

PART 2
**NORMS AND STANDARDS FOR COMMUNITY
BASED CLINIC INITIATED SERVICES**

PART 2**NORMS AND STANDARDS FOR COMMUNITY BASED CLINIC INITIATED SERVICES****COMMUNITY LEVEL WATER & SANITATION****INTRODUCTION**

A water supply and sanitation project is part of a comprehensive development strategy. It is people driven and is not sustainable unless people themselves are directly involved. Communities are involved in the planning, design, financing, construction and maintenance of improved water supplies with women's groups taking the leading role. Public and private sector resources provide initial training and long-term support to create an environment in which community management can function. Technology is affordable and sustainable. Development activities are demand driven, community based and of a level to provide a healthy environment which is a human right.

NORMS

1.	There are functioning community participation structures.
2.	There is access to district health expertise including the services of an environmental health officer.
3.	Reduce the under 5 mortality rate by 30%.
4.	Reduce the mortality of children under 5 due to diarrhea by 50%.
5.	Eradicate poliomyelitis by 2002.
6.	Reduce the prevalence of underweight for age among children under the age of 5 to 10%.
7.	Reduce the prevalence of stunting among children less than 5 to 20%.
8.	Reduce the prevalence of severe malnutrition in children under 5 to 1%.
9.	Eliminate micro deficiency disorders.
10.	Ensure 9.5 liters of water per person per day.
11.	The maximum distance that a person has to cart water to their dwelling is 200m.
12.	The flow rate of water from the outlet is not less than 10 liters per minute and water is available on a regular daily basis.
13.	A water service does not fail due to drought more than once in 50 years and there is no more than one week's interruption in supply per year.
14.	Once minimum quality of water is available, health related quality is important and in accordance with currently acceptable minimum standards with respect to chemical and microbial contaminants and acceptable to consumers in terms of its potability.
15.	Adequate basic provision of sanitation is one well-constructed VIP toilet to agreed standards per household.
16.	Phase out the bucket system over 5 years.
17.	Responsibility for sanitation services lies with the local authority or, if not, the local water committee is the vehicle for sanitation development.

STANDARDS

1	The capacity building hygiene education and training of the community health committee is achieved through linkage with the health sector as well as other development sectors such as water affairs and forestry
The competence of Environmental Health Officers (EHO)	
2	<p>The EHO working with the community has the following competencies and hence able to:</p> <p>2.1 Work with other sectors in development projects.</p> <p>2.2 Work with local clinic staff for teamwork in motivating community committees to improve water and sanitation.</p> <p>2.3 Work with health staff of clinics, NGOs and local government structures if present to provide hygiene education and training and build capacity of communities.</p> <p>2.4 Empower committee through training, technical advice and continuing support and monitoring to undertake and manage their own development including water and sanitation.</p> <p>2.5 Provide information to schools on undertaking water and sanitation and personal and public health.</p> <p>2.6 Monitor that sanitation and water systems do not create environmental problems.</p> <p>2.7 Assist communities develop the capacity to use the cycle of participation - assessment, analysis, and action - and provide particular assistance in preliminary assistance through environmental surveys.</p> <p>2.8 Work with DWAF personal to explain to communities through individual leadership dialogue or community, workshops the contents of the White Paper:</p> <p>2.8.1 Water supply and Sanitation Policy 1994</p> <p>2.8.2 National Sanitation Policy White Paper Oct. 1996, Guidelines for ground water protection for Community water supply and sanitation programme.</p>
Communities	
3	<p>Through education, training and improved communication communities develop the following competencies and hence are able to:</p> <p>3.1 Get rid of human excreta, dirty water and household refuse in a sustainable way without harm to the environment.</p> <p>3.2 Improve personal habits and behavior relating to water and sanitation.</p> <p>3.3 Relate diarrhoeal disease and its effects on nutrition, growth and development of children, skin disease, trachoma, periodic outbreaks of diarrhoea, dysentery, worm infections (including schistosomiasis) to poor water and sanitation in their community.</p> <p>3.4 Through women's groups work together to achieve both water and sanitation norms for their community and be more competent in rearing their children with good hygiene behavior.</p> <p>3.5 Ensure that sanitation systems in their community do not pollute rivers, dams and under ground water supplies.</p> <p>3.6 Understand the reasons for and be able to pay for maintenance of their water and sanitation services.</p> <p>3.7 Conduct assessments or surveys of the state of water supply and sanitation in their own community.</p> <p>3.8 Analyse the behavioural, cultural and socioeconomic factors leading to their health problems related to inadequate water and sanitation.</p> <p>3.9 Through community based education (through schools, churches, groups) ensure that the transmission pathways of disease from waste and excreta are known. These are hands, flies, food, fluids, and soil. The ways of blocking transmission by personal hygiene, household and community hygiene are also known.</p> <p>3.10 Achieve community hygiene through a high percentage of homesteads improving house hold hygiene so that there is no environmental contamination from excreta, dirty water and solid waste.</p> <p>3.11 Improve community hygiene by food vendors and other food handlers being educated about food hygiene based on the WHO Ten Golden Rules for Safe Food Preparation.</p> <p>3.12 Be aware of community problems created by keeping animals next to homes and of problems arising from blocked drains.</p>

Health Personnel

- 4 Clinical staff working with the EHO have the following competencies and are thus able to:
- 4.1 Ensure that health facilities are models for the community with respect to water and sanitation including patient toilets, staff toilets, and hand washing facilities.
 - 4.2 Lead school or community programme in environmental cleaning days.
 - 4.3 Provide health education on personal hygiene and health to patients, community groups, pre schools and schools.
 - 4.4 Initiate behaviour change dialogue with the community on the use of toilets and use of water to improve health.
 - 4.5 Feedback to the community information of the burden of water / sanitation related illness in the community as shown by analysis of the health information system.
 - 4.6 Ensure that all schools in the catchment area of the clinic are health-promoting schools (good toilets, good water supply, hygienic school feeding programme, hand-washing facilities, continuing education on hygiene).
 - 4.7 Work with community committees to ensure improved sanitation facilities at churches, sports grounds, markets, bus stops and creches.
 - 4.8 Assist communities obtain government subsidies after having organized themselves and planned a project.
 - 4.9 Provide advice to farmers on improvement of water and sanitation to their workers while also providing hygiene education to the workers.

- 5 Clinic teams and District Health Management Teams have the capacity to work with local NGOs in sanitation programmes and to assist them
- 5.1 In their training and capacity building,
 - 5.2 In helping communities plan and implement projects,
 - 5.3 provide health and hygiene education,
 - 5.4 Prepare communication material.

COMMUNITY LEVEL HOME-BASED CARE

NORMS

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|---|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 | Every community provides some home-based care and has access to community-based care through partnership of community-based and clinic-based health services. |
| 2 | All clinics serving communities in their catchment areas identify home-based carer co-ordinators for formal and informal sector activities. |
| 3 | All communities with home-based care have access to a referral system and to comprehensive support services. |
| 4 | All clinics have access to home-based care guidelines and palliative care guidelines so that they can assist communities and families. |

STANDARDS

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|---|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 | Home-based care is comprehensive and holistic, person centered, sensitive to culture, religion, values and respects privacy and dignity and maintains self-esteem. |
| 2 | It empowers and promotes functional independence of the individual and family. |
| 3 | The patient, the carer and the community are provided with appropriate targeted education. |
| 4 | Home-based care assists in reducing unnecessary visits and admissions to health facilities. |

5	Community groups and individual home-based carers receive training from the nearest competent resource - NGOs or the local clinics or visiting health team.
6	Community groups and clinics maintain records of home-care and it's continuity and consistency.
7	Patients referred from a health facility for home care have the homestead carer prepared and given adequate instruction on medication and daily living care. Referring facilities also provide prescribed medicine and assistive devices.
8	Protocols or manuals of care are provided to home-care patients from the local clinic on palliative care and the management of pain.
9	Community-based training of home-carers is based on adult education principles and practical simple guidelines.
10	Health staff assist in the development of case management plans which consider physical and psychological needs, environment social networks, diet, exercise and rest, personal habits, sexuality, recreation, dressing, washing, feeds, toilet, continence, hearing, seeing and home layout.
11	Community groups, family, neighbours or volunteers assist with continuing home needs.
12	Social workers assist with arranging legal assistance (e.g. wills) and application for disability grants and other social support.
13	Integrated community home-based services have a mosaic of categories, (medical, counselling, pastoral, rehabilitation and traditional) brought together around the individual and family through professional co-ordination.
Home Care for AIDS	
14	Home care for AIDS in the community includes access to common drugs, emotional support, consideration of families, help with households, kind relationships from clinic staff and financial support if available through social welfare or self-help groups.
15	The community care of AIDS patients involves a continuum of care, which links all available resources in a community.
16	The continuum of care starts from initial counselling to include care of psychosocial needs, medical and nursing needs and family needs such as care of children, legal advice and assistance.
17	Clinics, hospices, NGOs and community groups are linked in a network and this can be initiated by the clinic, NGOs or community groups.
18	The aims of AIDS home care are the same as for any home-based health care programme: 18.1 to prevent problems when possible 18.2 to take care of existing problems to know when and how to get help.

DIRECTLY OBSERVED TREATMENT (SHORT COURSE) STRATEGY "DOTS"

SERVICE DESCRIPTION

The national TB control strategy of directly observed treatment short course 5 key elements, are:

- o Directly observed treatment by the clinic/treatment supporter for 6 months.
- o Short course chemotherapy and uninterrupted drug supply
- o Standard reporting and recording system.

- Diagnosis based on positive sputum microscopy.
- Commitment to the DOTS programme by all.

NORMS

Achieve a minimum community-based directly observed tuberculosis treatment cure rate of new sputum positive TB cases of 85%.

STANDARDS

Accessibility	
1	DOTS supporters for TB cases are as near to the home of cases as is convenient to ensure regular treatment and periodic clinic supervision.
Equipment	
2	Community supporters of DOTS will have: <ol style="list-style-type: none"> 2.1 a box in which to store the supply of drugs specific for each patient being supported, 2.2 a supply of green cards for recording (as a duplicate) the treatment given while the patient keeps the original card issued by the clinic, 2.3 patient education material in the correct language.
Training	
3	All community DOTS supporters have received a course of training equivalent to at least one week, either continuous or in sessions.
4	Training covers knowledge, attitude change and skills in communication, simple counselling and problem solving in providing correct continuous directly observed treatment.
5	Suitable training manuals and health learning materials are provided.
Supervision	
6	DOTS supporters in the community receive supportive supervision by regular contact with the clinic nurse who will also record continuity of progress in the clinic TB register.
Evaluation	
7	Success is measured by recording: <ol style="list-style-type: none"> 7.1 The number of missed treatments and 7.2 The rapidity of re-establishing continuous treatment and sputum conversion at 2 months for new cases and 3 months for re-treatment cases and at 6 months and 8 months for new and re-treatment cases respectively. 7.3 % of patients on DOT. 7.4 smear conversion rate at 2/3 months of treatment. 7.5 % of patients who are cured.
Community Support	
8	The community health committee participates in identifying new potential DOTS supporters. This is a partnership between supporter, patient and clinic with the patient deciding who his supporter will be.
9	Committees may provide non-financial incentives such as community recognition of outstanding voluntary DOTS support.
Referrals and Transfers	
10	All referrals and transfers of community based DOTS patients are documented on the correct forms and followed up by the referring or transferring health facility.

INTEGRATED NUTRITION PROGRAMME

BASIC CONSIDERATIONS

The vision for nutrition is optimum nutrition for all South Africans. It is recognised that nutrition is multi-sectoral and complex. Nutrition status is improved through health-facility-based, community-based and nutrition promotion activities.

NORMS

1.	The UNICEF conceptual framework is used to understand and address the complexity of nutrition problems.
2.	The UNICEF Triple-A Cycle of assessment, analysis and action is used as the implementation methodology.
3.	Increase regular growth monitoring to reach 75% of children <2 years. (National Year 2000 Goals, Objectives and Indicators.)
4.	Increase the proportion of mothers who breast-feed their babies exclusively for 4-6 months, and who breast-feed their babies at 12 months. (National Year 2000 Goals, Objectives and Indicators.)
5.	Reduce the prevalence of under weight-for-age among children less than 5 years to 10%. (National Year 2000 Goals, Objectives and Indicators.)
6.	Reduce the prevalence of stunting among children <5 years to 20%. (National Year 2000 Goals, Objectives and Indicators.)
7.	Reduce the prevalence of severe malnutrition among children <5 years to 1%. (National Year 2000 Goals, Objectives and Indicators.)
8.	Eliminate micro nutrient deficiency disorders. (National Year 2000 Goals, Objectives and Indicators.)
9.	A protocol is in place for the management and referral of children with growth faltering or failure, management of micronutrient deficiency and obesity.
10.	Programmes address prevention of morbidity and mortality due to diseases of lifestyle e.g. obesity, diabetes mellitus, coronary artery disease.
11.	Programmes are in place to improve the care of pregnant and lactating women.

STANDARDS

1	REFERENCES, PRINTS, AND EDUCATIONAL MATERIALS
	1.1 Appropriate Health Education material for Nutrition, including breast-feeding and weaning, malnutrition, parasite infestation, food safety and diseases of lifestyle.
	1.2 Integrated Nutrition Programme for South Africa Draft Document, December 1997.
	1.3 Targeting Strategy form Community-based Nutrition Projects.
	1.4 Draft breastfeeding Policy as well as draft guidelines and recommendation for the feeding of infants of HIV positive mothers.
	1.5 Draft Policy Guidelines for Vitamin A Supplementation.
2	EQUIPMENT
	2.1 Road-to-Health Charts
	2.2 Weighing scales (for babies and older children).
	2.3 Skin fold callipers

	<p>2.4 Height measurements and infant meters</p> <p>2.5 Non-stretch tape measures</p> <p>2.6 Overhead projector.</p> <p>2.7 Video player/TV monitor.</p>
3	<p>MEDICINE & SUPPLIES</p> <p>3.1 Flip charts and markers for group work.</p> <p>3.2 Stationery.</p>
4	<p>COMPETENCIES</p> <p>4.1 Staff working at the district level have the following competencies, particularly applied to community-based, integrated nutrition:</p> <p>4.2 An understanding of the principles of nutrition.</p> <p>4.3 An understanding of the conceptual framework for the analysis of nutrition problems in communities.</p> <p>4.4 An understanding of methodologies used in nutrition assessment.</p> <p>4.5 The ability to design, implement and evaluate intersectoral programmes.</p> <p>4.6 The capacity for project management and application of innovative approaches to nutrition issues.</p> <p>4.7 The ability to communicate with a target group, analyse its needs and make appropriate choices of communication media and materials.</p> <p>4.8 The ability to train at community and other levels using good educational practice.</p> <p>4.9 The ability to follow-up and monitor the growth of children using the Road to Health Chart.</p> <p>4.10 The ability to recognise under-nutrition, micronutrients deficiency and obesity, and appropriately counsel and advise clients.</p>
5	<p>REFERRAL</p> <p>5.1 There is effective and efficient referral and counter referral system between district health facilities and community based services.</p>
6	<p>PATIENT EDUCATION</p> <p>6.1 Appropriately counsel and advise clients on under-nutrition, micronutrient deficiency and obesity.</p> <p>6.2 Appropriately counsel and advise clients on breastfeeding and weaning.</p> <p>6.3 Appropriately counsel and advise clients on infant feeding options for HIV positive mothers.</p> <p>6.4 Counselling and support of current coping strategies.</p>
7	<p>RECORDS</p> <p>7.1 Children's weight is recorded and graphed on the Road to Health Chart.</p> <p>7.2 Charting of weight and other appropriate parameters by the client on a home monitoring programme.</p>
8	<p>COMMUNITY & HOME BASED ACTIVITY</p> <p>8.1 The active participation of households, community leaders and structures, NGOs, CBOs and other community role players are mobilised in the district.</p> <p>8.2 Household coping strategies already in place are supported.</p> <p>8.3 Communities are empowered with the necessary skills and knowledge to become self-reliant with regard to their food and nutrition needs and to be in control of factors affecting their nutritional well being.</p>
9	<p>COLLABORATION</p> <p>9.1 Intersectoral collaboration of line departments and other sectors are mobilised at all levels to ensure joint action to ensure nutrition problems are addressed</p> <p>9.2 Collaboration between health-facilities and community-based programmes to implement the community component of the Integrated Management of Childhood Illness.</p>

SCHOOL HEALTH SERVICES

BASIC CONSIDERATIONS

The School Health Service is expected to provide a health promoting services by acting in a co-ordinating role, 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 and school health services at present 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 these schools and communities will have to be develop to provide acceptable services for these children. Teachers generally do not have the capacity to deal with these children 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 intrasectoral(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 promotive service dealing with the individual in the context of the family and community and with the school environment. The service encourages the school to seek 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 clinic will be able to access a specially trained nurse on school health within the district
3.	District School Health Promoting Teams are supported from provincial level with an appropriate, effective transformation training programme, and the development of standardised resource packs and the training occurs during those times of the year when schools are closed. The transformation is completed by the year 2003.
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

1	<p>REFERENCES PRINTS AND EDUCATIONAL MATERIAL</p> <p>1.1 A standardised questionnaire for use by teachers to screen for the presence of factors causing barriers to learning in the individual (e.g. "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).</p> <p>1.2 A standardised questionnaire for use by school health promoting teams to assist them detecting barriers to learning in the environment of the learner (e.g. the draft of "The Index - an instrument to assess Health Promoting Schools in South Africa").</p> <p>1.3 A resource register for the district for use by School Health Promotive 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.</p> <p>1.4 Health promoting educational materials in the local language and accessible to people with disabilities, including films, videos, posters, booklets, visual aids and audiotapes.</p>
2	<p>EQUIPMENT</p> <p>2.1 As for mobile teams</p> <p>2.2 Projector, video recorder, slide projector, white boards and audiotapes.</p> <p>2.3 Access to administrative support, including typing services, telephone and fax, photocopying services, stationary and appropriate transport for the environment.</p>
3	<p>MEDICINES, SUPPLIES AND ASSISTIVE DEVICES</p> <p>3.1 Access to medication for control of specific disease conditions identified at district level, e.g. prevention of blindness from trachoma, treatment of scabies outbreak.</p> <p>3.2 Assistive devices for daily living for people with disabilities. (Assistive devices required to access education is supplied by the Education Department).</p>
4	<p>COMPETENCIES</p> <p>4.1 The School Health Promoting Team is able to:</p> <p>4.1.1 Function as an effective and efficient team.</p> <p>4.1.2 Promote the whole person and life-style skills development of pupils and educators.</p> <p>4.1.3 Identify resource people and involve them to promote the transformation.</p> <p>4.1.4 Promote community participation and the participation of all stakeholders in programmes e.g. Participatory Learning and Action (PLA) skills.</p> <p>4.1.5 Plan and implement health promoting programmes.</p> <p>4.1.6 Apply and interpret the screening questionnaires for individuals and schools and transfer these skills to the teachers.</p> <p>4.1.7 Identify gaps in the service and barriers to learning.</p> <p>4.1.8 Promote healthy nutrition, mental health and reproductive health.</p> <p>4.1.9 Counsel for substance abuse and victims of violence including rape.</p> <p>4.1.10 Identify and seek to reduce stress.</p> <p>4.1.11 Promote healthy sexuality and deal with the results of unhealthy sexual behaviour.</p>
5	<p>PATIENT EDUCATION</p> <p>5.1 Address health risk behaviours with the provision of behaviour specific knowledge and opportunities to practice knowledge and skills.</p>
6	<p>REFERRAL</p> <p>6.1 Refer to nearest clinical service, the students that require more intense clinical assessment and management.</p>
7	<p>RECORDS</p> <p>7.1 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.</p>
8	<p>COMMUNITY BASED ACTIVITIES</p>

<p>8</p> <p>COMMUNITY BASED ACTIVITIES</p> <p>8.1 Promote the development of child-to-child programmes as an important resource.</p> <p>8.2 Work with school boards to promote activities in the community such as libraries and sport activities.</p>
<p>9</p> <p>COLLABORATION</p> <p>9.1 Clinic staff collaborate with and involve dis from health, welfare, education, agriculture sectors, educators, learners, parents, community leaders CBOs and NGOs,</p> <p>9.2 School Health Promoting Teams are intra- and intersectoral.</p>

COMMUNITY BASED REHABILITATION

SERVICE DESCRIPTION

The philosophy of Community Based Rehabilitation (CBR) is to promote the concept of shared governance, namely the active participation of people with disabilities and their family members in:

- Developing of a vision for their lives within the society in which they live,
- Identifying the needs and resources of people with disabilities within the community,
- Planning and implementing the vision and
- Monitoring and evaluating its implementation.

This participatory approach to governance and service implementation takes place at all levels of society from central government down to community groups and home based care. This chapter describes what happens in the community and at home, after listing the norms and standards that apply at all levels in society.

NORMS

STANDARDS

<p>1</p> <p>REFERENCES, PRINTS, AND EDUCATIONAL MATERIALS:</p> <p>1.1 Disabled Village Children: David Werner</p> <p>1.2 WHO Manual on Community based Rehabilitation.</p>
<p>2</p> <p>EQUIPMENT</p> <p>2.1</p>
<p>3</p> <p>MEDICINE & SUPPLIES</p> <p>3.1 Medical and surgical supplies and assistive devices are accessed from the nearest health facility.</p>
<p>4</p> <p>COMPETENCIES</p> <p>4.1 Community groups skills are available</p> <p>4.1.1 To organise and run regular, focused and functional meetings.</p> <p>4.1.2 In record keeping and minutes taking.</p> <p>4.1.3 To run committees and resolve conflicts.</p> <p>4.1.4 In bookkeeping, financial reporting and operating a bank accounts.</p> <p>4.1.5 In writing proposals and fund-raising.</p> <p>4.1.6 In developing job descriptions and monitoring the services of employees like cooks, day-care providers, drivers, etc.</p> <p>4.2 Day caretakers have</p> <p>4.2.1 Basic training in early education and can carry out a basic rehabilitation programme under the guidance of a therapist or therapy assistant.</p>

- 4.2.2 The ability to
 - 4.2.2.1 do a basic assessment of the rehabilitation needs of the children in their care, and record this in the local vernacular in a standardised format.
 - 4.2.2.2 keep a progress record of a child in his/her care in the local vernacular.
 - 4.2.2.3 keep a daily journal of their activities, attendance and incident registers and write half-yearly reports of the child's progress to the parents.
 - 4.2.2.4 construct toys from locally available material and plan stimulation programmes for a group of children.
 - 4.2.2.5 counsel parents on handling of the child.
 - 4.2.2.6 Identify children who are not adequately cared for by their families, even with support from community services, and refer these to welfare services.
 - 4.2.2.7 Know which social grants are available to people with disabilities and how to apply for such assistance.
- 4.2.3 Self-help and Income Generating Groups have skills are available in financial management and marketing products made.

Organising the service at all levels

- 4.3 Districts have a community-based level of service for rehabilitation, which is provided in partnership with people with disabilities and their caregivers.
- 4.4 Councils are in place at district and community level, based on the shared governance structure described as the model in the white paper on disability.
- 4.5 Health Department representatives at these levels participate in, and actively promote, the shared governance structures, in an empowering way, putting the leadership into the hands of the people with disabilities.
- 4.6 Health forums, hospital boards and community health committees have at least one member with a disability.
- 4.7 Meetings of the committees and boards are conducted in barrier free circumstances.
- 4.8 Services for people with disabilities are given priority.
- 4.9 The Health Sector gives technical support to shared governance structures and community-based services.
- 4.10 People with disabilities are involved in setting up and implementing disability information systems at all levels of service provision, and this information is used to prioritise and plan services.

Organising the service at community level

- 4.11 Opportunities are developed for care givers of disabled children, or people with disabilities to be involved in providing community based services.
- 4.12 Community based services include day care facilities for children with multiple severe disabilities, support groups, self help groups, protected workshops, home based care, sport opportunities and instruction for people with disabilities.
- 4.13 Each sub-district has a centre for rehabilitation with, as a minimum, facilities for day care and a workshop.
- 4.14 Community based service points are visited by a therapist or therapy assistant.
- 4.15 Suitable space is available for these services to be provided on or within health service facilities, if needed.

5 REFERRAL

- 5.1 There is effective and efficient referral and counter referral system between district health facilities and community based and owned facilities.

6 PATIENT EDUCATION

- 6.1 Assist in empowering people by them recognising their self-worth.
- 6.2 Handling of behavioural problems.

7 RECORDS

- 7.1 A progress record of a child in his/her care in the local vernacular.
- 7.2 Daily journal of day care centres, their activities, attendance and incident register,
- 7.3 Regular reports on the child's progress to the parents.

7.4 Record of a basic assessment of the rehabilitation needs of the children in their care in the local vernacular in a standardised format

8 COMMUNITY & HOME BASED ACTIVITY

- 8.1 Needs driven community training, counselling and awareness raising programmes to address issues concerning people with disabilities operate from these centres.
- 8.2 Community groups are actively involved in awareness raising activities within the district, especially the International Day of Disabled and other special days with related topics.

9 COLLABORATION

- 9.1 People with disabilities are involved in the planning, setting of standards and monitoring of the services of which they are the main benefactors.
- 9.2 Issues pertaining to disability are addressed, through intersectoral collaboration, with the community at community based service points.
- 9.3 Community based services are provided within a framework of accountability to a committee made up of stakeholders, which receives technical support from a service provider.
- 9.4 Rehabilitation centres are further developed to provide contact/service points with other sectors, e.g. welfare, labour, education, agriculture, as well as community gardens and adapted gardens for people with disabilities, sports facilities for disabled persons, and short term half way house boarding facilities.
- 9.5 Therapists and therapy assistants assist community-based groups to contact services from other sectors, NGOs and Disabled People's Organisations (DPO's).
- 9.6 District maintenance personnel provide technical support for these services e.g. construction of aids for daily living for individual clients.
- 9.7 Opportunities to contract the provision of services for the health sector to people with disabilities are developed e.g. making of pressure garments, sewing or repair of hospital linen, making of special chairs from Appropriate Paper Technology, garden services.
- 9.8 The education sector makes use of the resources within the Community Based Rehabilitation service to cater for the educational needs of children and adults with barriers to learning, and provides technical support to the groups.
- 9.9 Community Groups remain in contact with the Department of Labour, and are given priority in suitable skills training programmes.

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ABBREVIATIONS

AEFI	Adverse Effects Following Immunisation
AFP	Acid Fast bacillus
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante natal care
ARI	Acute Respiratory Infections
ART	Atraumatic Restorative Treatment
ATICC	Aids Training and counseling center
BCG	Bacillous
CBO	Community Based Organisation
CBR	Community Based Rehabilitation
CDL	Chronic Diseases of Lifestyle
CHW	Community Health Worker
CSF	Cerebro Spinal Fluid
DISCA	District STD Quality of Care Assessment
DOTS	Direct Observed Treatment
DPO	Disabled People's Organisation
DPT	Diphtheria-Pertussis-Tetanus
EDL	Essential Drug List
EHO	Environmental Health Officer
EPI	Expanded Programme of Immunisation
FEFO	First expiry, first out
FP	Family Planning
HBV	Hepatitis B Virus
HIB	Haemophilus vaccine
HIV	Human immunodeficiency Virus
IEC	Information Education and Counselling
IMCI	Integrated Management of Childhood Illnesses
INH	Isoniazid
MCWH	Maternal Child and Women's Health
MTCT	Mother To Child Transmission
NCSNET	National Commission of Special Needs in Education and Training
NCESS	National Committee on Education Support Services
ORS	Oral Rehydration Solution
OT	Occupational Therapy
PEP	Perinatal Education Programme
PHC	Primary Health Care
PLA	Participatory Learning and Action
PNC	Post Natal Care
POP	Plaster of Paris
RPR	Rapid Plasma Reagin (A syphilis test)
SOAP	Subjective, Objective Assessment Plan
STD	Sexually Transmitted Diseases
TB	Tuberculosis
TBA	Traditional Birth Attended
TOP	Termination of Pregnancy
TT	Tetanus toxoid
UV	Ultra Violet
UNICEF	United Nations Children's Fund
VDRL	Venereal Diseases Research Laboratory Test for Syphilis
VIP	Ventilated latrine
WHO	World Health Organisation