ORAL HEALTH

SERVICE DESCRIPTION

The Basic Primary Oral Health Care Services at clinic 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 surffces including atraumatic restorative treatment (ART)) and emergency relief of pain and sepsis (including dental extractions).

NORMS

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

STANDARDS

1	**REFERENCES PRINTS AND EDUCATIONAL MATERIALS** 1.1 National Oral Health Policy 1.2 National Norms, Standards and Practise Guidelines for Primary Health Care 1.3 Provincial Operational Health Policy 1.4 Oral health educational material (posters, pamphlets etc).
2	**EQUIPMENT.** 2.1 Dental unit complete with chair, light, hand piece unit with hand pieces, suction and compressor 2.2 Aseptic trolley 2.3 Dental Autoclave 2.4 Amalgamator 2.5 Dental X-ray unit 2.6 Intraoral X-ray film processor 2.7 X-ray view box 2.8 Lead apron 2.9 Ultrasonic scaler 2.10 Dental operating stool (2) 2.11 Dental hand instruments (refer 1.2 above) Portable dental equipment where fixed facilities are not available.
3	**MEDICINES AND SUPPLIES** **For** details of material required, refer to **1.2** above 3.1 Medicine according to the EDL 3.2 Local anaesthetic materials 3.3 Exodontia and oral surgery procedure materials 3.4 Prophylaxis materials 3.5 Conservative procedure materials
4	**COMPETENCE OF HEALTH STAFF** 4.1 Community health workers offer oral health education to patients. 4.2 The dental assistant is competent to do patient administration, surgery cleanliness and infection control as well as chair-side assisting. 4.3 The oral hygienist is competent to conduct oral examination, apply fissure sealants, topical fluorides, scaling and polishing and taking of intra-oral x-rays.

	4.4 The dental therapist is able to carry out oral hygienist competencies as well as tooth extractions and simple 1 to 3 surface filling of teeth.
5	**REFERRALS** 5.1 All patients whose needs fall beyond the scope of services provided at the clinic are referred to the next level of care.
6	**PATIENT EDUCATION** 6.1 All patients receive oral health education.
7	**RECORDS** 7.1 Patients records. 7.2 Patient register. 7.3 Statistics.
8	**COMMUNITY BASED SERVICES** 8.1 School oral health programmes consist of oral health education, tooth brushing and fluoride mouth rinsing and ART.
9	**COLLABORATION** 9.1 Collaboration with other departments: Education, Water Affairs, and Forestry and other sections within health such as Child Health, Health Promotion, Environmental Health, Nutrition, Communication etc..

MENTAL HEALTH

SERVICE DESCRIPTION

Mental health services form part of integrated comprehensive Primary Health Care. The service seeks improve mental health and social wellbeing of individuals and communities. Promotion of community me tal health is included in clinic and community based IEC. Preventive measures for mental disability a included in all services such as antenatal, infant, child, reproductive health and curative care.

NORMS

1.	All clinics have regular visits (for patient care, training, supervision and support) from dedicated mental health or psychiatric nurses from health centers, hospitals or mobile teams based in the district.
2.	**All** clinics have access (by referral or by periodic clinic visits) to specialist mental health expertise (psychiatrists, psychologists, occupational therapists) and social workers from district or regional level at least once a month.
3.	In every clinic there is a member of staff who has had continuing education in psychiatry or mental health (including community aspects) in the last year.
4.	In every clinic there is at least one person trained in counselling and the management of victims of violence and rape.

I	**REFERENCES, PRINTS AND EDUCATIONAL MATERNALS** 1.1 Mental health policy document for provinces.

	1.2 List of visiting psychiatric staff at nearest health centre, district hospital, psychiatric specialist hospital or outreach 'service. 1.3 Mental health assessment guidelines. 1.4 Psycho-social rehabilitation checklist for community work. 1.5 Checklist for daily living skills for rehabilitated patients. 1.6 Admission procedures under current Mental Health Act. 1.7 Emergency medication protocol. 1.8 Essential drug list for Primary Health Care. 1.9 24 Hour ability to telephone or use radio to psychiatric unit of district hospital or nearest Mental Hospital. 1.10 Posters and pamphlets on mental health, severe psychiatric conditions, available services and user rights.
2	EQUIPMENT 2.1
3	MEDICINES AND SUPPLIES 3.1 Emergency and routine medication provided according to protocol and EDL.
4	COMPETENCE OF HEALTH STAFF Recognising mental illness 4.1 Clinic staff consider risk factors for mental health within their catchment area: poverty, social power, unemployment, ill health, homelessness, migrancy, immigrants, isolated persons, HIV positives etc. 4.2 Staff identify and provide appropriate interventions for patients with depression, anxiety, stress related problems, male violence, substance abuse and special needs of women (child bearing, abortion, sterilisation, disability, malignancy etc.) 4.3 Clinic staff recognise the expression and signs of emotional distress and mental illness early (especially in young patients or in relapse of a psychiatric condition). 4.4 Clinic staff participate in the promotion of healthy life style in clinic attendees and the community. Organising services 4.5 Staff organise the clinic to have quarter periods of the day set aside for booked inter views. 4.6 Staff provide prompt help from or at the clinic if a patient's condition in the community deteriorates. 4.7 Staff ensure time is allocated for home visits to patients who have returned from mental hospital. 4.8 Staff ensure there is no segregation or stigmatisation at the clinic of patients who have to use other services e.g. family planning, antenatal care, etc. 4.9 Staff arrange access to a consistent member of staff for each consultation. Managing care 4.10 Specially trained staff are able to 4.10.1 Maintain relationships with patients that are just, caring, and based on the principles of human rights. 4.10.2 Perform an adequate medical examination which: 4.10.2.1 Identifies the general mental state e.g. psychotic or depressed. 4.10.2.2 Identifies the severity and level of crisis. 4.10.2.3 Rules out systematic illness. 4.10.2.4 Records temperature and blood glucose level. 4.10.3 Take a history that includes previous service use such as admission to hospital. 4.10.4 Take a family history and evaluate support. 4.10.5 Develop a sustained therapeutic relationship with patients and their families. 4.10.6 Know and implement standard treatment guidelines especially the section on delirium with acute confusion and aggression, acute psychosis and depression. 4.11 General nurses are able to: 4.11.1 Detect and provide services for severe psychiatric conditions as a component of

comprehensive Primary Health Care.

4.11.2 Make appropriate and informed referrals to other levels of care.

4.11.3 Provide basic psychiatric care and assess urgency and severity of symptoms.

4.11.4 Provide individual community maintenance and care for stable long-term patients who have severe psychiatric conditions and have been discharged from hospital.

4.11.5 Provide each stable long-term user with individualised comprehensive care which includes:

4.11.5.1 An ongoing assessment of mental state, functional ability and social circumstances.

4.11.5.2 Familiarity with the internationally recognised diagnostic system.

4.11.5.3 An ability to detect and monitor distress and relapse.

4.11.5.4 An ability to provide basic counselling and support to patient and family.

4.11.5.5 A basic knowledge, criteria and pathways for referral for disability grants.

4.11.5.6 Knowing community referral and support organisations.

4.11.5.7 The follow-up of all cases returned to community after hospitalisation and keeping a register.

4.11.5.8 An ability to use records to facilitate continuity of care, such that:-

4.11.6 The condition of patients in the community is monitored and poor compliance, functional deterioration, substance abuse and family conflict community ridicule are identified.

4.11.7 The onset of mental deterioration in HIV positive patients is recognised.

4.11.8 The prescription of sedation for aggressive of violent patients only as appropriate when other measures fail.

4.11.9 Coping with disturbed, intoxicated, aggressive suicidal behaviour without re sorting to violence, abuse of undue physical restraint.

4.12 Clinic staff provide patient and caregiver satisfaction with assistance in alleviating family burden, achieving social integration, improving quality of life and general functioning while improving symptoms.

4.13 Clinic staff conduct consultations in privacy and in a confidential way and informed con sent is obtained for communication to others.

5 REFERRAL

5.1 Referral pathways to other levels or types of care are known and expedited.

6 PATIENT EDUCATION

6.1 Patients, relatives and the community receive high quality information on mental health and mental illness.

6.2 Patients and their supporters are given individualised education when their situation is reviewed.

6.3 Patients and their supporters are educated on how to recognise predisposing factors and conditions to prevent relapse.

6.4 Clinic staff use education in the family and community to address ignorance, fear, and prejudice regarding patients with severe psychiatric conditions attending the clinic.

7 RECORDS

7.1 Records are kept according to protocol with emphasis on confidentiality and accuracy.

7.2 A register of psychiatric patients in the community is maintained.

7.3 Staff record mental health indicators on:-

7.3.1 The number and mix of cases

7.3.2 The frequency of contact

7.4 Staff analyse indicators and develop appropriate action.

8 COMMUNITY AND HOME BASED ACTIVITY

8.1 Staff participate in community awareness programmes for mental health according to the national and international calendar.

	8.2 Staff participate in the training of family and carers of patients to plan an active role in their rehabilitation. 8.3 Staff encourage patient and caregiver support groups in community. 8.4 Staff keep the addresses and phone numbers of people assisting with mental health and social problems (e.g. women's shelters, community self-help groups).
9	**COLLABORATION** 9.1 Staff respect and where appropriate seek collaborative association with local traditional healers. 9.2 Staff collaborate with all community services e.g. crisis counselling (lifeline, priests with counselling skills) and mental health groups especially those for youth. 9.3 Staff collaborate with the hospital for planning discharges to the community.

VICTIMS OF SEXUAL ABUSE, DOMESTIC VIOLENCE AND GENDER VIOLENCE

SERVICE DESCRIPTION

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

NORMS

1.	Every clinic has established working relationships with the nearest police officer and social wel fare officer by having visits from them at least twice a year.
2.	A member of staff of every clinic has received training in the identification and management of sexual, domestic and gender related violence. The training includes gender sensitivity and counselling.

STANDARDS

1	**REFERENCES PRINTS AND EDUCATIONAL MATERIALS** 1.1 All relevant guidelines / protocols related to women health issues. 1.2 A suitable library of references and journals on sexual offences, domestic and gender violence. 1.3 The clinic 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 cases. 1.4 The clinic has a list of names and addresses of NGOs or other organisations (e.g. CBO) which undertake appropriate counselling (e.g. FAMSA, ATIC) for violence, child abuse and sexual offences.
2	**EQUIPMENT** 2.1 There is a room available at short notice for private, confidential consultations.
3	**MEDICINES AND SUPPLIES** 3.1 Emergency contraceptive pills.
4	**COMPETENCE OF HEALTH STAFF** 4.1 The clinic staff fast track in a confidential manner any rape victim to a private room for appropriate counseling and examination.

4.2 The staff always include a question on gender violence in the history taking from women with depression, headaches, stomach pains or a known abusive partner.
4.3 The staff include diplomatic probing of the domestic situation in taking histories of children with failure to thrive, recurrent episodes of trauma or behavioural problems.
4.4 All cases of sexually transmitted disease in children are managed as cases of sexual offence or abuse.
4.5 When a person presenting at a clinic 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.
4.6 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.
4.7 Staff explain that referral is necessary to an accredited health practitioner and arrangements are made expeditiously and while awaiting referral emergency medical treatment is given with the consent of the victim: prophylactic treatment against STD and post-coital contraception.
4.8 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.
4.9 The staff even though non-accredited are not prohibited from dealing with rape victims but must keep patient records.
4.10 Victims are not allowed to wash before being seen by an accredited health practitioner.
4.11 Women who have been raped or abused are attended to by a female health worker and if this is not possible (e.g. a male district surgeon comes *to* the clinic) then another women is present during the examination.
4.12 The victim is given brief information about the legal process and the right to lay a charge.
4.13 If the victim now indicates a desire to lay charges the police are called to the clinic.
4.14 Clinic staff inquire if charges will or have been laid with the SA Police Service.
4.15

5 REFERRALS

5.1 All patients are referred to the next level of care when their needs fall beyond the scope of competence of clinic staff.

6 PATIENT EDUCATION

6.1 All patients, community, and children attending clinic are educated and informed on abuse.

7 RECORDS

7.1 Patients records are kept according to protocol with emphasis on confidentiality and accuracy.
7.2 The clinic keeps a confidential record of all claims of sexual offences, wife battering and child abuse (sexual, physical, emotional and nutritional).

8 COMMUNITY BASED SERVICES

8.1 Clinic staff establish links with relevant organisations already operating and providing services for victims of abuse.
8.2 Staff encourage community participation on health promotion to curb domestic and gender violence.

9 COLLABORATION

9.1 Staff collaborate with other departments like the police, relevant NGOs and CBOs to reduce the violence and give reassurance and support.

SUBSTANCE ABUSE

SERVICE DESCRIPTION

By preventing and managing substance abuse in the clinic, the service aims to reduce substance abuse among adolescents 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

1.	Reduce school attendees admitting to drink alcohol and smoke tobacco.
2.	Reduce the use of illegal substances including cocaine, mandrax, heroin and marijuana.
3.	Reduce the consumption of alcohol and other drugs among women and especially pregnant women.

1	**REFERENCES PRINTS AND EDUCATIONAL MATERIALS** 1.1 The latest Report of Mental Health and Substance Abuse 1.2 Health learning materials on alcohol, cannabis, mandrax and other drugs in local languages.
2	**EQUIPMENT** 2.1
3	**MEDICINES AND SUPPLIES** 3.1
4	**COMPETENCE OF HEALTH STAFF** 4.1 Clinics have regular visits by mental health trained staff where training includes care of substance abusing patients. 4.2 Patients are able to request visits by social workers. 4.3 In problem (urban) areas staff attend workshops on relevant substance abuse. 4.4 Patients needing detoxification for substance abuse withdrawal symptoms have entry to clinic care via NGOs, teachers, employers, traditional healers, police and are referred rapidly to general hospitals with detoxification facilities and have a social worker to arrange follow up and social reintegration on discharge. 4.5 Patients referred to clinics by NGO, teachers, employers, traditional healers and police (not requiring detoxification) are given appointments with periodically visiting specially trained mental health nurses. 4.6 Clinic staff have rapport with their communities and are culturally accessible to substance-abusing patients to discuss their problems or have their families discuss their problem with them. 4.7 Patients with TB, STD/HIV, mental disorders and families with violence are sufficiently at ease with staff to be able to bring out any problem of alcohol or drug abuse. 4.8 In the clinic catchment area or district of the clinic, staff are able to work when required with correctional services, educators, labour, welfare and NGOs (e.g. Alcohol Anonymous). 4.9 Staff can identify tobacco, alcohol and marijuana abuse and provide basic counselling for behaviour changes and referral to NGOs specialising in substance abuse. 4.10 Staff are aware of the age groups at risk and the predominant social settings in the community for substance abuse: e.g. male youth of 10 - 15 age, limited social integration in the family, shebeens and people who have been in prison. 4.11 The clinic arranges meetings between SANCA and parents and teachers to initiate a drug prevention, education and early identification programme.

	4.12 Staff participate in life skills programmes in schools and discuss substance abuse. 4.13 Staff mount community awareness programme with youth, NGOs and CBOs. 4.14 The clinic is maintained as a smoke free zone. 4.15 Staff are able to recognise the problem of foetal alcohol syndrome and include education on this with antenatal groups. 4.16 Staff identify patients needing referral, do this with patient compliance, accept patients back for follow up and assist with family reintegration. 4.17 Staff identify school children with behaviour problems and discuss with parents and teachers the possibility of drug involvement.
5	**REFERRALS** 5.1 **All** patients are referred to the next level of care when their needs fall beyond the scope of competence of clinic staff.
6	**PATIENT EDUCATION** 6.1 All patients attending clinics for service receive health education.
7	**RECORDS** 7.1 Patients records kept up to date.
8	**COMMUNITY BASED SERVICES** 8.1 Community encouraged to initiate community based services. 8.2 In client and community discussion staff advise on harm reduction strategies (cigarette smoking, alcohol, glue sniffing) and collaborate with traditional healers who assist sub stance-abusing clients.
9	**COLLABORATION** 9.1 Staff collaborate with other sectors like education, correctional services, labour, welfare as well as other relevant NGOs and CBOs to improve mental health. 9.2 Staff collaborate with traditional healers for involvement in improving mental care at community level.

CHRONIC DISEASES AND GERIATRICS

SERVICE DESCRIPTION

Chronic diseases may be inherited, but many lifestyle and environmental factors such as smoking, inappropriate diet, sedentary lifestyle and heavy alcohol consumption are known to increase risks. These are to some extent within the control of a well-informed individual but there are often other factors such as poverty, under-nutrition in utero and in infancy, genetic predisposition, over which the individual has little control.

Besides early diagnosis, management and harm reduction there are opportunities at every stage for prevention and for promoting healthy behaviour.

Priority chronic diseases are hypertension, diabetes type 2, asthma, epilepsy, stroke, renal disease and obstructive lung disease.

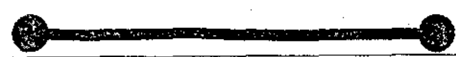
NORMS

1	Increase by 50% the proportion of clinics providing comprehensive services for persons with chronic diseases.
2	Assess patient satisfaction and quality of care 6 monthly by a supervisor who also evaluates the degree of community involvement in care planning.
3	Reduce the number of people with BMI greater than 30.

4	Minimise patient travel by prescribing supplies of drugs to last 1-3 months.

STANDARDS

1	**REFERENCES PRINTS AND EDUCATIONAL MATERIALS** 1.1 Copy of National Guideline on Primary Prevention of Chronic Diseases of Lifestyle. 1.2 Management protocols on Type II diabetes at primary health care level. 1.3 Health promotion and educational materials relating to chronic diseases of lifestyle, ageing and cancer in local languages.
2	**EQUIPMENT and SPECIAL FACILITIES** 2.1 Working sphygmomanometer with range of cuffs, and stethoscope. 2.2 Urine test strips for glucose, protein and ketones. 2.3 Blood glucose testing equipment. 2.4 Snellen Chart. 2.5 Clinics have easy access for the aged, those in wheelchairs and those with arthritis.
3	**MEDICINES AND SUPPLIES** 3.1 Arrangements are made by the clinic to minimise patient travel by prescribing supplies of drugs to last 1-3 months.
4	**COMPETENCE OF HEALTH STAFF** 4.1 Every clinic has a staff member who has skills to prevent, diagnose and manage chronic conditions including geriatrics, nutrition, genetics, mental health and reproductive health. 4.2 Patients are able to see the same nurse for repeat visits and a system of recall on cards or calendars is used to ensure continuity of care. 4.3 Staff are able to provide counselling and motivation on disease acceptance, continuity of care and compliance. 4.4 Staff are able to establish in patients a feeling of always being welcome even though they keep coming frequently over the years. 4.5 All staff show respect and concern for the elderly and the disabled. 4.6 Staff have the skills and attitude to protect and promote the rights of patients with regard to a full knowledge of health status, participation in decisions, access to own health records and becoming a partner in own health care. 4.7 Staff know that the prevalence of diabetics in South Africa is high (10% in Indian community and 5 - 6% in black community) and are able, using epidemiological skills, to estimate how many cases there are in the clinic catchment areas and are alert to identify them early. 4.8 Staff are receptive to periodic visits from doctors or district surgeons/medical officers and use the visits to review chronic disease patients.
5	**REFERRALS** 5.1 All patients are referred to the next level of care when their diagnosis and needs fall beyond the scope of competence as recommended by the protocols. 5.2 Staff know where to phone the nearest hospital/doctor for advice. 5.3 Detailed information is kept on the frequency of follow-up visits 1 -3 monthly and yearly for detailed examination by doctor. 5.4 Patients suspected of having diabetes are referred to hospital for diagnosis.
6	**PATIENT EDUCATION** 6.1 Afler diagnosis patients and caretakers are supported and their capacity developed regarding self care, self-monitoring, compliance, prevention of complications and management of the disease. 6.2 Education activities are sensitive to the cultural and economic realities of the patient and home.
7	**RECORDS**



	7.1 Patient register of chronic conditions and treatment record. 7.2 Patient carried cards. 7.3 Home-based care records.
8	COMMUNITY BASED SERVICES 8.1 Staff work with any district NGO and CBO dealing with chronic conditions. 8.2 After analysis of the chronic disease register attempts are made to provide education in the community on modifiable risk factors, healthy food plans, less salt (iodised), weight control, sport and exercise, substance abuse especially alcohol, smoke (tobacco, smoke in houses), UV protection for albinos, early recognition of symptoms and periodic check-ups. 8.3 Educational activities are culturally and linguistically appropriate.
9	COLLABORATION 9.1 Staff collaborate with other departments and sectors whose activities have a bearing on chronic diseases. 9.2 Staff facilitate the initiation of clubs and special groups for people with chronic diseases 9.3 Clinic staff approach the catchment area population through community health committees, NGOs, CBOs, youth groups and the church to reduce common risk factors operating in the community.

DIABETES

SERVICE DESCRIPTION

Norms and standards on materials, equipment, supplies and general competencies are dealt with in t chapter on chronic diseases. This chapter deals specifically with competence and referral standards diabetes.

NORMS

STANDARDS

1	REFERENCE PRINTS AND EDUCATIONAL MATERIAL 1.1 See chronic diseases
2	EQUIPMENT 2.1 Sphygmomanometer with different size cuffs 2.2
3	MEDICINE AND SUPPLIES 3.1 As per EDL list
4	COMPETENCE OF HEALTH STAFF 4.1 Staff know that prevalence of diabetics in South Africa is high (10% in Indian community and 5 - 6% in the black community) and estimate how many cases there are in clinic catchment areas and are alert to identify them early. 4.2 The interrelationship between abdominal obesity, hypertension and cardiovascular disease and initial presentation with complications of diabetics are known. Hypertension patients are investigated for diabetes. 4.3 All pregnant women have urine examined for glycosuria. 4.4 Patients suspected of having diabetes (history and risk factors, clinic blood and urine testing indicating diabetes) are referred to hospital for diagnosis. 4.5 Nurse knows where to phone the nearest hospital/doctor for advice.

	4.6 Staff counsel on disease acceptance, continuity of care and compliance. 4.7 On return from diagnosis the patient is further educated in an inter-active problem solving way on: 4.8 Prevention detection and management of complications 4.9 Principles of nutrition, physical activity, hygiene and weight control 4.10 Self-monitoring with urine glucose strips or preferably blood glucose strips and maintaining urine glucose free. 4.11 Maintaining a body mass of (kg/m) for men 20 - 27 and women 19 - 26. 4.12 The drugs used. 4.13 The symptoms and treatment for hypoglycaemia. 4.14 Contraception and pregestational counselling. 4.15 Not smoking. 4.16 Six monthly or annual referral for assessment of progress, depending on the control of diabetes mellitus and complications.
5	**INDICATORS FOR REFERRAL** 5.1 Urgent referral to the nearest hospital: 5.1.1 If nausea and vomiting, dehydration and hypotension, ketonuria (>2+) significant hyperglycaemia with symptoms, stupor, confusion, coma, deterioration in vision, gangrene, severe infections (TB, pneumonia) 5.2 As soon as possible: 5.2.1 Pregnancy 5.2.2 Newly diagnosed cases 5.2.3 Recurring hypoglycaemic symptoms 5.2.4 Foot problems 5.2.5 Recurring hyperglycemia/glycosemia 5.2.6 Persistent infections.
6	**PATIENT EDUCATION** 6.1 all hypertensive or obese patients or those with a family history of hypertension are given non-pharmacological advice
7	**RECORDS** 7.1 See chronic diseases
8	**COMMUNITY BASED SERVICES** 8.1 See chronic diseases
9	**RECORDS** 9.1 See chronic diseases

HYPERTENSION

SERVICE DESCRIPTION

The service aims at increasing detection, treatment and control of hypertension and preventing target organ damage, cardiovascular disease and strokes and adverse interaction with diabetes.

NORMS

1.	Reduce the incidence of strokes and congestive cardiac failure and renal failure.
2.	Reduce the prevalence of overweight and obese clients.
3.	The majority of patients are compliant and on continuous treatment.

STANDARDS

1 REFERENCE PRINTS AND EDUCATIONAL MATERIAL

1.1 Patients health learning materials available on hypertension diet, exercise and weight reduction.

2 EQUIPMENT

2.1 Sphygmomanometer with different size cuffs
2.2 Urine test strips (blood, protein and glucose)

3 MEDICINE AND SUPPLIES

3.1

4 COMPETENCE OF HEALTH STAFF

4.1 All adults entering clinic have blood pressure measured routinely every five years.
4.2 All patients with high normal values (135-139/85-89mm Hg) or previous high reading have blood pressure measured yearly.
4.3 At least two measurements of blood pressure are made at each of several visits to determine blood pressure.
4.4 Staff measure blood pressure seated but standing if patient elderly or diabetic.
4.5 Referral is made to a doctor for the start of treatment for all people with sustained systolic blood pressure ?160mm Hg or sustained diastolic blood pressure > 100mm Hg.
4.6 Patients with a systolic pressure between 140-159mm Hg or sustained diastolic pressure between 90-99 are referred if they are obese, diabetic or have a strong family history.
4.7 The stepwise treatment outlined in the Standard Guidelines and Essential Drug list is followed.
4.8 Target blood pressure during anti-hypertensive treatment is less than 140 systolic and less than 85mm diastolic and is maintained with minimal side effects.
4.9 Combinations of drugs are prescribed by the hospital or visiting doctors.
4.10 Staff identify hypertensive emergencies (neurological signs, pulmonary oedema) and treat with oral nifedipine 5mg and refer.
4.11 Staff check compliance and ensure continuity.

5 REFERRAL

5.1 Patients on treatment are referred if there is no therapeutic response.
5.2 All pregnant women are referred.
5.3 All children with hypertension are referred.
5.4 All hypertensive emergencies are referred.

6 PATIENT EDUCATION

6.1 All hypertensive or obese patients or those with a family history of hypertension are given non-pharmacological advice:
- 6.1.1 Weight reduction via reduced fat and total caloric intake, regular brisk physical exercise and limited alcohol consumption.
- 6.1.2 Reduced intake of salt.
- 6.1.3 Increased consumption of fruit and vegetables.
- 6.1.4 Stopping smoking.

7 RECORDS

7.1 Blood pressure and weight recorded regularly.
7.2 A chronic disease register maintained showing patient's dates and monitoring monthly returns.

8 COMMUNITY AND HOME-BASED ACTIVITY

8.1 Community-based education programmes are initiated in all areas with high levels of obesity.
8.2 Community-based life-style improvement programmes are carried out with youth groups.

9 COLLABORATION

9.1 Staff collaborate with NGO or CBO dealing with obesity, diabetes and heart disease.

REHABILITATION SERVICES

BASIC CONSIDERATIONS

Rehabilitation services are an integral part of the services provided at the primary level. This constitutes a 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. This precludes a disability service from being seen 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 clinic is the first point where people with disabilities, their family members or caregivers meet health staff. Clinics need to become creative in their approach to the problems experienced by these patients.

SERVICE DESCRIPTION

The purpose of rehabilitation at clinic 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 clinic, 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 affordable basis.

Specific **rehabilitative** services include a basic assessment of people with disabilities e.g. 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 his family. Consumable assistive devices e.g. 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 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 clinic.
3.	Institute a functional referral system between the community-clinic-district hospital, as well as other relevant sectors.
4.	Institute a system of obtaining, repairing and maintaining essential assistive devices for rehabilitation at clinic level.

STANDARDS

1	**REFERENCES, PRINTS AND EDUCATIONAL MATERIALS:** 1.1 A register of all local, regional, provincial and national resources for referral for rehabilitation, education and training.

1.2 OT reference pack.
1.3 "Disabled village children" by David Werner, as reference book

2 EQUIPMENT
2.1

3 MEDICINES & SUPPLIES:
3.1 Consumables such as axillary rubbers, rubber ferrules and cane tips.
3.2 Readv-made oacks on order oer soecified oatient

4 COMPETENCE OF HEALTH STAFF

Clinic Staff are able to:
4.1 Use of standardised questionnaire for the detection of hearing loss.
4.2 Identify and refer patients requiring rehabilitation.

The Therapy Assistant is able **to:**
4.3 Teach prevention of pressure sores and pressure sore care.
4.4 Identify and implement techniques in a walking re-education programme.
4.5 Construct simple aids for daily living from locally available materials and teach the patient how to make and use them.
4.6 Teach mobility and daily living skills to a blind person.
4.7 Identify articulation, language and fluency disorders.
4.8 Plan, implement and monitor language stimulation programmes.
4.9 Use augmentative and alternative communication methods with appropriate patients, construction of simple communication boards, and teach the family how to use them.
4.10 Plan, implement and monitor basic programmes for the rehabilitation of people with neurogenic disorders of communication.
4.11 Counsel the family and teachers of a person with hearing impairment on simple measures to improve communication.
4.12 Have knowledge of available resources for rehabilitation.
4.13 Construct and instruct in the making of corner chairs with table, standing frames and walkers out of Appropriate Paper Technology.
4.14 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.
4.15 Teach basic maintenance of wheelchairs, hearing aids, callipers and crutches.
4.16 Teach an exercise programme for the prevention and treatment of backache.
4.17 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 Therapist are able to:
4.18 Design treatmenffrehabilitation programmes for people with stroke, spinal injury, spina bifida, cerebral palsy, barriers to learning, sports injuries, backache, arthritis, amputations, blindness, to be implemented by the therapy assistant or family members of the person with a disability.
4.19 Assess people with disabilities for the need for Specialised Assistive Devices, and prescribe and order these from the District, Regional or Tertiary Hospital.
4.20 Assess patients with burn scar tissue, and prescribe and order pressure garments.
4.21 Assess scholars with barriers to learning
4.22 Guide doctor in assessment of degree of disability for applications for disability and care dependency grants.
4.23 Design and direct needs driven awareness raising, education and prevention programmes.
4.24 Assess the need for surgical release of contractures and other corrective procedures.
4.25 Supervise and arrange the continuing education of community therapy assistants.

The visiting PHC doctor **is** able to:
4.26 Assess continence problems, and advise suitable continence management in consultation with the therapist or therapy assistant, patient and family.
4.27 Manage spasms related to spinal injury with drug treatment and/or detection and treatment of stress factors.
4.28 Assess persons for disability grants and care dependency grants.

4.29 Use a Schiotz Tonometer.
4.30 Diagnose disabilities as early as possible, and develop a system of referral. (National Year 2000 Goals, Objectives and Indicators.)
4.31 Clinics are accessible to wheelchairs and trolleys and have toilet facilities for people on wheelchairs.
4.32 People with disabilities are given preference when queuing for services and, where feasible, appointments are given to patients to reduce waiting times.

5 REFERRAL

5.1 From district hospital to clinic:
- 5.1.1 All patients with newly acquired disabilities, who have completed the acute phase of their rehabilitation for follow up by the therapy assistant.
- 5.1.2 All newly detected patients with disabilities, who have been assessed by a therapist, doctor or specialist, for follow up and rehabilitation at the nearest clinic.

5.2 In the clinic to the rehabilitation service:
- 5.2.1 All children detected with a developmental delay for assessmenf.
- 5.2.2 Patients with healed burns that cover a joint surface for the prevention of contractures and treatment of scarring.
- 5.2.3 Patients with disabilities for alleviation programmes and rehabilitation.
- 5.2.4 All patients with chronic deforming arthritis.

5.3 Referral of patients to doctor or multidisciplinary team:
- 5.3.1 Patients with spinal chord injury with troublesome spasms.
- 5.3.2 Patients with continence problems for institution of an adequate continence programme.

5.4 From clinic for specialist assessment or treatment:
- 5.4.1 Patients with physical disabilities amenable to corrective surgery, assuming that a therapy follow-up service is available.
- 5.4.2 Patients with chronic disabling rheumatoid arthritis for assessment and monitoring.

5.5 From clinic to hospital:
- 5.5.1 Patients requiring intensive daily rehabilitative therapy.
- 5.5.2 Patients with extensive bedsores.
- 5.5.3 Patients in need of more assistive devices not available at district level.
- 5.5.4 Complicated burns (facial, perineal, burns involving a joint or over 10% of body surface).
- 5.5.5 Patients with spinal injury and sudden increase in spasms, temperature and high blood pressure.

5.6 From clinic to other sectors:
- 5.6.1 Children with sensory loss to LSEN schools.
- 5.6.2 Patients with disabilities who are capable of working, to department of labour for employment opportunities
- 5.6.3 Patients with disabilities for training in suitable occupational skills.
- 5.6.4 Patients with disabilities that are not suitable for the open labour market, to community groups for disabled people, self-help groups, or protected workshops.
- 5.6.5 Any other sectors which are deemed useful for the development of social and economic independence of the disabled person e.g. training centres for the blind.
- 5.6.6 Peer support groups.
- 5.6.7 Patients with disability who are not acceptably cared for in the community to the welfare department
- 5.6.8 Severely disabled children, who are not accepted at schools to community day care centres

6 PATIENT EDUCATION

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

7 RECORDS

7.1 Data collected at clinics to be used for development of a district data base on disability for use for programme planning

7.2 Patient information recorded using the SOAP Format.
7.3 Initial assessment and follow up forms standardised for the district, and kept in the chronic file of the patient at the clinic.
7.4 A summary note of the diagnosis, referral and treatment is in the patient held record.
7.5 The visiting therapist ensures that data and information, and records are accurately and consistently maintained.
7.6 Data fields for clients referred for rehabilitation are included in the clinic register.

8 COMMUNITY & HOME BASED ACTIVITY.

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

9 COLLABORATION

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