc.	PHC headcount under 5 years	All individual patients not yet reached five years (60 months) of age attending the facility during the reporting period (usually month) for Primary Health Care. Each patient is counted once for each day they appear at the facility, regardless of the number of services utilised during the visit.	Include any child given individual service(s) during e.g. a home or crèche visit. CONTEXT: Workload indicators and monitoring of facility utilisation and accessibility.
					PHC headcount 5 years and older	All individual patients five years (60 months) and older attending the facility during the reporting period (usually month) for Primary Health Care. Each patient is counted once for each day they appear at the facility, regardless of the number of services utilised during the visit.	Only the mother is counted with regard to a delivery. DOTS visits to the facility (NOT DOTS in community/workplace/home) are included in total headcount.
					Enrolled Nurse clinical workdays	The number of actual workdays by Enrolled Nurses, irrespective of rank, used to perform clinical services in the facility during the reporting period (usually month). One actual workday is normally equivalent to an 8-hour shift (40 hours).	Do not confuse this data element with `Clinical days open during month`, as the two would only be equal when there is only ONE nurse in the facility. Only days PRIMARILY used to handle patients are included, NOT days primarily used for e.g. training courses, meetings and other administrative issues.
8	Nursing Assistant clinical work load - PHC	PHC total headcount	Nursing Assistant clinical workdays	The average number of patients seen per Nursing Assistant per clinical workday. PHC total headcount is used as a proxy numerator. Nurse workloads are relevant for analysing utilisation patterns, efficiency, need for more/less staff, more training, etc.	PHC headcount under 5 years	All individual patients not yet reached five years (60 months) of age attending the facility during the reporting period (usually month) for Primary Health Care. Each patient is counted once for each day they appear at the facility, regardless of the number of services utilised during the visit.	Include any child given individual service(s) during e.g. a home or crèche visit. CONTEXT: Workload indicators and monitoring of facility utilisation and accessibility.
					PHC headcount 5 years and older	All individual patients five years (60 months) and older attending the facility during the reporting period (usually month) for Primary Health Care. Each patient is counted once for each day they appear at the facility, regardless of the number of services utilised during the visit.	Only the mother is counted with regard to a delivery. DOTS visits to the facility (NOT DOTS in community/workplace/ home) are included in total headcount.
					Nursing Assistant clinical workdays	The number of actual workdays by Nursing Assistants used to perform clinical services in the facility during the reporting period (usually month). One actual workday is normally equivalent to an 8-hour shift (40 hours of work per week).	Do not confuse this data element with `Clinical days open during month`, since the two would only be equal when there is only ONE nurse in the facility. Only days PRIMARILY used to handle patients are included, NOT days primarily used for e.g. training courses, meetings and other administrative issues.

9	Pharmacy staff clinical work load - PHC	PHC total headcount	Pharmacy staff clinical workdays	The number of patients seen per pharmacy staff member per clinical workday. PHC total headcount is used as a proxy numerator. Pharmacy workload is relevant for analysing utilisation patterns, efficiency, need for more/less staff, more training, etc. Note that pharmacy staff can be pharmacists, pharmacy assistants, or other clinical staff like nurses working full-time with dispensing drugs. CONTEXT: Equitable workload is important for both staff and patients.	PHC headcount under 5 years	All individual patients not yet reached five years (60 months) of age attending the facility during the reporting period (usually month) for Primary Health Care. Each patient is counted once for each day they appear at the facility, regardless of the number of services utilised during the visit.	Include any child given individual service(s) during e.g. a home or crèche visit. CONTEXT: Workload indicators and monitoring of facility utilisation and accessibility.
					PHC headcount 5 years and older	All individual patients five years (60 months) and older attending the facility during the reporting period (usually month) for Primary Health Care. Each patient is counted once for each day they appear at the facility, regardless of the number of services utilised during the visit.	Only the mother is counted with regard to a delivery. DOTS visits to the facility (NOT DOTS in community/workplace/ home) are included in total headcount.
					Pharmacy staff clinical workdays	The number of actual workdays by Pharmacy staff, irrespective of rank, used to perform pharmacy services in the facility during the reporting period (usually month). One actual workday is normally equivalent to an 8-hour shift (40 hours).	Include the working days for all pharmacy staff who are involved in processing prescriptions, or in other words involved with the `clinical` side, whether these are qualified pharmacists or not. CONTEXT: Workload indicators and monitoring.
10	Nurse clinical work load - PHC	PHC total headcount	Nurse clinical workdays	The number of patients seen per nurse per clinical workday. Doctor workloads are relevant for analysing utilisation patterns, efficiency, need for more/ less staff, more training, etc. CONTEXT: Equitable workload is important for both staff and patients.	PHC headcount under 5 years	All individual patients not yet reached five years (60 months) of age attending the facility during the reporting period (usually month) for Primary Health Care. Each patient is counted once for each day they appear at the facility, regardless of the number of services utilised during the visit.	Include any child given individual service(s) during e.g. a home or crèche visit. CONTEXT: Workload indicators and monitoring of facility utilisation and accessibility.
					PHC headcount 5 years and older	All individual patients five years (60 months) and older attending the facility during the reporting period (usually month) for Primary Health Care. Each patient is counted once for each day they appear at the facility, regardless of the number of services utilised during the visit.	Only the mother is counted with regard to a delivery. DOTS visits to the facility (NOT DOTS in community/workplace/home) are included in total headcount.
					Professional Nurse clinical workdays	The number of actual workdays by Professional Nurses, irrespective of rank, used to perform clinical services in the facility during the reporting period (usually month). One actual workday is normally equivalent to an 8-hour shift (40 hours).	Do not confuse this data element with `Clinical days open during month` - the two would only be equal when there is only ONE nurse in the facility. Only days PRIMARILY used to handle patients are included, NOT days primarily used for e.g. training courses, meetings and other administrative issues.
					Enrolled Nurse clinical workdays	The number of actual workdays by Enrolled Nurses, irrespective of rank, used to perform clinical services in the facility during the reporting period (usually month). One actual workday is normally equivalent to an 8-hour shift (40 hours).	Do not confuse this data element with `Clinical days open during month`, since the two would only be equal when there is only ONE nurse in the facility. Only days PRIMARILY used to handle patients are included, NOT days primarily used for e.g. training courses, meetings and other administrative issues.
					Nursing Assistant clinical workdays	The number of actual workdays by Nursing Assistants used to perform clinical services in the facility during the reporting period (usually month). One actual workday is normally equivalent to an 8-hour shift (40 hours of work per week).	Do not confuse this data element with `Clinical days open during month`, as the two would only be equal when there is only ONE nurse in the facility. Only days PRIMARILY used to handle patients are included, NOT days primarily used for e.g. training courses, meetings and other administrative issues.

11	Doctor clinical work load - PHC	PHC case seen by doctor	Doctor clinical workdays	The number of patients seen per doctor per clinical workday. Doctor workloads are relevant for analysing utilisation patterns, efficiency, need for more/ less staff, more training, etc. CONTEXT: Equitable workload is important for both staff and patients.	PHC case seen by doctor – referred	A patient/client (child or adult) seen by a doctor for a Primary Health Care curative service (diagnosis and treatment), after the patient/client had been seen by a Professional Nurse or a Clinical Nurse Practitioner and subsequently referred.	This data element should be collected in all PHC facilities with full- or part-time doctors, as well as in hospitals that see a considerable number of PHC cases. The cause of the referral or the type of screening and/or treatment provided.
					PHC case seen by doctor – not referred	A patient/client (child or adult) seen by a doctor for a Primary Health Care curative service (diagnosis and treatment), after the patient/client had been seen by a Professional Nurse or a Clinical Nurse Practitioner and subsequently referred.	This data element should be collected in all PHC facilities with full- or part-time doctors, as well as in hospitals that see a considerable number of PHC cases. The cause of the referral or the type of screening and/or treatment provided.
					Doctor clinical workdays	The number of actual work days by doctors, irrespective of rank or specialty, used to perform clinical services in the facility during the reporting period (usually month). One actual work day is normally equivalent to an 8-hour shift (40 hours).	This figure should include ONLY clinical work (i.e. handling patients/clients), including normal administrative work related to patients/clients. Paid days related to e.g. training courses, meetings and other administrative issues.
12	Proportion of PHC cases seen by doctor that is referred from nurse	PHC case seen by doctor - referred	PHC case seen by doctor - referred and not referred	The percentage of total headcount that are referred to a Medical Officer. USE: To determine how well the policy of nurse-driven services is functioning at primary level. COMMENTS: The national health policy has indicated that primary level services are to be nurse-driven. This indicator can show where services are being nurse-driven and where additional training for nursing staff is required.	PHC case seen by doctor – referred	A patient/client (child or adult) seen by a doctor for a Primary Health Care curative service (diagnosis and treatment), after the patient/client had been seen by a Professional Nurse or a Clinical Nurse Practitioner and subsequently referred.	This data element should be collected in all PHC facilities with full- or part-time doctors, as well as in hospitals that see a considerable number of PHC cases. The cause of the referral or the type of screening and/or treatment provided.
					PHC case seen by doctor – not referred	A patient/client (child or adult) seen by a doctor for a Primary Health Care curative service (diagnosis and treatment), after the patient/client had been seen by a Professional Nurse or a Clinical Nurse Practitioner and subsequently referred.	This data element should be collected in all PHC facilities with full- or part-time doctors, as well as in hospitals that see a considerable number of PHC cases. The cause of the referral or the type of screening and/or treatment provided.
13	Campaign coverage under 5 years	Campaign headcount under 5 years	Population under 5 years	The percentage of children under 5 years in the target population that were vaccinated during a vaccination campaign.	Campaign headcount under 5 years.	Total number of children under 5 years reached through a mass campaign of children under 5 years reached through a mass campaign.	
14	Campaign coverage 5 years and older	Campaign headcount 5 years and older	Population 5 years and older	The percentage of children 5 years and older in the target population that were vaccinated during a vaccination campaign.	Campaign headcount 5 years and older.	Total number of clients 5 years and older reached through a mass campaign.	
15	Proportion of fixed facilities with functional committee/ board	Minuted meeting of committee / board during period	All fixed facilities	The percentage of all fixed health facilities with a health committee or hospital board that have regular meetings and keep minutes.	Minuted meetings of committee/ board during period.	The number of minuted (recorded) meetings of the clinic committee and/or the hospital board during the reporting period.	Only count minuted meetings – meetings without minutes are regarded as informal. CONTEXT: All PHC facilities and hospitals should have a functional committee and/or board.
16	Supervision visit rate	Supervisor visit this month	All PHC facilities	The rate at which PHC facilities are having formal visits by supervisors with written feedback and a visit report.	Supervisor visit this month	The number of visits to the facility by a dedicated clinic supervisor, who performs a visit according to the policy on clinic supervision and using the red flag or regular review tools.	Dropping in for tea, delivering mail, and/or delivering drugs and supplies do NOT qualify as a supervisor visit, even when done by the supervisor.
Child Health							

27	Weighing coverage under 5 years	Child under 5 years weighed	Target weighings of children under 5 years (pop<1yr*12 + pop1yr*6 + pop2yr*2 + pop3yr *2 + pop4yr*2)	The children <5 years actually weighed during the reporting period as a percentage of the total number of expected weighings in the target population. Expected weighings are defined as one weighing per month (12 per year) for children under 1 year, one weighing every second month for 1-year-old children (6 per year), and 2 weighings per year for children 2-4 years (24 weighings in total over 5 years). USE: To evaluate the coverage or completeness of growth monitoring - weighing would normally always be combined with a brief clinical assessment, in particular for children that are underweight or not gaining weight.	Child under 5 years weighed	A child weighed and the weight plotted onto the Road to Health card, the patient folder and other relevant recording.	All children under five years should be weighed whenever visiting a facility, but the child should be COUNTED as weighed only once per month even if they come more frequently (e.g. for a follow-up visit). CONTEXT: Regular weighing of all children is vital for growth monitoring. Weight of a child under 5 is the single most important indicator of the well-being of a child. Including this data element reminds staff about the importance of weighing children. The element can also be used both as a numerator (weighing coverage) and a denominator (% of children weighed that did not gain weight).
28	Weighing rate under 5 years	Child under 5 years weighed	PHC headcount under 5 years	The percentage of PHC headcount under 5 years that were weighed. : Since children weighed should be counted only ONCE per month, it is unlikely that this indicator will reach 100%. CONTEXT: Monitoring whether the policy of weighing all children seen at least once a month is being adhered to.	Child under 5 years weighed	A child weighed and the weight plotted onto the Road to Health card, the patient folder and other relevant recording.	All children under five years should be weighed whenever visiting a facility, but the child should be COUNTED as weighed only once per month even if they come more frequently (e.g. for a follow-up visit). CONTEXT: Regular weighing of all children is vital for growth monitoring. Weight of a child under 5 is the single most important indicator of the well-being of a child. Including this data element reminds staff about the importance of weighing children. The element can also be used both as a numerator (weighing coverage) and a denominator (% of children weighed that did not gain weight).
					PHC headcount under 5 years	All individual patients not yet reached five years (60 months) of age attending the facility during the reporting period (usually month) for Primary Health Care. Each patient is counted once for each day they appear at the facility, regardless of the number of services utilised during the visit.	Include any child given individual service(s) during e.g. a home or crèche visit. CONTEXT: Workload indicators and monitoring of facility utilisation and accessibility.

29	Not gaining weight rate under 5 years	Not gaining weight under 5 years	Child under 5 years weighed	The percentage of children weighed who had an episode of growth faltering/failure during the period. USE: To plan, evaluate and monitor nutrition programmes. COMMENTS: Monitoring growth faltering/failure is done in the hope of 'catching' under-nourished children BEFORE they become underweight or seriously malnourished, take corrective action (e.g. put them on PEM) and thereby avoid long term negative effects (stumping etc). If this indicator is significantly higher than the indicators measuring underweight or severely malnourished children, it points to this 'early warning' strategy working. If the percentages are more equal, though, it indicates that corrective actions are NOT being taken in time.	Not gaining weight under 5 years	A child under 5 years that has not gained weight compared to the weight recorded at least one month earlier on the Road-to-Health Card.	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 (e.g. for a follow-up visit).
					Child under 5 years weighed	A child weighed and the weight plotted onto the Road to Health card, the patient folder and other relevant recording.	All children under five years should be weighed whenever visiting a facility, but the child should be COUNTED as weighed only once per month even if they come more frequently (e.g. for a follow-up visit). CONTEXT: Regular weighing of all children is vital for growth monitoring. Weight of a child under 5 is the single most important indicator of the well-being of a child. Including this data element reminds staff about the importance of weighing children.
30	Underweight for age rate under 5 years	Underweight for age under 5 years – new cases	Child under 5 years weighed	Of all children under 5 years weighed, the percentage of children that are underweight for age.	Underweight for age under 5 years – new case	A child under 5 years identified as being BELOW the third centile but EQUAL TO or OVER 60% of Estimated Weight for Age (EWA) on the Road-to-Health chart. Include any such child irrespective of the reason for the underweight – malnourishment, premature birth, genetic disorders, etc.	Only count each episode ONCE, do NOT count repeat visits for the same episode (incidence!). The child will also be entered into the Malnutrition Register if that is used at the facility. A child previously identified as underweight for age ???
					Child under 5 years weighed	A child weighed and the weight plotted onto the Road to Health card, the patient folder and other relevant recording.	All children under five years should be weighed whenever visiting a facility, but the child should be COUNTED as weighed only once per month even if they come more frequently (e.g. for a follow-up visit). CONTEXT: Regular weighing of all children is vital for growth monitoring. Weight of a child under 5 is the single most important indicator of the well-being of a child. Including this data element reminds staff about the importance of weighing children. The element can also be used both as a numerator (weighing coverage) and a denominator (% of children weighed that did not gain weight).
31	Severe malnutrition under 5 years incidence	Severe malnutrition under 5 years – new ambulatory	Population under 5 years	The number of children who weigh below 60% Expected Weight for Age (new cases that month) per 1,000 children in the target population. USE: To plan, evaluate and monitor nutrition programmes. COMMENTS: This group include Marasmus, Kwashiorkor and similar cases of clinical malnutrition. All of these cases must be considered as serious malnutrition cases, and such children will often be hospitalised. The hospitals should NOT count such children referred from a PHC facility.	Severe malnutrition under 5 years – new ambulatory	A new child found to weigh less than 60% of Estimated Weight for Age (EWA), or to suffer from Marasmus, Kwashiorkor, or similar, EXCLUDING new-born babies. Severe malnutrition might also be denoted as CLINICALLY malnourished. `Ambulatory` means that the patient is able to walk (or equivalent condition for infants not yet walking).	Only count each case when encountered for the FIRST time during that episode – the child must NOT be counted again during repeat visits. Since such cases might be referred to a hospital, the referral hospital should NOT count cases referred.

34	Diarrhoea without dehydration incidence under 5 years	Diarrhoea without dehydration under 5 years – new ambulatory	Population under 5 years	The number of diarrhoea cases with no dehydration under 5 years per 1,000 children under 5 years in the catchment population. GUIDE FOR USE: To determine the health status of children and identify potential environmental hazards (e.g. contamination of water sources). CONTEXT: Diarrhoeal disease is one of the leading causes of infant mortality, and is closely related to both socio-economic situation and environmental health issues like access to clean water.	Diarrhoea without dehydration under 5 years – new ambulatory	The number of children with diarrhoea with NO visible dehydration. Diarrhoea occurs when stools contain more water than normal. Mothers usually know whether their children have diarrhoea. Diarrhoea with NO visible dehydration is present when the child has diarrhoea with not enough signs to classify as severe or mild dehydration. `Ambulatory` means that the patient is able to walk (or equivalent condition for infants not yet walking).	
35	Diarrhoea with dehydration incidence under 5 years	Diarrhoea with dehydration under 5 years – new ambulatory	Population under 5 years	The number of diarrhoea cases with severe or mild dehydration under 5 years per 1,000 children under 5 years in the catchment population. GUIDE FOR USE: To determine the health status of children and identify potential environmental hazards (e.g. contamination of water sources). CONTEXT: Diarrhoeal disease is one of the leading causes of infant mortality, and is closely related to both socio-economic situation and environmental health issues like access to clean water.	Diarrhoea with dehydration under 5 years – new ambulatory	The number of children with diarrhoea presenting with severe or mild dehydration. Diarrhoea occurs when stools contain more water than normal. Mothers usually know whether their children have diarrhoea. Dehydration is present when a diarrhoea is accompanied by two of the following signs: lethargic or unconscious, sunken eyes, not able to drink or drinking poorly or drinking eagerly, skin pinch goes back very slowly, restless/ irritable, and/or thirsty. `Ambulatory` means that the patient is able to walk (or equivalent condition for infants not yet walking).	The child is only counted the first time it presented with the current diarrhoea at the facility (new case). Follow-up visits for the same episode of diarrhoea should not be counted here. CONTEXT: Over time this indicator will give us an estimate of the severity of diarrhoeal disease, and whether the caregiver is able to meet the fluids needs of the child with diarrhoea i.e. if the number of children with severe dehydration and with some dehydration decrease, but the number of children with no visible dehydration increases, we can assume that caregivers are becoming more experienced in treating diarrhoea.
36	Diarrhoea incidence under 5 years	Diarrhoea under 5 years – new ambulatory	Population under 5 years	The number of children with diarrhoea per 1,000 children in the catchment population. Diarrhoea is formally defined as 3 or more watery stools in 24 hours, but any episode diagnosed and/or treated as diarrhoea after an interview with the adult accompanying the child should be counted. USE: To determine the health status of children and identify potential environmental hazards (e.g. contamination of water sources). COMMENTS: It is assumed that health personnel, through interviewing the person accompanying the child, confirm that the problem most likely is diarrhoea and not just a temporary running stomach due to e.g. intake of certain drinks/foodstuffs. Diarrhoeal disease is one of the leading causes of infant mortality, and is closely related to both socio-economic situation and environmental health issues like access to clean water.	Diarrhoea without dehydration under 5 years – new ambulatory	The number of children with diarrhoea with NO visible dehydration. Diarrhoea occurs when stools contain more water than normal. Mothers usually know whether their children have diarrhoea. Diarrhoea with NO visible dehydration is present when the child has diarrhoea with not enough signs to classify as severe or mild dehydration. `Ambulatory` means that the patient is able to walk (or equivalent condition for infants not yet walking).	The child is counted only the first time it presents at the facility with diarrhoea (new case). Follow-up visits for the same episode of diarrhoea should not be counted here. CONTEXT: This indicator will serve as a marker of success in the communication skills of health workers, the child care skills of caregivers, and hence community participation and understanding of health care. Having children with diarrhoea, and no visible dehydration would mean that caregivers have been empowered to manage diarrhoea at home effectively.
					Diarrhoea with dehydration under 5 years – new ambulatory	The number of children with diarrhoea presenting with severe or mild dehydration. Diarrhoea occurs when stools contain more water than normal. Mothers usually know whether their children have diarrhoea. Dehydration is present when a diarrhoea is accompanied by two of the following signs: lethargic or unconscious, sunken eyes, not able to drink or drinking poorly or drinking eagerly, skin pinch goes back very slowly, restless/ irritable, and/or thirsty. `Ambulatory` means that the patient is able to walk (or equivalent condition for infants not yet walking).	

39	Pneumonia incidence under 5 years	Pneumonia under 5 years – new ambulatory	Population under 5 years	The number of children under 5 years diagnosed with pneumonia, per 1,000 children in the catchment population.	Pneumonia under 5 years – new ambulatory	The number of children with pneumonia. Pneumonia is defined as cough or difficult and fast breathing and any one of the following general danger signs: child unable to drink or breastfeed, child vomits everything, child has convulsions during this illness, child is lethargic or unconscious or chest drawing or stridor in a calm child. The speed of fast breathing depends on the age of the child: Age 1 week up to 2 months: 60 breaths per minute or more = fast breathing. Age 2 months up to 12 months: 50 breaths per minute or more. Age 12 months up to 5 years: 40 breaths per minute	The child should be counted only for the first visit presenting with pneumonia. Follow-up visits for the same episode of pneumonia should not be counted here. CONTEXT: This indicator will give an indication of the need for oxygen at primary care level.
44	HIV positive rate under 5 years	HIV positive under 5 years – new cases	HIV test done on child under 5 years	The percentage of all children under 5 years tested for HIV that tested positive.	HIV positive under 5 years – new cases	New cases of children under 5 years that tested positive for HIV.	Counted only on the day on which a positive HIV result was obtained. Confirmation tests and/or follow-up visits should not be counted. CONTEXT: To determine the HIV positive rate amongst children under 5 years.
					HIV test done on child under 5 years	Children under 5 years tested for HIV, excluding testing of babies as part of the PMTCT programme.	Counted only on the day on which the test was done. Any follow-up or confirmation test should not be included.
Nutrition							
45	Vitamin A coverage under 1 year	Vitamin A supplement to 6-11 months infant	Target population under 1 year	Percentage of infants 6-11 months receiving vitamin A 100,000 units. : Note that all infants are supposed to get the dose as close to reaching 6 months of age as possible, so the denominator will be all infants under 1 year from the Census data.	Vitamin A supplement to 6-11 months infant	The number of Vitamin A doses, 100,000 units, given once to infants aged at least 6 months and not yet 12 months.	Vitamin A boosts the immune system of children.
46	Vitamin A coverage 1-4 years	Vitamin A supplement to 12-59 months child	Target population 12-59 months multiplied by 2	Percentage of children 12-59 months receiving vitamin A 200,000 units twice a year. The denominator is therefore the target population 1-4 years multiplied by 2.	Vitamin A supplement to 12-59 months child	Vitamin A doses of 200,000 units given to each child every six months from 12 to 59 months	Vitamin A boosts the immune system of children. The main challenge related to providing vitamin A to 12-59 months children is that the majority of them currently do not visit PHC facilities often and/or regularly enough for treatment.

47	Vitamin A coverage – new mothers	Vitamin A supplement to women within 8 weeks after delivery	Deliveries total (in facility, BBAs, outside facility)	Percentage of newly delivered mothers receiving a single dose of 200,000 units vitamin A prior to 8 weeks after delivery.	Vitamin A supplement to women within 8 weeks after delivery	The number of Vitamin A doses, 200,000 units, given to women within 8 weeks after delivery.	Each newly delivered mother should receive a single dose of 200,000 units of Vitamin A, preferably immediately after delivery and not later than 8 weeks after delivery.
					Delivery in facility	Delivery in facility is the total number of women who delivered in a health facility under the supervision of trained medical/nursing staff. Note that this number can be less than the Total Births in facility if multiple births occur.	
					Live birth (BBA)	Live births to women who delivered on their way to the facility, or who ended up delivering at home but where the mother had a booking and/or a clear intention to deliver in a facility (e.g. due to rapid delivery, lack of transport, no relative at home, bad weather, etc). The assumption is that the mother will arrive at the (nearest) facility for normal post-delivery case within 72 hours after delivery. Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of involuntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.	
					Still birth (BBA)	Still births to women who delivered on their way to the facility, or who ended up delivering at home but where the mother had a booking and/or a clear intention to deliver in a facility (e.g. due to rapid delivery, lack of transport, no relative at home, bad weather, etc). The assumption is that the mother will arrive at the (nearest) facility for normal post-delivery case within 72 hours after delivery. Still birth is death prior to the complete expulsion or extraction from its mother of a product of conception, and where the delivery took place before arrival in the facility; the death is indicated by the fact that after such separation the foetus does not breathe or show any evidence of life, such as beating of the heart, pulsation of the umbilical cord or definite movement of the involuntary muscles. Still births should only be counted when the foetus is of 26 or more weeks gestational age and/or weighs 500g or more. A still-born foetus might have been dead for a while (macerated) or died just before or during expulsion or extraction (fresh) from its mother.	
					Live birth outside facility (excluding BBA)	Live births to women who chose or had to deliver at home or in some other place outside of a health facility, and who visit a health facility with the baby within 8 weeks after delivery. This excludes those who had intended/booked a facility delivery, were forced to deliver before arrival, but who arrived at a health facility within 72 hours for normal post-delivery care (BBAs). Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of involuntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.	

Immunisation							
48	Immunisation coverage under 1 year	Immunised fully under 1 year – new	Target population under 1 year	The percentage of all children in the target area under one year who complete their primary course of immunisation. A Primary Course includes BCG, OPV 1,2 & 3, DTP-Hib 1,2 & 3, HepB 1,2 & 3, and 1st measles (usually at 9 months).	Immunised fully under 1 year – new	A child who has completed his/her 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 before 1 year.	The child should only be counted ONCE as fully immunised when receiving the last vaccine in the course, – usually the 1st measles immunisation – AND there is documentary proof of all required vaccines (e.g. on the Road to Health card). This parameter is the most important immunisation parameter collected, but it is commonly being mishandled because the same child is counted more than once. After completion, a child must be counted only ONCE and the vaccination card marked accordingly (i.e. if marked as completed at 9 months, the child must NOT be marked again during later visits at, for example, 10 or 11 months).
49	BCG coverage	BCG dose under 1 year	Target population under 1 year	The percentage of expected live born babies that received BCG under 1 year of age (note: usually given immediately after birth). USE: Immunisation monitoring. COMMENTS: Many babies are born in hospital maternity wards that currently might not be submitting PHC data.	BCG dose under 1 year	BCG (tuberculosis) vaccine given to a child under 1 year of age, preferably immediately after birth.	All babies/infants receiving BCG should be counted, including babies coming to clinics after home deliveries and babies/infants that received their BCG later than usual due to, for example, temporary shortages of vaccine.
50	OPV 1st dose coverage	OPV 1st dose	Target population under 1 year	The percentage of children under 1 immunised with OPV dose 1. USE: Immunisation monitoring.	OPV 1st dose	OPV (Poliomyelitis) vaccine 1st dose given to a child under one year, preferably around 6 weeks after birth.	GUIDE FOR USE: Do not count possible repeat doses (e.g. given during large vaccination campaigns), only doses given and noted on the Road-to-Health card. CONTEXT: Monitoring drop-out rates (5-20% from dose 1 to 3 in SA) and identification of vaccine delivery problems. Poliomyelitis is a viral infection that spreads faecal-orally. Most infections are asymptomatic; the risk of paralysis in infants and children aged <15 years ranges from 1 in 100 to 1 in 500 infections, depending on several factors. Risk factors that increase the likelihood of paralysis include the administration of injections or tonsillectomy during the incubation period of poliovirus infection, pregnancy, stress and trauma.
51	OPV 3rd dose coverage	OPV 3rd dose	Target population under 1 year	The percentage of children under 1 immunised with OPV dose 3. USE: Immunisation monitoring.	OPV 3rd dose	OPV (Poliomyelitis) vaccine 3rd dose given to a child under one year, preferably around 14 weeks after birth.	Do not count possible repeat doses (e.g. given during large vaccination campaigns), only doses given and noted on the Road-to-Health card. CONTEXT: Monitoring drop-out rates (5-20% from dose 1 to 3 in SA) and identification of vaccine delivery problems.
52	HepB 1st dose coverage	HepB 1st dose	Target population under 1 year	The percentage of children who received their first Hepatitis B dose (normally at 14 weeks) – annualised. USE: To monitor the immunisation programme.	HepB 1st dose	Hepatitis B vaccine 1st dose given to a child under one year, preferably at around 6 weeks after birth.	If there are no problems with vaccine delivery in the area, so that HepB is always given together with OPV and DTP-Hib, the three doses could be combined on the data collection form and automatically multiplied later using computer software.
53	HepB 3rd dose coverage	HepB 3rd dose	Target population under 1 year	The percentage of children who received their third Hepatitis B dose (normally at 14 weeks) – annualised. USE: To monitor the immunisation programme.	HepB 3rd dose	Hepatitis B vaccine 3rd dose given to a child under one year, preferably at around 14 weeks after birth.	If there are no problems with vaccine delivery in the area, so that HepB is always given together with OPV and DTP-Hib, the three doses could be combined on the data collection form and automatically multiplied later using computer software.

54	DTP-Hib 1st dose coverage	DTP-Hib 1st dose	Target population under 1 year	The percentage of children who received their first DTP-Hib dose (normally at 6 weeks) – annualised. USE: To monitor the immunisation programme.	DTP-Hib 1st dose	DTP-Hib (Diphtheria/Tetanus/Pertussis-Haemophilus influenzae B) vaccine 1st dose given to a child under one year, preferably at around 6 weeks after birth.	If there are no problems with vaccine delivery in the area, so that DTP-Hib is always given together with OPV and HepB, the three doses could be combined on the data collection form and automatically multiplied later using computer software.
55	DTP-Hib 3rd dose coverage	DTP-Hib 3rd dose	Target population under 1 year	The percentage of children who received their third DTP-Hib dose (normally at 14 weeks) – annualised. USE: To monitor the immunisation programme.	DTP-Hib 3rd dose	Hepatitis B vaccine 3rd dose given to a child under one year, preferably at around 14 weeks after birth	If there are no problems with vaccine delivery in the area, so that HepB is always given together with OPV and DTP-Hib, the three doses could be combined on the data collection form and automatically multiplied later using computer software.
56	DTP-Hib 1-3 doses drop-out rate	DTP-Hib 1st dose – DTP-Hib 3rd dose	DTP-Hib 1st dose	The percentage of children who dropped out of the immunisation schedule between the first doses (normally at 6 weeks) and the third doses (normally at 14 weeks). The DTP-Hib numbers are used for this purpose.	DTP-Hib 1st dose	Hepatitis B vaccine 1st dose given to a child under one year, preferably at around 6 weeks after birth.	If there are no problems with vaccine delivery in the area, so that HepB is always given together with OPV and DTP-Hib, the three doses could be combined on the data collection form and automatically multiplied later using computer software.
					DTP-Hib 3rd dose	DTP-Hib (Diphtheria/Tetanus/Pertussis-Haemophilus influenzae B) vaccine 3rd dose given to a child under one year, preferably at around 14 weeks after birth.	If there are no problems with vaccine delivery in the area, so that DTP-Hib is always given together with OPV and HepB, the three doses could be combined on the data collection form and automatically multiplied later using computer software.
57	DTP-Hib 3 - Measles 1 doses drop-out rate	DTP-Hib 3rd dose – Measles 1st dose under 1 year	DTP-Hib 3rd dose	The percentage of children who dropped out of the immunisation schedule between the third doses (normally at 14 weeks / 3.5 months) and the first measles dose (normally at 9 months). The DTP-Hib numbers are used for this purpose.	DTP-Hib 3rd dose	DTP-Hib (Diphtheria/Tetanus/Pertussis-Haemophilus influenzae B) vaccine 3rd dose given to a child under one year, preferably at around 14 weeks after birth.	If there are no problems with vaccine delivery in the area, so that DTP-Hib is always given together with OPV and HepB, the three doses could be combined on the data collection form and automatically multiplied later using computer software.
					Measles 1st dose under 1 year	Measles vaccine 1st dose given to a child under one year of age (preferably at 9 months after birth).	GUIDE FOR USE: 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. Also do not count doses given as part of mass vaccination campaigns. CONTEXT: Measles is an acute viral infection transmitted by close respiratory contact and may also spread via aerosolised droplets. Most deaths occur from secondary infections of the respiratory and/or gastrointestinal tract. Note that the vaccine efficiency is only 85% at 9 months, so a booster dose at 18 months is important.
58	Measles coverage under 1 year	Measles 1st dose under 1 year	Target population under 1 year	The percentage of children who received their 1st measles dose (normally at 9 months) – annualised. GUIDE FOR USE: Numerator should indclude ONLY 1st doses given as part of the regular Primary Course of Immunisation, not mass campaign vaccination or emergency doses at 6 months.	Measles 1st dose under 1 year	Measles vaccine 1st dose given to a child under one year of age (preferably at 9 months after birth).	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. Also do not count doses given as part of mass vaccination campaigns.

59	Measles 2nd dose coverage	Measles 2nd dose	Target population of 1 year olds	The percentage of children who received their 2nd measles dose (normally at 18 months) – annualised. GUIDE FOR USE: All 2nd doses given should be counted, EXCEPT measles vaccines given as part of a mass vaccination campaign. CONTEXT: The 1st measles dose is only around 85% effective, so the 2nd dose is important as a booster.	Measles 2nd dose	Measles vaccine 2nd dose given to a child above one year of age (preferably at 18).	GUIDE FOR USE: Do not count doses given as part of mass vaccination campaigns. CONTEXT: Immunisation coverage indicators related to the part of the immunisation programme targeting children 1 year and older (i.e. it is also used as a proxy for assessing OPV at 18 months and 5 years, DPT booster at 18 months, and the DT 5 year booster dose). Measles is an acute viral infection transmitted by close respiratory contact and may also spread via aerosolised droplets. Most deaths occur from secondary infections of the respiratory and/ or gastrointestinal tract. Note that the vaccine efficiency is only 85% at 9 months, whereas the overall routine immunisation programme coverage is 80%. This booster dose at 18 months is therefore very important.
60	Measles 1-2 doses drop-out rate	Measles 1st dose under 1 year Measles 2nd dose	Measles 1st dose under 1 year	The percentage of children who dropped out between the first (normally at 9 months) and second normally at 18 months) measles dose. USE: To monitor the immunisation programme.	Measles 1st dose under 1 year	Measles vaccine 1st dose given to a child under one year of age (preferably at 9 months after birth).	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. Also do not count doses given as part of mass vaccination campaigns.
					Measles 2nd dose	Measles vaccine 2nd dose given to a child above one year of age (preferably at 18).	Do not count doses given as part of mass vaccination campaigns. CONTEXT: Immunisation coverage indicators related to the part of the immunisation programme targeting children 1 year and older (i.e. it is also used as a proxy for assessing OPV at 18 months and 5 years, DPT booster at 18 months, and the DT 5 year booster dose).
61	Td dose coverage at 6 years	DT dose at 5 years	Target population at 6 years	The percentage of children who received their DT booster dose at around 5 years of age (annualised).	Td dose at 6 years	Td booster dose given to a child around 6 years of age. Note that this replaced DT booster dose at 5 years from February 2008.	Only include DT doses given routinely, including `mopping up` campaigns, but NOT any doses given as part of mass vaccination campaigns. Mass vaccination is understood to mean that children are vaccinated without checking their vaccination history.
62	Td dose coverage at 12 years	Td dose at 12 years	Target population at 12 years	The percentage of children who received their Td booster dose at around 12 years of age (annualised).	Td dose at 12 years	Td last booster doses given to children around 12 years.	Only include Td doses given routinely, including `mopping up` campaigns, but NOT any doses given as part of mass vaccination campaigns. Mass vaccination is understood to mean that children are vaccinated without checking their vaccination or Road-to-Health cards, whereas routine vaccinations are only targeting those not yet vaccinated.
	PCV7 1st dose coverage	PCV7 1st doses to children under 1 year	Target population under 1 year	The proportion of children who received their first PCV7 dose (normally at 6 weeks) – annualised.	PCV7 1st doses to children under 1 year	Pneumococcal (PCV7) vaccine 1st dose given to a child under one year, preferably around 6 weeks after birth.	
	PCV7 2nd dose coverage	PCV7 2nd doses to children under 1 year	Target population under 1 year	The proportion of children who received their second PCV7 dose (normally at 14 weeks) – annualised.	PCV7 2nd doses to children under 1 year	Pneumococcal (PCV7) vaccine 2nd dose given to a child under one year, preferably around 14 weeks after birth.	
	RV 1st dose coverage	RV 1st doses to children under 1 year	Target population under 1 year	The proportion of children who received their first RV dose (normally at 6 weeks) – annualised.	RV 1st doses to children under 1 year	Rota Virus (RV) vaccine 1st dose given to a child under one year, preferably around 6 weeks after birth and NOT later than 14 weeks after birth.	

	RV 2nd dose coverage	RV 2nd doses to children under 1 year	Target population under 1 year	The proportion of children who received their second RV dose (normally at 14 weeks) – annualised.	RV 2nd doses to children under 1 year	Rota Virus (RV) vaccine 2nd dose given to a child under one year, preferably around 14 weeks after birth and NOT later than 24 weeks after birth.	
	PCV7 3rd dose coverage	PCV7 3rd doses to children under 1 year	Target population under 1 year	The proportion of children who received their third PCV7 dose (normally at 9 months) – annualised.	PCV7 3rd doses to children under 1 year	Pneumococcal (PCV7) vaccine 3rd dose given to a child under one year, preferably around 9 months after birth.	
	DTaP-IPV/Hib 1st dose coverage	DTaP-IPV/Hib 1st doses to children under 1 year	Target population under 1 year	The proportion of children under 1 year who received their first DTaP-IPV/ Hib (Pentaxim) 1st dose, normally at 6 weeks – annualised	DTaP-IPV/Hib 1st doses to children under 1 year	This vaccine provides protection against diphtheria, tetanus, pertussis, poliomyelitis and invasive infections caused by Haemophilus influenzae type b (such as meningitis, septicaemia, cellulitis, arthritis, epiglottitis, pneumopathy and osteomyelitis). The vaccine contains acellular pertussis and inactivated polio vaccine, both of which have been found to be effective and have a better side-effect profile.	
	DTaP-IPV/Hib 3rd dose coverage	DTaP-IPV/Hib 3rd doses to children under 1 year	Target population under 1 year	The proportion of children under 1 year who received their first DTaP-IPV/ Hib (Pentaxim) 3rd dose, normally at 14 weeks – annualised.	DTaP-IPV/Hib 3rd doses to children under 1 year	This vaccine provides protection against diphtheria, tetanus, pertussis, poliomyelitis and invasive infections caused by Haemophilus influenzae type b (such as meningitis, septicaemia, cellulitis, arthritis, epiglottitis, pneumopathy and osteomyelitis). The vaccine contains acellular pertussis and inactivated polio vaccine, both of which have been found to be effective and have a better side-effect profile.	
	DTaP-IPV/Hib 4th dose coverage	DTaP-IPV/Hib 4th doses to children at 18 months	Target population 1 year	The proportion of children 1 year of age who received their first DTaP-IPV/ Hib (Pentaxim) 4th dose, normally at 18 months – annualised.	DTaP-IPV/Hib 4th doses to children at 18 months	This vaccine provides protection against diphtheria, tetanus, pertussis, poliomyelitis and invasive infections caused by Haemophilus influenzae type b (such as meningitis, septicaemia, cellulitis, arthritis, epiglottitis, pneumopathy and osteomyelitis). The vaccine contains acellular pertussis and inactivated polio vaccine, both of which have been found to be effective and have a better side-effect profile.	
Reproductive Health							

63	Women year protection rate	Contraceptive years dispensed (excluding sterilisations)	Female target population 15-44 years	The rate at which couples (specifically women) are protected against pregnancy using modern contraceptive methods, EXCLUDING sterilisations. USE: Couple Year Protection Rate is a calculation which aims at estimating how many women in a given community are protected against pregnancy. COMMENTS: The Women Year Protection Rate must not be confused with another common indicator called 'Couple Year Protection Rate', as they are defined differently. Also note that this indicator primarily focuses on the REPRODUCTIVE aspects and underplays STI aspects of reproductive health (one vasectomy is equivalent to 5,000 condoms in the formula).	IUCD inserted	Intra Uterine Contraceptive Device (IUCD) inserted into a woman.	IUCDs are relatively uncommon in developing countries, and the numbers are small compared to, for example, injectable or oral contraceptives. Facility numbers above 10 during one reporting period should be verified.
					Oral pill cycle	A packet (cycle) of oral contraceptives issued to a woman between 15 and 45 years, each containing pills for one cycle (28 days).	Count each packet issued. This would normally range from around 3 given to new/young users that need closer monitoring for side-effects and up to 6 given to older women that have used pills for many years without known side-effects. CONTEXT: This data element forms part of the input into the Women Year Protection Rate (WYPR, and excludes sterilisations and vasectomies) and Couple Year Protection Rate (CYPR, which includes sterilisations and vasectomies) indicators. A woman needs 13 oral pill packets to be fully protected for one year.
					Medroxy-progesterone injection	Medroxyprogesterone acetate (Depo Provera/Petogen) injection given to a woman between 15 and 45 years. This injection provides contraceptive protection for 3 months.	Ensure that Medroxyprogesterone and Norethisterone enantate injections are not mixed up.
					Norethisterone enanthate injection	Any Norethisterone enantate (Nuristerate) injection given to a woman between 15 and 45 years. This injection provides contraceptive protection for 2 months.	Ensure that Medroxyprogesterone and Norethisterone enantate injections are not mixed up.
					Male condoms distributed	Male condoms from the stock of the facility which were given out at distribution points at the facility or elsewhere in the community (i.e. campaigns, non-traditional outlets, etc.).	GUIDE FOR USE: Condoms should preferably be counted per box or per carton once they leave the store of the facility, i.e by using the local stock register. Another method would be to count stock at the beginning of each reporting period (for instance month). Add the number in stock at the beginning of the reporting period to supplies received during the period, and subtract what was left at the end of the period (beginning of NEXT period). The difference is the number of condoms distributed.
					Female condoms distributed	Female condoms from the stock of the facility which were given out at distribution points at the facility or elsewhere in the community (such as campaigns, non-traditional outlets).	GUIDE FOR USE: Condoms should preferably be counted per box or per carton once they leave the store of the facility, that is, by using the local stock register. Another method would be to count stock at the beginning of each reporting period (for instance, month). Add the number in stock at the beginning of the reporting period to supplies received during the period, and subtract what was left at the end of the period (beginning of NEXT period). The difference is the number of condoms distributed.

64	Couple year protection rate	Contraceptive years dispensed (including sterilisations)	Female target population 15-44 years	The rate at which couples (specifically women) are protected against pregnancy using modern contraceptive methods INCLUDING sterilisations. USE: Couple Year Protection Rate is a calculation which aims at estimating how many women in a given community are protected against pregnancy. COMMENTS: The Couple Year Protection Rate must not be confused with another common indicator called 'Women Year Protection Rate', as they are defined differently. Also note that this indicator primarily focuses on the REPRODUCTIVE aspects and underplays STI aspects of reproductive health (one vasectomy is equivalent to 5,000 condoms in the formula).	IUCD inserted	Intra Uterine Contraceptive Device (IUCD) inserted into a woman.	IUCDs are relatively uncommon in developing countries, and the numbers are small compared to injectable or oral contraceptives. Facility numbers above 10 during one reporting period should be verified.
					Oral pill cycle	A packet (cycle) of oral contraceptives issued to a woman between 15 and 45 years, each containing pills for one cycle (28 days).	Count each packet issued. This would normally range from around 3 given to new/young users that need closer monitoring for side-effects and up to 6 given to older women that have used pills for many years without known side-effects. CONTEXT: This data element forms part of the input into the Women Year Protection Rate (WYPR, which excludes sterilisations and vasectomies) and Couple Year Protection Rate (CYPR which includes sterilisations and vasectomies) indicators. A woman needs 13 oral pill packets to be fully protected for one year.
					Medroxy-progesterone injection	Medroxyprogesterone acetate (Depo Provera/Petogen) injection given to a woman between 15 and 45 years. This injection provides contraceptive protection for 3 months.	Ensure that Medroxyprogesterone and Norethisterone enantate injections are not mixed up.
					Norethisterone enanthate injection	Any Norethisterone enantate (Nuristerate) injection given to a woman between 15 and 45 years. This injection provides contraceptive protection for 2 months.	GUIDE FOR USE: Ensure that Medroxyprogesterone and Norethisterone enantate injections are not mixed up.
					Sterilisation – female	Any planned operative procedure that results in a woman being sterilised.	GUIDE FOR USE: Count each case only in the facility where the operation is actually performed. CONTEXT: This parameter forms part of the input into the Couple Year Protection Rate (CYPR) indicator. Each sterilisation is on average equivalent to 10 years.
					Sterilisation – male	Any planned operative procedure that results in a man being sterilised (also called vasectomy).	GUIDE FOR USE: Count each case only in the facility where the operation is actually performed. CONTEXT: This parameter forms part of the input into the Couple Year Protection Rate (CYPR) indicator. Each sterilisation is on average equivalent to 20 years.
65	Male sterilisation rate	Male sterilisation performed	Male target population 15-44 years	The number of male sterilisations (vasectomies) performed per 1,000 males 15-44 years old in the target population.	Sterilisation - male	Any planned operative procedure that results in a man being sterilised (also called vasectomy).	Count each case only in the facility where the operation is actually performed. CONTEXT: This parameter forms part of the input into the Couple Year Protection Rate (CYPR) indicator. Each sterilisation is on average equivalent to 10 years.
66	Female sterilisation rate	Female sterilisation performed	Female target population 15-44 years	The number of female sterilisations (either interval or postpartum) performed per 1,000 females 15-44 years old in the target population.	Sterilisation – female	Any planned operative procedure that results in a woman being sterilised.	Count each case only in the facility where the operation is actually performed. CONTEXT: This parameter forms part of the input into the Couple Year Protection Rate (CYPR) indicator. Each sterilisation is on average equivalent to 20 years.

67	Termination of Pregnancy rate	Terminations of Pregnancy performed	Expected pregnant women in catchment population (proxy: children under 1 year * 1.3)	The number of Termination of Pregnancies performed in a health facility as a percentage of all expected pregnancies in the catchment population. GUIDE FOR USE: Only count TOPs performed by professional staff in a health facility, not the so-called `back-street abortions`.	Termination of Pregnancy performed	A Termination of Pregnancy performed under safe conditions in a health facility.	Count each case ONLY in the facility where the termination is actually performed. PHC facilities that want to count clients counselled and referred elsewhere for a TOP should use the data element `Referred for Termination of Pregnancy`. Note that Emergency Contraception must be counted separately from TOP.
68	Cervical cancer screening coverage	Cervical smear in woman 30years and above	Female target population 30years and above	The number of women 30 years and above that have had cervical smears (pap smears) taken, as a percentage of all females 30 years and above in the target population. GUIDE FOR USE: All cases in this age bracket should be counted, even if some of them are linked to symptomatic or suspect cases that strictly speaking are not directly related to the mass screening programme for cervical cancer.	Cervical smear in woman 30 years and above	A cervical (pap) smear done for women between thirty and sixty years for screening purposes according to the national policy of screening all women in this age category every 10 years. Diagnostic smears or repeat smears are NOT included, and the smear must be of sufficient quality to enable screening (e.g. include endo-cervical cells).	
Maternal Health - Antenatal Care							
Antenatal Care							
	Antenatal visits before 20 weeks rate	Antenatal 1st visit before 20 weeks	Antenatal 1st visits	The percentage of women who have a booking visit (first visit) before they are 20 weeks (about half way) into their pregnancy. USE: Monitor to what extent antenatal services are reaching pregnant women early, which is crucial for many types of interventions. COMMENTS: The causes of late booking visits need to be determined, and facilities where this indicator is low should systematically interview latecomers to find out why they did not report earlier.	Antenatal 1st visit before 20 weeks	A first visit by a pregnant woman to a health facility for the primary purpose of receiving antenatal care, often referred to as a `booking visit`, that occurs before 20 weeks after conception. The actual protocol followed during the visit might vary, but it should include relevant screening procedures, laboratory tests (e.g. for syphilis), and counselling/ health promotion (the latter often done in groups).	A visit purely to take a pregnancy test should NOT be counted as a first antenatal visit. Maternal health Indicators like antenatal care coverage gives an estimate of the proportion of pregnant women who have presented for first antenatal visits compared to the number of expected deliveries in the community. Quality of care is partially measured by the number of visits per antenatal client (usually 2-4 in rural areas and 4-6 in urban areas), by the distribution of visits through the pregnancy (currently only 20-40% occur before 20 weeks), and so forth. The official government target is that ALL pregnant women should receive antenatal care, that their first visit should happen in the first trimester, and that there should be at least three visits (a minimum of one in each trimester). Others, like the Nursing incomplete Associationrecommend???up to 10 antenatal visits during each pregnancy with shortening intervals as delivery approaches.
					Antenatal 1st visit 20 weeks or later	A first visit by a pregnant woman to a health facility for the primary purpose of receiving antenatal care, often referred to as a 'booking visit', that occurs at 20 weeks after conception or later. The actual protocol followed during the visit might vary, but it should include relevant screening procedures, laboratory tests (e.g. for syphilis), and counselling/ health promotion (the latter often done in groups).	A visit purely to take a pregnancy test should NOT be counted as a first antenatal visit.

70	Antenatal coverage	Antenatal 1st visits	Potential antenatal clients in population (proxy: Children under 1 year * 1.15)	The percentage of pregnant women coming for at least one antenatal visit. The census number of children under one year factorised by 1.15 is used as a proxy denominator – the extra 0.15 (15%) is a rough estimate to cater for late miscarriages (~10 to 28 weeks), still births (after 28 weeks gestation), and infant mortality. USE: Monitoring to what extent antenatal services are reaching pregnant women. COMMENTS: This indicator must be analysed together with the indicator 'Antenatal visits per antenatal client'. Low antenatal coverage should prompt public campaigns, whereas a low number of visits per antenatal client is more likely related to quality of care (women see little reason to come for repeated visits).	Antenatal 1st visit before 20 weeks	A first visit by a pregnant woman to a health facility for the primary purpose of receiving antenatal care, often referred to as a `booking visit`, that occurs before 20 weeks after conception. The actual protocol followed during the visit might vary, but it should include relevant screening procedures, laboratory tests (e.g. for syphilis), and counselling/ health promotion (the latter often done in groups).	
					Antenatal 1st visit 20 weeks or later	A first visit by a pregnant woman to a health facility for the primary purpose of receiving antenatal care, often referred to as a 'booking visit', that occurs at 20 weeks after conception or later. The actual protocol followed during the visit might vary, but it should include relevant screening procedures, laboratory tests (e.g. for syphilis), and counselling/ health promotion (the latter often done in groups).	
71	Antenatal visits per antenatal client rate	Antenatal total visits	Antenatal 1st visits	The total number of antenatal visits over the number of first antenatal visits (equivalent to number of antenatal clients). USE: Monitoring to what extent antenatal services are able to encourage pregnant women to come at least 3 times during the pregnancy and/or monitoring how many times they actually come. COMMENTS: The health policy target is that every pregnant woman should have at least 3 antenatal visits, preferably one in each trimester. This indicator must be analysed together with the indicator 'Antenatal coverage'. Low antenatal coverage should prompt public campaigns, whereas a low number of visits per antenatal client is more likely related to quality of care (women see little reason to come for repeated visits, or they don't understand why they should).	Antenatal 1st visit before 20 weeks	A first visit by a pregnant woman to a health facility for the primary purpose of receiving antenatal care, often referred to as a `booking visit`, that occurs before 20 weeks after conception. The actual protocol followed during the visit might vary, but it should include relevant screening procedures, laboratory tests (e.g. for syphilis), and counselling/ health promotion (the latter often done in groups).	
					Antenatal 1st visit 20 weeks or later	A first visit by a pregnant woman to a health facility for the primary purpose of receiving antenatal care, often referred to as a 'booking visit', that occurs at 20 weeks after conception or later. The actual protocol followed during the visit might vary, but it should include relevant screening procedures, laboratory tests (e.g. for syphilis), and counselling/ health promotion (the latter often done in groups).	A visit purely to take a pregnancy test should NOT be counted as a first antenatal visit.
					Antenatal follow-up visit	Any antenatal visit other than a first antenatal visit. GUIDE FOR USE: Count any follow-up antenatal visit, whether the woman is receiving other services (e.g. curative) or not.	
72	Tetanus Toxoid coverage of pregnant women	Tet Tox 2nd/Booster dose to pregnant woman	Potential antenatal clients in population (proxy: Children under 1 year * 1.15)	The percentage of pregnant women receiving Tetanus Toxoid 2nd dose or booster dose. The census number of children under one year factorised by 1.15 is used as a proxy denominator - the extra 0.15 (15%) is a rough estimate to cater for late miscarriages (~10 to 28 weeks), still births (after 28 weeks gestation), and infant mortality. USE: Monitoring to what extent pregnant women are protected. COMMENTS: The choice of 2nd/ Booster dose instead of 3rd/Booster dose (or even later doses) is based on international standards.	Tet Tox 2nd/ Booster dose to pregnant woman	The second Tet Tox dose given to a pregnant women. 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. All others are regarded as fully immunised against Tetanus Toxoid after 2 doses. GUIDE FOR USE: Count the woman only once when she receives either the 2nd dose or the booster dose. CONTEXT: Tetanus immunisation is standard practice only in some provinces.	
Syphillis							

106	Proportion antenatal clients tested for syphilis	Antenatal client tested for syphilis	Antenatal 1st visits	The proportion of women coming for their first antenatal visit that are tested for syphilis – the assumption is that ALL antenatal clients are offered a syphilis test as part of the normal antenatal protocol.	Antenatal client tested for syphilis	A pregnant woman who has been tested for syphilis. The standard test method is through a blood test (WR).	
					Antenatal 1st visit before 20 weeks	A first visit by a pregnant woman to a health facility for the primary purpose of receiving antenatal care, often referred to as a `booking visit`, that occurs before 20 weeks after conception. The actual protocol followed during the visit might vary, but it should include relevant screening procedures, laboratory tests (e.g. for syphilis), and counselling/ health promotion (the latter often done in groups).	
					Antenatal 1st visit 20 weeks or later	A first visit by a pregnant woman to a health facility for the primary purpose of receiving antenatal care, often referred to as a 'booking visit', that occurs at 20 weeks after conception or later. The actual protocol followed during the visit might vary, but it should include relevant screening procedures, laboratory tests (e.g. for syphilis), and counselling/ health promotion (the latter often done in groups).	
107	Syphilis prevalence among antenatal clients tested	Antenatal client tested positive for syphilis – new	Antenatal client tested for syphilis	The percentage of antenatal clients who accept to be tested for syphilis, and then test positive.	Antenatal client tested positive for syphilis – new	Any antenatal client diagnosed as having syphilis, normally as a result of a positive blood test (WR).	
					Antenatal client tested for syphilis	A pregnant woman who has been tested for syphilis. The standard test method is through a blood test (WR).	
HIV /VCT / PMTCT / STI/TB							
PMTCT							
1	Proportion of antenatal clients pre-test counselled for HIV	Antenatal client pre-test counselled for HIV	Antenatal 1st visits (Antenatal 1st visit before 20 weeks + Antenatal 1st visit 20 weeks or later)	The proportion of pregnant women who were pre-test counselled for HIV in antenatal care during their current pregnancy.	Antenatal client pre-test counselled for HIV	All antenatal clients that have been pre-test counselled for HIV/AIDS and then offered testing.	HIV testing should be routinely offered to all antenatal clients. Make sure you count ALL antenatal clients receiving counselling, INCLUDING those that later say no to being tested. Do NOT mix up POST-counselling with PRE-test counselling.
					Antenatal 1st visit before 20 weeks	A first visit by a pregnant woman to a health facility for the primary purpose of receiving antenatal care, often referred to as a `booking visit`, that occurs before 20 weeks after conception. The actual protocol followed during the visit might vary, but it should include relevant screening procedures, laboratory tests (e.g. for syphilis), and counselling/ health promotion (the latter often done in groups).	
					Antenatal 1st visit 20 weeks or later	A first visit by a pregnant woman to a health facility for the primary purpose of receiving antenatal care, often referred to as a 'booking visit', that occurs at 20 weeks after conception or later. The actual protocol followed during the visit might vary, but it should include relevant screening procedures, laboratory tests (e.g. for syphilis), and counselling/ health promotion (the latter often done in groups).	

2	Proportion of antenatal clients tested for HIV	Antenatal client tested for HIV – new	1st Antenatal visits	The proportion of pregnant women who accepted and were tested for HIV for the first time during their current pregnancy.	Antenatal client tested for HIV – new	A pregnant woman who was tested for HIV after pre-test counselling.	
					Antenatal 1st visit before 20 weeks	A first visit by a pregnant woman to a health facility for the primary purpose of receiving antenatal care, often referred to as a `booking visit`, that occurs before 20 weeks after conception. The actual protocol followed during the visit might vary, but it should include relevant screening procedures, laboratory tests (e.g. for syphilis), and counselling/ health promotion (the latter often done in groups).	
					Antenatal 1st visit 20 weeks or later	A first visit by a pregnant woman to a health facility for the primary purpose of receiving antenatal care, often referred to as a 'booking visit', that occurs at 20 weeks after conception or later. The actual protocol followed during the visit might vary, but it should include relevant screening procedures, laboratory tests (e.g. for syphilis), and counselling/ health promotion (the latter often done in groups).	
3	Proportion of antenatal clients tested positive for HIV	Antenatal client tested positive for HIV – new	Antenatal client tested for HIV – new	The proportion of pregnant women who tested positive for HIV in the first HIV test done during the current pregnancy, reflecting HIV prevalence. The other two HIV positive groups would be those with known and documented HIV positive status, and those who either were not offered, or who refused, testing.	Antenatal client tested positive for HIV – new	A pregnant woman who tested positive for HIV in the first HIV test done during the current pregnancy, and thus is among those eligible for PMTCT and possibly HAART (depending on subsequent CD4 count test and/ or HIV staging).	Count ONLY once – that is on the day the test result became available (This refers to both rapid and/or Rapid test tests). Do NOT count antenatal clients with known and documented HIV positive status here, but count them under the data element `Antenatal client with documented HIV positive status`.
					Antenatal client tested for HIV –- new	A pregnant woman who was tested for HIV after pre-test counselling.	
4	Proportion of antenatal clients re-tested for HIV at 32 weeks or later	Antenatal client re-tested for HIV at 32 weeks or later	Antenatal client tested negative for HIV – new	Women who were re-tested at around 32 weeks gestation as a proportion of those who tested negative at the initial test during the current pregnancy.	Antenatal client re-tested for HIV at 32 weeks or later	A pregnant woman who was re-tested for HIV around 32 weeks gestation after testing negative for HIV during an earlier antenatal visit. At least 6 weeks should elapse before a re-test is done.	Antenatal clients who test HIV negative during their first antenatal visit should be offered a repeat HIV test at or around 32 weeks, in order to detect late sero-converters.
					Antenatal client tested negative for HIV – new	A pregnant woman who tested negative for HIV in the first HIV test done during the current pregnancy.	Count ONLY once – that is on the day the test result became available (this refers to both rapid and/or Rapid test tests).
5	Proportion of antenatal clients re-tested positive for HIV at 32 weeks or later	Antenatal client re-tested positive for HIV at 32 weeks or later	Antenatal client re-tested for HIV at 32 weeks or later	The proportion of women who initially tested HIV negative, then re-tested positive for HIV at around 32 weeks gestation or later.	Antenatal client re-tested positive for HIV at 32 weeks or later	A pregnant woman who tested HIV positive when re-tested for HIV around 32 weeks gestation or later, after testing negative for HIV during an earlier (usually the first) antenatal visit.	Only count clients that had a negative HIV test earlier in their pregnancy.
					Antenatal clients re-tested for HIV at 32 weeks or later	A pregnant woman who was re-tested for HIV around 32 weeks gestation after testing negative for HIV during an earlier antenatal visit. At least 6 weeks should elapse before a re-test is done.	

6	Proportion of HIV positive antenatal clients not on HAART receiving AZT prophylaxis	Antenatal HIV positive client initiating AZT prophylaxis	Antenatal HIV positive clients eligible for AZT prophylaxis (Antenatal client tested positive for HIV – new + Antenatal client re-tested positive for HIV at 32 weeks + Antenatal client with documented HIV positive status and not on HAART)	The proportion of HIV positive pregnant women not on HAART who received AZT prophylaxis from 28 weeks onward during the current pregnancy.	Antenatal HIV positive client initiating AZT prophylaxis	AZT prophylactic treatment initiated at 28 weeks of pregnancy or as soon as possible thereafter in a HIV positive pregnant woman, in order to reduce maternal HIV viral load and further reduce the risk of vertical transmission to the infant.	Women presenting at 28 weeks or later should be started on AZT prescribed by a registered health professional (in line with the relevant legislation and regulations) at that visit, unless clinically diagnosed as anaemic (pale) or laboratory findings indicate that they are severely anaemic (i.e. Hb<7g/dl).
					Antenatal client tested positive for HIV – new	A pregnant woman who tested positive for HIV in the first HIV test done during the current pregnancy, and thus is among those eligible for PMTCT and possibly HAART (depending on subsequent CD4 count test and/ or HIV staging).	
					Antenatal client re-tested positive for HIV at 32 weeks	A pregnant woman who tested HIV positive when re-tested for HIV around 32 weeks gestation or later, after testing negative for HIV during an earlier (usually the first) antenatal visit.	
					Antenatal client with documented HIV positive status and not on HAART	All antenatal clients who during their first antenatal visit can document that they are HIV positive, or whose HIV positive status is known from their existing patient folder or Electronic Health Record, but who have NOT been put on anti-retroviral treatment.	Count all known and documented HIV positive antenatal clients, but only those NOT already on HAART (those on HAART will not be given AZT or Nevirapine prophylaxis). The majority is likely to be long-term clients whose patient folders include the required documentation, but also count first time visitors to a facility that bring their documented patient history, or whose history can be obtained from their previous health provider. This group of clients should obviously NOT be counted under pre-test counselling and/or testing, UNLESS they for some reason are tested again, but they will be offered prophylaxis (AZT and/or NVP).
7	Proportion of HIV positive women not on HAART receiving Nevirapine prophylaxis during labour	Nevirapine prophylaxis to women during labour	Antenatal HIV positive clients eligible for Nevirapine prophylaxis (Antenatal client tested positive for HIV – new + Antenatal client re-tested positive for HIV at 32 weeks + Antenatal client with documented HIV positive status and not on HAART	The proportion of HIV positive pregnant women not on HAART who received Nevirapine prophylaxis during labour.	Nevirapine prophylaxis to women during labour	Nevirapine prophylaxis given to/ taken by HIV positive pregnant women during labour.	Count all HIV positive pregnant women receiving Nevirapine during labour (one or more doses, which usually will depend how long they are in labour). In some cases the dose(s) were given to them during antenatal care to be taken at the onset of labour, and in other cases the dose(s) were (additional) doses provided in the maternity ward.
					Antenatal client tested positive for HIV – new	A pregnant woman who tested positive for HIV in the first HIV test done during the current pregnancy, and thus is among those eligible for PMTCT and possibly HAART (depending on subsequent CD4 count test and/ or HIV staging).	
					Antenatal client re-tested positive for HIV at 32 weeks	A pregnant woman who tested HIV positive when re-tested for HIV around 32 weeks gestation or later, after testing negative for HIV during an earlier (usually the first) antenatal visit.	
					Antenatal client with documented HIV positive status and not on HAART	All antenatal clients who during their first antenatal visit can document that they are HIV positive, or whose HIV positive status is known from their existing patient folder or Electronic Health Record, but who have NOT been put on anti-retroviral treatment.	

8	Proportion of HIV positive antenatal clients receiving CD4 count testing	Antenatal HIV positive client with CD4 test	Antenatal HIV positive clients eligible for CD4 count testing (Antenatal client tested positive for HIV – new + Antenatal client re-tested positive for HIV at 32 weeks + Antenatal client with documented HIV positive status and not on HAART)	The proportion of HIV positive pregnant women not on HAART who received CD4 count testing during the current pregnancy.	Antenatal HIV positive client with CD4 test	All antenatal HIV positive clients who were tested for their CD4 count, in order to determine whether they are eligible for HAART.	All HIV positive pregnant women, except those on HAART (HAART regimens include regular CD4 testing), should have a CD4 cell count taken on the same day that their HIV positive status is established, preferably at the first antenatal visit (or at the earliest opportunity). They should also be clinically staged according to WHO staging, unless staging had already been done. Women with CD4 cell count 200 or below (advanced HIV) are particularly vulnerable to opportunistic infections and have a high viral load with increased risk of mother-to-child transmission of HIV (MTCT) and should start treatment with Highly Active Antiretroviral Therapy (HAART) in order to delay progression of disease and reduce the risk of MTCT of HIV.
					Antenatal client tested positive for HIV – new	A pregnant woman who tested positive for HIV in the first HIV test done during the current pregnancy, and thus is among those eligible for PMTCT and possibly HAART (depending on subsequent CD4 count test and/or HIV staging).	
					Antenatal client re-tested positive for HIV at 32 weeks	A pregnant woman who tested HIV positive when re-tested for HIV around 32 weeks gestation or later, after testing negative for HIV during an earlier (usually the first) antenatal visit.	
					Antenatal client with documented HIV positive status and not on HAART	All antenatal clients who during their first antenatal visit can document that they are HIV positive, or whose HIV positive status is known from their existing patient folder or Electronic Health Record, but who have NOT been put on anti-retroviral treatment.	

9	Proportion of all HIV positive antenatal clients with live birth	Live birth to HIV positive women	All known HIV positive pregnant women (Antenatal client tested positive for HIV – new + Antenatal client re-tested positive for HIV at 32 weeks + Antenatal client with documented HIV positive status and not on HAART + Antenatal client with documented HIV positive status and already on HAART)	The proportion of all known HIV positive pregnant women with live birth. This is a process indicator used to monitor the completeness of both ANC HIV testing data and Live births to HIV positive women data. Indicator value should ideally be around 98% - 100% minus 3% still births and plus 1.5% multiple births (twins).	Live birth to HIV positive woman	The number of live births to women who are known HIV positive, including BBAs. Mothers with unknown HIV status at delivery that get tested within 72 hours after birth and test positive (baby receives Nevirapine dose) should be counted as well.	
					Antenatal client tested positive for HIV – new	A pregnant woman who tested positive for HIV in the first HIV test done during the current pregnancy, and thus is among those eligible for PMTCT and possibly HAART (depending on subsequent CD4 count test and/ or HIV staging).	
					Antenatal client re-tested positive for HIV at 32 weeks	A pregnant woman who tested HIV positive when re-tested for HIV around 32 weeks gestation or later, after testing negative for HIV during an earlier (usually the first) antenatal visit.	
					Antenatal client with documented HIV positive status and not on HAART	All antenatal clients who during their first antenatal visit can document that they are HIV positive, or whose HIV positive status is known from their existing patient folder or Electronic Health Record, but who have NOT been put on anti-retroviral treatment.	
					Antenatal client with documented HIV positive status and already on HAART	All antenatal clients who during their first antenatal visit can document that they are HIV positive and who have already been put on anti-retroviral treatment.	Count only pregnant women who were already on HAART at their first antenatal visit, but do NOT count those (presumably) few that were put on HAART afterwards.
10	Proportion of HIV exposed babies receiving Nevirapine prophylaxis	Nevirapine prophylaxis to babies born to HIV positive women	Live birth to HIV positive women	The proportion of live babies born to known HIV positive mothers who received Nevirapine prophylaxis within 72 hours after birth.	Nevirapine prophylaxis to baby born to HIV positive woman	Nevirapine prophylaxis given to newborn babies as soon as possible after birth, preferably within 6 hours but not later than 72 hours after birth.	
					Live birth to HIV positive woman	The number of live births to women who are known HIV positive, including BBAs. Mothers with unknown HIV status at delivery that get tested within 72 hours after birth and test positive (baby receives Nevirapine dose) should be counted as well. Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of involuntary muscles.	Count ALL live births including BBAs to women with known HIV positive status, whether the mother and/or baby receive HAART prophylaxis (PMTCT) / HAART or not.

11	Proportion of HIV exposed babies initiated on AZT prophylaxis	AZT prophylaxis initiated to baby born to HIV positive woman	Live birth to HIV positive woman	The proportion of live babies born to known HIV positive mothers who were initiated on AZT prophylaxis for 7 or 28 days after birth.	AZT prophylaxis initiated to baby born to HIV positive woman	AZT prophylaxis initiated to an infant born to a known HIV positive mother. The treatment lasts for 7 days in cases where the mother received optimal PMTCT or HAART prophylaxis, and for 28 days where the mother received sub-optimal PMTCT or HAART.	
					Live birth to HIV positive woman	The number of live births to women who are known HIV positive, including BBAs. Mothers with unknown HIV status at delivery that get tested within 72 hours after birth and test positive (baby receives Nevirapine dose) should be counted as well. Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of involuntary muscles.	
12	Proportion of HIV exposed infants PCR tested for HIV around 6 weeks	HIV PCR test of infant born to HIV positive mother around 6 weeks	Live birth to HIV positive woman	The proportion of infants born to known HIV positive mothers who were PCR tested for HIV 6 weeks after birth.	HIV PCR test of infant born to HIV positive mother around 6 weeks	HIV-exposed infants tested around 6 weeks of age using a PCR test (Polymerase Chain Reaction tests – PCR tests detect viral DNA or RNA direct).	HIV-exposed infants should be tested at 6 weeks of age using a PCR test. HIV antibody tests (Rapid test) should not be used to diagnose or confirm HIV infection in asymptomatic infants younger than 18 months, since positive antibody tests in these infants could reflect `inherited` maternal antibodies and therefore HIV exposure. However, a negative antibody test in an infant younger than 18 months means that the infant is not HIV infected, providing that breastfeeding has stopped 6 weeks or more prior to the test date.
					Live birth to HIV positive woman	The number of live births to women who are known HIV positive, including BBAs. Mothers with unknown HIV status at delivery that get tested within 72 hours after birth and test positive (baby receives Nevirapine dose) should be counted as well. Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of involuntary muscles.	
13	Proportion of HIV exposed infants PCR tested positive for HIV around 6 weeks	HIV PCR test positive of infant born to HIV positive mother around 6 weeks	HIV PCR test of infant born to HIV positive mother around 6 weeks	The proportion of infants born to known HIV positive mothers who were PCR tested for HIV and found to be positive around 6 weeks after birth.	HIV PCR test positive of infant born to HIV positive mother around 6 weeks	HIV-exposed infants tested HIV positive around 6 weeks of age using a PCR test (Polymerase Chain Reaction tests – PCR tests detect viral DNA or RNA direct).	This is the positive testing rate at any given infant follow-up service. The term `vertical transmission rate` is not used as it requires a very high follow-up rate and covers all infants until breastfeeding has ceased. This indicates the number of HIV positive infants who should receive HAART. Early infant HIV diagnosis and management is essential for child survival.
					HIV PCR test of infant born to HIV positive mother at 6 weeks	HIV-exposed infants tested around 6 weeks of age using a PCR test (Polymerase Chain Reaction tests – PCR tests detect viral DNA or RNA direct).	

14	Proportion of HIV exposed children tested HIV positive at 18 months	HIV antibody test positive of child born to HIV positive mother at 18 months	HIV antibody test of child born to HIV positive mother at 18 months	The proportion of children born to known HIV positive mothers who were tested for HIV antibodies and found to be positive 18 months after birth.	HIV antibody test positive of child born to HIV positive mother at 18 months	The number of babies born to HIV positive women who were tested for HIV antibodies at 18 months using a Rapid test and tested positive. Do not use a positive HIV antibody test to diagnose or confirm HIV infection in asymptomatic infants younger than 18 months (positive antibody tests in these infants could reflect `inherited` maternal antibodies and therefore HIV exposure). However, a negative antibody test in an infant younger than 18 months means that the infant is not HIV infected, providing that breastfeeding has stopped 6 weeks or more prior to the test date.	
					HIV antibody test of child born to HIV positive mother at 18 months	The number of babies born to HIV positive women who were tested for HIV antibodies at 18 months using a Rapid test and tested positive. Do not use a positive HIV antibody tests to diagnose or confirm HIV infection in asymptomatic infants younger than 18 months (positive antibody tests in these infants could reflect maternal antibodies and therefore HIV exposure). However, a negative antibody test in an infant younger than 18 months means that the infant is not HIV infected, providing that breastfeeding has stopped 6 weeks or more prior to the test date.	At 18 months ALL exposed children (negative and positive) should be tested to confirm their HIV status. HIV Rapid test testing can be used to confirm HIV status in infants older than 18 months.
15	Proportion of HIV positive antenatal clients initiated on HAART	HIV positive antenatal client initiated on HAART – new	HIV positive antenatal client medically eligible for HAART	The proportion of HIV positive antenatal clients that is medically eligible for HAART, who were initiated on HAART therapy during the pregnancy, either because their CD4 count was 200 or below or because of staging.	HIV positive antenatal client initiated on HAART - new	HIV positive antenatal clients who were initiated on HAART during this pregnancy.	
					HIV positive antenatal client medically eligible for HAART	All HIV positive antenatal clients with advanced HIV that meet criteria to start treatment with Highly Active Antiretroviral Therapy (HAART) in order to delay progression of disease. A pregnant woman is medically eligible for ART when the CD4 cell count is ≤ 200 cells/mm3 or when the woman is stage IV according to the WHO clinical staging of HIV and AIDS for adults. Stage IV includes any of the following conditions/disease: HIV wasting syndrome, Pneumocystis pneumonia, Recurrent severe bacterial pneumonia, Chronic herpes simplex infection (orolabial, genital or anorectal of >1 months duration or visceral at any site), Oesophagael candidiasis (or candidiasis of trachea, bronchi or lungs), Extrapulmonary tuberculosis, Kaposis sarcoma\ Cytomegalovirus infection other than liver, spleen or lymph node (CMV), CNS toxoplasmosis (Toxo), HIV encephalopathy (ADC), Cryptococcosis – non-pulmonary, Disseminated mycosis (i.e. histoplasmosis, coccidiomycosis), Progressive multifocal leucoencephalopathy (PML), Cryptosporidiosis plus diarrhoea >one month, Chronic Isosporiasis plus diarrhoea, Herpes simplex infection; visceral or >one month mucocutaneous (HSV), Atypical mycobacteriosis disseminated (MOTT), Atypical disseminated leishmeniasis, Non-typhoidal Salmonella septicaemia, Lymphoma, Kaposi's sarcoma (KS), Invasive cervical carcinoma and/or performance, Symptomatic HIV-associated nephropathy or symptomatic HIV-associated cardiomyopathy	Do NOT count antenatal clients that were already registered on HAART at the first antenatal visit, only count those diagnosed as HIV positive during antenatal care and those with known HIV positive status but NOT on ART during their first antenatal visit. The purpose of establishing the clinical stage of an HIV positive pregnant woman is to treat women with advanced HIV that meet criteria to start treatment with Highly Active Antiretroviral Therapy (HAART) in order to delay progression of disease. Whilst being used for maternal health, it is expected that this regimen will also reduce the risk of mother-to-child transmission of HIV.

16	Proportion of HIV exposed infants initiated on Co-Trimoxazole prophylaxis from 6 weeks	HIV exposed infant receiving Co-Trimoxazole prophylaxis from 6 weeks	Live birth to HIV positive woman	The proportion of infants born to HIV positive women who were initiated on Co-Trimoxazole prophylaxis from 6 weeks.	HIV exposed infant receiving Co-Trimoxazole prophylaxis from 6 weeks – new	Infants born to HIV positive women who receive Co-Trimoxazole prophylaxis from 6 weeks.	Cotrimoxazole prophylaxis is one of the Interventions that can keep HIV-exposed infants healthy by preventing opportunistic infections.
					Live birth to HIV positive woman	The number of live births to women who are known HIV positive, including BBAs. Mothers with unknown HIV status at delivery that get tested within 72 hours after birth and test positive (baby receives Nevirapine dose) should be counted as well. Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of involuntary muscles.	
17	Proportion of HIV positive mothers receiving counselling on infant feeding options	HIV positive pregnant or post-delivery woman receiving counselling on infant feeding options	All HIV positive mothers (Antenatal client tested positive for HIV – new + Antenatal client re-tested positive for HIV at 32 weeks + Antenatal client with documented HIV positive status and not on ART) Antenatal client with documented HIV positive status and already on HAART)	The proportion of new HIV positive mothers who received counselling according to the Acceptability, Feasibility, Affordability, Safety and Sustainability criteria (AFASS) and assisted to make the feeding choice that would be most appropriate for their individual situation.	HIV positive pregnant or post-delivery woman receiving counselling on infant feeding options	HIV positive pregnant women that received counselling according to the Acceptability, Feasibility, Affordability, Safety and Sustainability criteria (AFASS) and assisted to make the feeding choice that would be most appropriate for her individual situation.	Count all counselling on feeding options to HIV positive clients, whether it was done as part of antenatal care or as part of postnatal care.
					Antenatal client tested positive for HIV – new	A pregnant woman who tested positive for HIV in the first HIV test done during the current pregnancy, and thus is among those eligible for PMTCT and possibly HAART (depending on subsequent CD4 count test and/or HIV staging).	
					Antenatal client re-tested positive for HIV at 32 weeks	A pregnant woman who tested HIV positive when re-tested for HIV around 32 weeks gestation or later, after testing negative for HIV during an earlier (usually the first) antenatal visit.	
					Antenatal client with documented HIV positive status and not on ART	All antenatal clients who during their first antenatal visit can document that they are HIV positive, or whose HIV positive status is known from their existing patient folder or Electronic Health Record, but who have NOT been put on anti-retroviral treatment.	Count all known and documented HIV positive antenatal clients, but only those NOT already on HAART (those on HAART will not be given AZT or Nevirapine prophylaxis). The majority is likely to be long-term clients whose patient folders include the required documentation, but also count first time visitors to a facility that bring their documented patient history, or whose history can be obtained from their previous health provider. This group of clients should obviously NOT be counted under pre-test counselling and/or testing, UNLESS they for some reason are tested again, but they will be offered prophylaxis (AZT and/or NVP).
					Antenatal client with documented HIV positive status and already on HAART)	All antenatal clients who during their first antenatal visit can document that they are HIV positive and who have already been put on anti-retroviral treatment.	Count only pregnant women who already were on HAART at their first antenatal visit, but do NOT count those (presumably) few that were put on HAART after delivery.
ART Assessment							

87	CD4 testing rate	Blood drawn for CD4	HIV test positive new (excluding antenatal) + Antenatal client tested HIV positive – new	The percentage of new HIV positive cases that had blood drawn for a CD4 count.	Blood drawn for CD4	Any case where blood specimens were sent to the laboratory to have a CD4 count done.	The overwhelming majority of these cases will be HIV positive individuals. Note that this element does NOT differentiate between for instance CD4 count tests done as part of eligibility assessment for Anti-Retroviral Therapy (ART) and tests.
					HIV test positive – new (excluding antenatal)	Any client/patient tested positive for HIV, excluding antenatal clients.	
					Antenatal client tested HIV positive – new	A pregnant woman who tested positive for HIV in the first HIV test done during the current pregnancy, and thus is among those eligible for PMTCT and possibly HAART (depending on subsequent CD4 count test and/ or HIV staging).	
88	ART assessment referral rate	Referral to ART service point for ART assessment – new	HIV test positive new (excluding antenatal) + Antenatal client tested HIV positive new	The percentage of new HIV positive cases that were referred to an ART site for assessment.	Referral to ART service point for ART assessment – new	HIV positive patients referred to an ART service point for ART assessment for the first time.	To be counted at the referring facility, NOT at the receiving ART service point. CONTEXT: HIV positive patients will increasingly be referred to ART service points with doctors only occasionally, with regular monitoring of patients on ART.
					HIV test positive – new (excluding antenatal)	Any client/patient tested positive for HIV, excluding antenatal clients.	
					Antenatal client tested HIV positive – new	A pregnant woman who tested positive for HIV in the first HIV test done during the current pregnancy, and thus is among those eligible for PMTCT and possibly HAART (depending on subsequent CD4 count test and/ or HIV staging).	
91	Scheduled dose ART regimen defaulting rate	Scheduled dose defaulted (> 3 days) ART any regimen	Scheduled dose of ART any regimen – total	The percentage of patients on ART that defaulted in taking their doses for more than 3 days.	Scheduled dose defaulted (> 3 days) ART any regimen	Any scheduled ARV dose (monthly dose or shorter) for which a patient on any ART regimen had an appointment for drug collection (whether at ART service point or other facility) AND where the dose was issued within 3 days of the appointment.	CONTEXT: ART adherence is of paramount importance, to avoid drug-resistance.
					Scheduled dose issued (within 3 days) ART any regimen	Any scheduled ARV dose (monthly dose or shorter) for which a patient on any ART regimen had an appointment for drug collection (whether at ART service point or other facility) AND where the dose was NOT issued within 3 days of the appointment.	CONTEXT: ART adherence is of paramount importance, to avoid drug-resistance.
92	STI treated new episode among ART patients incidence	STI treated new episode – ART patient	Registered ART patient on any adult regimen	The number of cases treated as STIs among patients on ART.	STI treated new episode – ART patient	A new episode of a symptomatic Sexually Transmitted Infection (STI) treated according to the Syndromic Approach, and where the patient is on ART. One patient can have more than one new episode at the same time.	
					Registered ART patient on any adult regimen		
STI							

93	STI treated new episode incidence	STI treated new episode	Population 15 years and older	The percentage of people 15 years and older that have been treated for a new episode of an STI (annualised). USE: To monitor the spread, identification, and treatment of STIs. COMMENTS: A number of patients counted here, in particular women, who present with symptoms of STIs and are being treated using the Syndromic Approach do not necessarily have an STI but another type of infection.	STI treated – new episode	A new episode of a symptomatic Sexually Transmitted Infection (STI) treated according to the Syndromic Approach.	The data element counts new episodes, not patients. Count ONLY NEW episodes of a SYMPTOMATIC STI. Sometimes it is difficult to decide whether it is a new episode or a persistent episode: A thorough history needs to be taken in patients who report again to the facility shortly after receiving treatment of a previous STI: If symptoms of the previous episode disappeared, or substantially improved and there is a history of recent, unprotected intercourse with a sexual partner whose infection status is unknown or who has not been treated, a new episode should be assumed.
94	Male Urethritis Syndrome treated new episode incidence	Male Urethritis Syndrome treated – new episode	Male population 15 years and older	The percentage of males 15 years and older that have been treated for a new episode of Male Urethritis Syndrome (annualised). USE: Tracking the spread of Sexually Transmitted Diseases in the target population, as well as assessing how many are treated and (hopefully) cured by comparing with data from mass screening surveys.	Male Urethritis Syndrome treated – new episode	A new episode of Male Urethritis Syndrome.	Each new episode of MUS must ALSO be counted under `STI treated – new episode`. The data element counts new episodes, not patients. Sometimes it is difficult to decide whether it is a new episode or a persistent episode: A thorough history needs to be taken in patients who report again to the facility shortly after receiving treatment of a previous STI: If symptoms of the previous episode disappeared, or substantially improved and there is a history of recent, unprotected intercourse with a sexual partner whose infection status is unknown or who has not been treated, a new episode should be assumed.
95	Male Urethritis Syndrome rate	Male Urethritis Syndrome treated – new episode	STI treated – new episode	Male Urethritis Syndrome cases as a percentage of all new STI episodes treated.	Male Urethritis Syndrome treated – new episode	A new episode of Male Urethritis Syndrome.	Each new episode of MUS must ALSO be counted under `STI treated – new episode`. The data element counts new episodes, not patients. Sometimes it is difficult to decide whether it is a new episode or a persistent episode: A thorough history needs to be taken in patients who report again to the facility shortly after receiving treatment of a previous STI: If symptoms of the previous episode disappeared, or substantially improved and there is a history of recent, unprotected intercourse with a sexual partner whose infection status is unknown or who has not been treated, a new episode should be assumed.
					STI treated – new episode	A new episode of a symptomatic Sexually Transmitted Infection (STI) treated according to the Syndromic Approach.	The data element counts new episodes, not patients. Count ONLY NEW episodes of a SYMPTOMATIC STI. Sometimes it is difficult to decide whether it is a new episode or a persistent episode: A thorough history needs to be taken in patients who report again to the facility shortly after receiving treatment of a previous STI: If symptoms of the previous episode disappeared, or substantially improved and there is a history of recent, unprotected intercourse with a sexual partner whose infection status is unknown or who has not been treated, a new episode should be assumed.

96	STI partner notification rate	STI partner notification slips issued	STI treated – new episode	The number of partner notification slips issued as a percentage of all new STI episodes treated.	STI partner notification slip issued	A slip issued to notify a sexual partner of a patient with an STI.	Count all slips issued to a patient, since a patient with several sexual partners will result in several partner notification slips issued. CONTEXT: This data is used to calculate the STI partner tracing rate and the STI partner treatment rate.
					STI treated – new episode	A new episode of a symptomatic Sexually Transmitted Infection (STI) treated according to the Syndromic Approach.	GUIDE FOR USE: The data element counts new episodes, not patients. Count ONLY NEW episodes of a SYMPTOMATIC STI. Sometimes it is difficult to decide whether it is a new episode or a persistent episode: A thorough history needs to be taken in patients who report again to the facility shortly after receiving treatment of a previous STI: If symptoms of the previous episode disappeared, or substantially improved and there is a history of recent, unprotected intercourse with a sexual partner whose infection status is unknown or who has not been treated, a new episode should be assumed. CONTEXT: This data element provides overall case load for conditions/episodes treated `as STIs` according to the syndromic approach.
97	STI partner tracing rate	STI partner treated – new	STI partner notification slips issued	Partners treated as a percentage of notification slips issued. USE: To monitor efficiency of the partner notification system.	STI partner treated – new	Any patient/client that presented with a notification for STI treatment and received treatment for a suspected or confirmed STI. ONLY the FIRST visit after a notification is counted.	GUIDE FOR USE: The patient/client can be symptomatic or asymptomatic. If the patient presents with a new episode of a symptomatic STI, the new episode must ALSO be counted under `STI treated – new episode`. If the client is asymptomatic, NO tally should be made.
					STI partner notification slip issued	A slip issued to notify a sexual partner of a patient with an STI.	GUIDE FOR USE: Count all slips issued to a patient, since a patient with several sexual partners will result in several partner notification slips issued. CONTEXT: This data is used to calculate the STI partner tracing rate and the STI partner treatment rate.
98	STI partner treatment rate	STI partner treated – new	STI treated – new episode	The percentage of all new STI episodes treated that came with a partner slip.	STI partner treated – new	Any patient/client that presented with a notification for STI treatment and received treatment for a suspected or confirmed STI. ONLY the FIRST visit after a notification is counted.	GUIDE FOR USE: The patient/client can be symptomatic or asymptomatic. If the patient presents with a new episode of a symptomatic STI, the new episode must ALSO be counted under `STI treated – new episode`. If the client is asymptomatic, NO tally should be made.
					STI treated – new episode	A new episode of a symptomatic Sexually Transmitted Infection (STI) treated according to the Syndromic Approach.	The data element counts new episodes, not patients. Count ONLY NEW episodes of a SYMPTOMATIC STI. Sometimes it is difficult to decide whether it is a new episode or a persistent episode: A thorough history needs to be taken in patients who report again to the facility shortly after receiving treatment of a previous STI: If symptoms of the previous episode disappeared, or substantially improved and there is a history of recent, unprotected intercourse with a sexual partner whose infection status is unknown or who has not been treated, a new episode should be assumed. CONTEXT: This data element provides overall case load for conditions/episodes treated `as STIs` according to the syndromic approach.

99	Male condom distribution rate	Male condoms distributed	Male population 15 years and older	The number of male condoms distributed, to patients at the facility or through other channels, per male 15 years and older. USE: To assess distribution of male condoms in the country.	Male condoms distributed	Male condoms distributed.	Male condoms from the stock of the facility which were given out at distribution points at the facility or elsewhere in the community (i.e. campaigns, non-traditional outlets).
HIV/VCT							
104	HIV testing coverage	Clients tested for HIV	Total population	The total number of clients tested for HIV per 1,000 population.	HIV client tested (excluding antenatal)	Any client/patient tested for HIV except antenatal clients.	
					Antenatal client tested for HIV		A pregnant woman who was tested for HIV after pre-test counselling.
100	Proportion clients HIV pre-test counselled (excluding antenatal)	HIV pre-test counselled (excluding antenatal)	PHC headcount 5 years and older MINUS (antenatal 1st visit before 20 weeks + antenatal 1st visit 20 weeks and later + antenatal follow up visit)	The percentage of PHC headcount 5 years and older excluding ANC visits that have received VCT counselling. GUIDE FOR USE: Count all VCT pre-test counselling sessions, even if a few of them actually might be repeats when clients are `shopping` around. CONTEXT: Monitoring what the penetration of VCT in the community.	HIV pre-test counselled (excluding antenatal)	All clients that have been pre-test counselled for HIV/ AIDS and then offered testing, excluding antenatal clients.	Make sure you count ALL clients receiving counselling, INCLUDING those that later say no to be tested. Do NOT mix up POST-counselling with PRE-counselling.
					PHC headcount 5 years and older		
					Antenatal 1st visit before 20 weeks	A first visit by a pregnant woman to a health facility for the primary purpose of receiving antenatal care, often referred to as a `booking visit`, that occurs before 20 weeks after conception. The actual protocol followed during the visit might vary, but it should include relevant screening procedures, laboratory tests (e.g. for syphilis), and counselling/ health promotion (the latter often done in groups).	
					Antenatal 1st visit 20 weeks or later	A first visit by a pregnant woman to a health facility for the primary purpose of receiving antenatal care, often referred to as a 'booking visit', that occurs at 20 weeks after conception or later. The actual protocol followed during the visit might vary, but it should include relevant screening procedures, laboratory tests (e.g. for syphilis), and counselling/ health promotion (the latter often done in groups).	
					Antenatal follow-up visit	Any antenatal visit other than a first antenatal visit. GUIDE FOR USE: Count any follow-up antenatal visit, whether the woman is receiving other services (e.g. curative) or not.	
101	HIV testing rate (excluding antenatal)	HIV client tested (excluding antenatal)	HIV pre-test counselled (excluding antenatal)	The percentage of clients, excluding antenatal clients, receiving pre-test counselling, that accepted testing and were tested for HIV.	HIV client tested (excluding antenatal)	Any client/patient tested for HIV except antenatal clients.	
					HIV pre-test counselled (excluding antenatal)	All clients that have been pre-test counselled for HIV/ AIDS and then offered testing, excluding antenatal clients.	
102	HIV prevalence among clients tested (excluding antenatal)	HIV test positive - new (excluding antenatal)	HIV client tested (excluding antenatal)	The percentage of clients, excluding antenatal clients, tested for HIV and found to be positive.	HIV test positive –- new (excluding antenatal)	Any client/patient tested positive for HIV, excluding antenatal clients.	
					HIV client tested (excluding antenatal)	Any client/patient tested for HIV except antenatal clients.	

PEP							
112	Proportion ARV prophylaxis among sexual cases	Rape case given ARV prophylaxis – new	Rape case – new	The proportion of sexual assault survivors reporting to a health facility that were provided with ARV prophylaxis.	Sexual assault case given ARV prophylaxis – new	Any client receiving antiretroviral prophylactic treatment subsequent to a sexual assault. GUIDE FOR USE: Only count cases where ARV prophylaxis is prescribed as a direct result of sexual assault and intended to reduce the possibility of infection. CONTEXT: Although accurate estimates are very difficult, it is widely accepted that sexual assaults and rape are one signficant factor in the spread of HIV and AIDS in many countries. ARV prophylaxis reduces the chance of the virus `taking hold` in the survivor, even in cases where initial infection has taken place.	
					Sexual assault case – new	A client presenting with physical or emotional trauma related to sexual assault (commonly referred to as a rape survivor). This includes emergency cases, even if data for such cases are collected separately. GUIDE FOR USE: Sexual assault cases should almost always be regarded as emergency cases, even where there is no obvious physical trauma, because of the psychological trauma and the risk of HIV exposure. CONTEXT: Rape and other forms of sexual assault are a major cause of morbidity and mortality in many countries. Root causes are typically high crime levels combined with a `macho` gender culture and general disempowerment of women and children. Health data on assaults should therefore be combined with indicators from other sources like the police and/ or social services to provide a more comprehensive picture.	
113	Proportion ARV prophylaxis among occupational HIV exposure cases	Occupational HIV exposure case given ARV prophylaxis – new	Occupational HIV exposure case – new	The proportion of health workers exposed to HIV infection through, for example, needle pricks that were provided with ARV prophylaxis.	Occupational HIV exposure case given ARV prophylaxis – new	Any case where a health worker has been exposed to the body fluids of a known or suspected HIV positive patient, for instance via a needle prick injury, and subsequently started ARV prophylaxis during the reporting period. GUIDE FOR USE: Only count health workers in the reporting period when they start treatment, do not count them again in the following period even if treatment continues. CONTEXT: Health workers are very vulnerable when dealing with a high proportion of HIV positive patients over a long period of time, and both management and staff must continuously work to improve practices and routine to minimise the risk.	
					Occupational HIV exposure – new case	Any case where a health worker has been exposed to the body fluids of a known or suspected HIV positive patient during the report period, for instance via a needle prick injury. GUIDE FOR USE: CONTEXT: Health workers are very vulnerable when dealing with a high proportion of HIV positive patients over a long period of time, and both management and staff must continuously work to improve practices and routine to minimise the risk.	
HIV/TB Collaboration							

114	Proportion of new HIV positive patients screened for TB	HIV positive new patient screened for TB	HIV test positive new (excl ANC) + ANC client tested HIV positive new	The proportion of all new clients tested HIV positive that were screened for TB.	HIV positive new patient screened for TB	The number of HIV positive clients that have been screened for TB.	
					HIV test positive – new (excluding antenatal)	Any client/patient tested positive for HIV, excluding antenatal clients. GUIDE FOR USE: This can be set up as a calculated element of client under 5 years tested positive plus client 5 years and older (ANC excluded) tested positive. CONTEXT: Monitoring HIV testing results as a proxy for how many HIV positive clients are identified and told about their situation.	
					Antenatal client tested HIV positive – new	A pregnant woman who tested positive for HIV in the first HIV test done during the current pregnancy, and thus is among those eligible for PMTCT and possibly HAART (depending on subsequent CD4 count test and/or HIV staging).	
115	Proportion of new HIV positive patients with confirmed TB	HIV positive new patient with confirmed TB	HIV test positive new (excl ANC) + ANC client tested HIV positive – new	The proportion of all new clients tested HIV positive that were confirmed for TB.	HIV positive new patient with confirmed TB	The number of HIV positive patients confirmed with TB.	
					HIV test positive – new (excluding antenatal)	Any client/patient tested positive for HIV, excluding antenatal clients. GUIDE FOR USE: This can be set up as a calculated element of client under 5 years tested positive plus client 5 years and older (ANC excluded) tested positive. CONTEXT: Monitoring HIV testing results as a proxy for how many HIV positive clients are identified and told about their situation.	
					Antenatal client tested HIV positive – new	A pregnant woman who tested positive for HIV in the first HIV test done during the current pregnancy, and thus are among those eligible for PMTCT and possibly HAART (depending on subsequent CD4 count test and/or HIV staging).	
116	Proportion of new HIV positive patients started INH prevention therapy	HIV positive new patient started on INH prevention therapy	HIV test positive new (excl ANC) + ANC client tested HIV positive – new	The percentage of clients newly eligible for INH as prophylaxis for TB that started treatment this month.	HIV positive new patient started on INH prevention therapy	The number of HIV positive clients started on INH prevention therapy during the reporting period.	Only count clients starting INH prevention therapy for the first time. CONTEXT: INH prevention therapy is used to reduce the chances of TB `outbreaks` in HIV positive clients.
					HIV test positive – new (excluding antenatal)	Any client/patient tested positive for HIV, excluding antenatal clients. GUIDE FOR USE: This can be set up as a calculated element of client under 5 years tested positive plus client 5 years and older (ANC excluded) tested positive. CONTEXT: Monitoring HIV testing results as a proxy for how many HIV positive clients are identified and told about their situation.	
					Antenatal client tested HIV positive – new	A pregnant woman who tested positive for HIV in the first HIV test done during the current pregnancy, and thus is among those eligible for PMTCT and possibly HAART (depending on subsequent CD4 count test and/or HIV staging).	

117	Proportion of new HIV positive patients started Co-trimoxazole prophylaxis	HIV positive new patient started on Co-trimoxazole prophylaxis	HIV test positive new (excl ANC) + ANC client tested HIV positive new	The percentage of HIV positive clients newly eligible for co-trimoxazole prophylaxis that started treatment this month.	HIV positive new patient started on Co-trimoxazole prophylaxis	The number of HIV positive clients started on Co-trimoxazole prophylaxis during the reporting period.	Only count clients starting Co-trimoxazole prophylaxis for the first time. CONTEXT: Co-trimoxazole prophylaxis used for early treatment and/or prevention of opportunistic infection.
					HIV test positive – new (excluding antenatal)	Any client/patient tested positive for HIV, excluding antenatal clients. GUIDE FOR USE: This can be set up as a calculated element of client under 5 years tested positive plus client 5 years and older (ANC excluded) tested positive. CONTEXT: Monitoring HIV testing results as a proxy for how many HIV positive clients are identified and told about their situation.	
					Antenatal client tested HIV positive – new	A pregnant woman who tested positive for HIV in the first HIV test done during the current pregnancy, and thus is among those eligible for PMTCT and possibly HAART (depending on subsequent CD4 count test and/or HIV staging).	
Routine TB							
118	TB case finding index	Suspected TB case with sputum sent	PHC headcount 5 years and older	The percentage of PHC clients 5 years and older suspected of TB with sputum samples sent to the laboratory.	Suspected TB case with sputum sent	Any case where one or more sputum specimens were sent to the laboratory with the possible diagnosis of tuberculosis.	Each patient must be counted only ONCE, regardless of the number of sputum samples sent. Do NOT include cases that are culture positive but smear negative and where treatment is started.
					PHC headcount 5 years and older		
119	Proportion of TB suspects smear positive	Suspected TB case smear positive	Suspected TB case with sputum sent	The percentage of suspected cases with sputum sent that were smear positive.	Suspected TB case smear positive	Any case where one or more sputum specimens of a patient were sent to the laboratory and the result of that patient is confirmed as a smear positive Pulmonary TB. It can be a new or a retreatment case.	Each patient must be counted only ONCE, regardless of the number of sputum samples sent. Do NOT include cases that are culture positive but smear negative.
					Suspected TB case with sputum sent	Any case where one or more sputum specimens were sent to the laboratory with the possible diagnosis of tuberculosis.	Each patient must be counted only ONCE, regardless of the number of sputum samples sent. Do NOT include cases that are culture positive but smear negative and where treatment is started.
120	Proportion treatment start among TB smear positive	Suspected TB case smear positive – treatment start	Suspected TB case smear positive	The proportion of confirmed TB cases with a positive sputum that started treatment.	Suspected TB case smear positive – treatment start	Suspected TB case smear positive – treatment started.	Any case where a patient confirmed as a smear positive Pulmonary TB is starting treatment. It can be a new or a retreatment case.
					Suspected TB case smear positive	Any case where one or more sputum specimens of a patient were sent to the laboratory and the result of that patient is confirmed as a smear positive Pulmonary TB. It can be a new or a retreatment case.	Each patient must be counted only ONCE, regardless of the number of sputum samples sent. Do NOT include cases that are culture positive but smear negative.
121	Smear result turnaround time under 48 hours rate	Sputum results received within 48 hours	All sputum samples sent	The proportion of all sputum samples sent where the result was received at the facility within 48 hours of sending the samples. GUIDE FOR USE: Highly useful indicator for the quality and reach of laboratory and transport/communication services.	Sputum results received within 48 hours	The number of sputum samples where the result was received by the facility within 48 hours of sending the sample.	Saturdays and Sundays should be excluded when assessing the number received within 48 hours.
					All sputum samples sent	All sputum samples sent to the laboratory.	Include all samples, whether they are samples from suspected cases or samples from patients already on treatment.
Routine Mental Health							

150	Mental health case load	Mental health visit	PHC total headcount	The number of mental health visits as a percentage of PHC total headcount.	Mental health visit	Any visit of a client with identified mental health problems, and where this is the primary reason for the consultation. Cases counted relate to problems that can affect an individual psychologically, emotionally and/or physically and where there seems to be a need for mental health intervention (e.g. counselling, psychotropic medication or referral to a mental health worker/service). Typical examples are mood disorders, anxiety, post traumatic stress disorder, schizophrenia, organic brain disease, dementia, substance abuse disorders, psychosis, mental handicap, attention deficit disorders and enuresis. Bereavement, psychosomatic problems, relationship difficulties, stress and burn-out, adjustment problems, behavioural problems in children and adolescents, or any other problem that seriously affect the person psychologically, emotionally and/or physically would also qualify.	
					PHC headcount under 5 years		
					PHC headcount 5 years and older		
Chronic Care							
151	Hypertension detection rate	Hypertension case put on treatment – new	Population 45 years and older	The percentage of the catchment population 45 years and older that were diagnosed as hypertensive and put on treatment.	Hypertension case put on treatment –- new	A client diagnosed with hypertension (high blood pressure) and put on treatment.	
152	Hypertension visits per hypertensive client rate	Hypertension visits	Hypertension clients on register	The number of hypertension visits per hypertensive client registered.	Hypertension case put on treatment – new	A client diagnosed with hypertension (high blood pressure) and put on treatment.	
					Hypertension follow-up visit	Any follow-up visit related to the regular treatment/ management of hypertension.	
					Hypertension clients on register	The total number of clients diagnosed with hypertension, put on treatment and who receive treatment on a regular basis according to treatment guidelines.	
153	Diabetes mellitus detection rate	Diabetes mellitus case put on treatment – new	Population 45 years and older	The percentage of the catchment population 45 years and older that were diagnosed with diabetes mellitus and put on treatment during the period.	Diabetes mellitus case put on treatment – new	A client diagnosed with diabetes mellitus for the first time and put on treatment.	
154	Diabetes mellitus visits per diabetes mellitus client rate	Diabetes mellitus visits	Diabetes mellitus clients on register	The number of diabetes mellitus visits per diabetes mellitus client registered.	Diabetes mellitus case put on treatment – new	A client diagnosed with diabetes mellitus for the first time and put on treatment.	
					Diabetes mellitus follow-up visit	Any follow-up visit related to the regular treatment/ management of Diabetes mellitus.	
					Diabetes mellitus clients on register	The total number of clients diagnosed with diabetes mellitus, put on treatment and who receive treatment on a regular basis according to treatmentguidelines.	

155	Asthma under 18 years rate	Asthma visit under 18 years	Asthma visit	The number of asthma visits under 18 years as a percentage of all asthma visits.	Asthma visit under 18 years	A visit by a person under 18 years diagnosed and on treatment for asthma, according to the protocol for initial and continuation treatment of asthma.	
					Asthma visit 18 years and older	A visit by a person 18 years and older diagnosed and on treatment for asthma, according to the protocol for initial and continuation treatment of asthma.	
156	Asthma case load	Asthma visit	PHC total headcount	The number of asthma visits as a percentage of PHC total headcount.	Asthma visit under 18 years	A visit by a person under 18 years diagnosed and on treatment for asthma, according to the protocol for initial and continuation treatment of asthma.	
					Asthma visit 18 years and older	A visit by a person 18 years and older diagnosed and on treatment for asthma, according to the protocol for initial and continuation treatment of asthma.	
					PHC headcount under 5 years		
					PHC headcount 5 years and older		
Routine Oral Health							
157	Dental extractions to restorations rate	Tooth extractions	Tooth restorations	The rate between the number of teeth extracted and the number of teeth restored. GUIDE FOR USE: Sealed teeth should be counted as part of teeth restored. CONTEXT: This is a key indicator of dental service. QUALITY: poor quality services normally mean a large number of extractions compared to restorations. Extractions are also a result of poor oral hygiene in general combined with lack of regular dental check-ups.	Tooth extraction	The actual number of teeth extracted during the month by an Oral Health worker.	
					Tooth restoration	The actual number of teeth that were restored by an Oral Health worker.	
158	Dental utilisation ratio	Dental visits	Total population	Dental visits per 1,000 population. GUIDE FOR USE: Count all dental visits, whether new or repeats. CONTEXT: Good oral heath services will vary from community to community, since issues like fluoridated water and general oral hygiene have a major impact on tooth decay. One dental check-up per year should be regarded as a minimum.	Dental visit	All individual patients attending the Oral Health facility/unit during the reporting period. Each patient is counted once for each day they appear, regardless of the number of services provided on the day(s) they were seen.	
Rehab							
159	Wheelchair issued rate	Wheelchair issued –- new	Clients on register requiring wheelchair	Wheelchairs issued per 1,000 population.	Wheelchair issued – new	Wheelchair issued to a patient that did not have this before.	
160	Hearing aid issued rate	Hearing aid issued – new	Clients on register requiring hearing aid	Hearing aids issued per 1,000 population.	Hearing aid issued – new	Hearing aid issued to a patient that did not have this before.	

161	Walking aid issued rate	Walking aid issued – new	Clients on register requiring walking aid	Walking aids issued per 1,000 population.	Walking aid issued – new	Walking aid issued to a patient that did not have this before.	
Stock-outs and Drug Management							
172	Tracer items stock-out rate	Tracer item stock-outs any time in reporting period	Total number of tracer items	The number of tracer items out of stock as a percentage of all tracer items.	All tracer items listed below that were out of stock any time in reporting period.	(All tracer items listed below that were out of stock at any time in reporting period).	Any stock-out at the facility of a tracer item this month regardless of the period that the drug was out of stock. TRACER ITEMS: ACE inhibitor, Adrenalin, Amoxicillin 125mg/5ml suspension (75ml), Amoxicillin capsules, Any ARV drug, Any nutrition supplement, Any TB drug, Cetriaxone, Cotrimoxazole 480mg, Cotrimoxazole syrup, DTP-Hib vaccine, Male condom, Ibuprofen, Insulin, Morphine, Norethisterone enant or Medroxyprogesterone injection, Paracetamol 500mg, Rapid HIV test, Salbutamol inhaler, vaccine fridge missing or not working.
173	ACE inhibitor stock-out rate	ACE inhibitor stock-out	All facilities reporting	The percentage of all reporting facilities that had stock-out of ACE inhibitor.	ACE inhibitor stock-out	ACE inhibitor stock-out.	Whether Angiotensin Converting Enzyme (ACE) Inhibitor drugs have been out of stock at ANY time during the reporting period.
174	Adrenalin stock-out rate	Adrenalin stock-out	All facilities reporting	The percentage of all reporting facilities that had stock-out of Adrenalin.	Adrenalin stock-out	Adrenalin stock-out.	Whether Adrenalin has been out of stock at ANY time during the reporting period.
175	Amoxicillin 125mg/5ml suspension (75ml) stock-out rate	Amoxicillin 125mg/5ml suspension (75ml) stock-out	All facilities reporting	The percentage of all reporting facilities that had stock-out of Amoxicillin 125mg/5ml suspension (75ml).	Amoxicillin 125mg/5ml suspension (75ml) stock-out	Amoxicillin 125mg/5ml suspension (75ml) stock-out.	Whether Amoxicillin 125mg/5ml suspension (75ml) has been out of stock at ANY time during the reporting period.
176	Amoxicillin capsules stock-out rate	Amoxicillin capsules stock-out	All facilities reporting	The percentage of all reporting facilities that had stock-out of Amoxicillin capsules.	Amoxicillin capsules stock-out	Amoxicillin capsules stock-out.	Whether Amoxicillin capsules have been out of stock at ANY time during the reporting period.
177	Any ARV drug stock-out rate	Any ARV drug stock-out	All facilities reporting	The percentage of all reporting facilities that had stock-out of any ARV drug.	Any ARV drug stock-out	Any ARV drug stock-out.	Whether any Anti-Retro-Viral drugs have been out of stock at ANY time during the reporting period.
178	Any nutrition supplement stock-out rate	Any nutrition supplement stock out	All facilities reporting	The percentage of all reporting facilities that had stock-out of any nutrition supplement.	Any nutrition supplement stock out	Any nutrition supplement stock-out.	Whether any nutrition supplements have been out of stock at ANY time during the reporting period.
179	Any TB drug stock out rate	Any TB drug stock-out	All facilities reporting	The percentage of all reporting facilities that had stock-out of any TB drug.	Any TB drug stock-out	Any TB drug stock-out.	Whether any Tuberculosis drugs have been out of stock at ANY time during the reporting period.
180	Cetriaxone stock-out rate	Cetriaxone stock-out	All facilities reporting	The percentage of all reporting facilities that had stock-out of Cetriaxone.	Cetriaxone stock-out	Cetriaxone stock-out.	Whether Ceftriaxone has been out of stock at ANY time during the reporting period.
181	Co-trimoxazole 480mg stock-out rate	Co-trimoxazole 480mg stock-out	All facilities reporting	The percentage of all reporting facilities that had stock-out of Co-Trimoxazole 480mg.	Co-trimoxazole 480mg stock-out	Co-trimoxazole 480mg stock-out.	Whether Co-Trimoxazole 480mg tablets have been out of stock at ANY time during the reporting period.
182	Co-trimoxazole syrup stock-out rate	Co-trimoxazole syrup stock-out	All facilities reporting	The percentage of all reporting facilities that had stock-out of Co-Trimoxazole syrup.	Co-Trimoxazole syrup stock-out	Co-Trimoxazole syrup stock-out.	Whether Co-Trimoxazole syrup has been out of stock at ANY time during the reporting period.
183	DTP-Hib vaccine stock-out rate	DTP-Hib vaccine stock-out	All facilities reporting	The percentage of all reporting facilities that had stock-out of DTP-Hib vaccine.	DTP-Hib vaccine stock-out	DTP-Hib vaccine stock-out.	Whether DTP-Hib vaccines have been out of stock at ANY time during the reporting period.

184	Ibuprofen stock-out rate	Ibuprofen stock-out	All facilities reporting	The percentage of all reporting facilities that had stock-out of Ibuprofen.	Ibuprofen stock-out	Ibuprofen stock-out.	Whether any Ibuprofen drugs have been out of stock at ANY time during the reporting period.
185	Insulin stock-out rate	Insulin stock-out	All facilities reporting	The percentage of all reporting facilities that had stock-out of Insulin.	Insulin stock-out	Insulin stock-out.	Whether Insulin has been out of stock at ANY time during the reporting period.
186	Male condom stock-out rate	Male condom stock-out	All facilities reporting	The percentage of all reporting facilities that had stock-out of male condoms.	Male condom stock-out	Male condom stock-out.	Whether male condoms have been out of stock at ANY time during the reporting period.
187	Morphine stock-out rate	Morphine stock-out	All facilities reporting	The percentage of all reporting facilities that had stock-out of Morphine.	Morphine stock-out	Morphine stock-out.	Whether any Morphine drugs have been out of stock at ANY time during the reporting period.
188	Norethisterone enant or Medroxyprogesterone injection stock-out rate	Norethisterone enant or Medroxy-progesterone injection stock-out	All facilities reporting	The percentage of all reporting facilities that had stock-out of Norethisterone enanthate or Medroxyprogesterone injections.	Norethisterone enant or Medroxy-progesterone injection stock-out	Norethisterone enant or Medroxyprogesterone injection stock-out.	Whether Norethisterone enanthate or Medroxyprogesterone injections have been out of stock at ANY time during the reporting period.
189	Paracetamol 500mg stock-out rate	Paracetamol 500mg stock-out	All facilities reporting	The percentage of all reporting facilities that had stock-out of Paracetamol 500mg.	Paracetamol 500mg stock-out	Paracetamol 500mg stock-out.	Whether Paracetamol 500mg tablets have been out of stock at ANY time during the reporting period.
190	Rapid HIV test stock-out rate	Rapid HIV test stock-out	All facilities reporting	The percentage of all reporting facilities that had stock-out of Rapid HIV tests.	Rapid HIV test stock-out	Rapid HIV test stock-out.	Whether Rapid HIV test kits have been out of stock at ANY time during the reporting period.
191	Salbutamol inhaler stock-out rate	Salbutamol inhaler stock-out	All facilities reporting	The percentage of all reporting facilities that had stock-out of Salbutamol inhalers.	Salbutamol inhaler stock-out	Salbutamol inhaler stock-out.	Whether Salbutamol inhalers have been out of stock at ANY time during the reporting period.
192	Items per prescription	Items dispensed	Prescriptions issued	The number of items per prescription.	Item dispensed	Item dispensed.	The number of different items/medications dispensed to each patient visiting the facility. It is normal practice for a Professional Nurse or Medical Officer to prescribe medicine to a patient as needed. The actual number of different items/ medications that has been issued to the client - following a prescription, should be counted here. Family planning (contraceptives), immunisation, and consumables (syringes, bandages, etc) must NOT be included.
					Prescription issued	Prescription issued.	Number of prescriptions issued in the facility – either by the Professional Nurse or a medical doctor. A prescription is the act whereby a professional is prescribing treatment for a PHC patient. This prescription can be on the patient file. Family planning (contraceptives), immunisation, and consumables (syringes, bandages, etc) must NOT be included here.
193	Proportion of vaccine fridges missing or not working	Vaccine fridge missing or not working	All facilities reporting	The percentage of all reporting units with either no vaccine fridge or a vaccine fridge that is not working for whatever reason.	Vaccine fridge missing or not working	Vaccine fridge missing or not working.	Whether the vaccine fridge was missing or not working (for any reason) at any time during the reporting.

Annex B

Record of Staff Training

Record of .... training in each facility

PHC facility name/mobile team:		Date:	
District and subdistrict:		District code:	
Supervisor/programme manager name:		Signature:	

Supervisor: Use this form to maintain a record of health workers trained / not trained in each facility and the date(s) of support visit(s). As staff change and are trained, revise this information.

NAMES OF PROFESSIONAL NURSES (PNS)	TRAINED IN --------- MM / YY	DATE OF INITIAL FOLLOW UP VISIT MM / YY	SUPPORT VISIT DATES				DATE HEALTH WORKER NO LONGER IN FACILITY MM / YY
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NAMES OF ENS AND ENAS							
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DATE OF SUPPORT VISIT TO CLINIC DD / MM / YY	NO. OF PNS IN CLINIC	NO. OF PNS TRAINED IN IMCI (%)	> 60% TRAINED Y / N	NO. WHO HAVE HAD AN INITIAL FOLLOW UP VISIT (%)	NO. OF ENS/ ENAS TRAINED IN IMCI	NO OF COUNSELORS
/ /						
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South Africa National Department of Health
Directorate: Quality Assurance
P/Bag X828
Pretoria 0001
Fax: 012 312 0507