In many instances patients are “adopted” by friends and even strangers who are willing to care for them after discharge. The personal interest and loving care given these patients a sense of belonging. At several psychiatric hospitals “Friends of” organizations are established which consist of friends and relatives of patients as well as members of the community, for example “Friends of Umgeni,” “Friends of Fort Napier”.

Members of these organizations act as voluntary workers in the hospitals. Their services are invaluable because they assist in the stimulation of the patients, resocialization, encouraging interaction and teaching social, and interpersonal skills. They assist the patient when performing simple tasks like using the telephone or taking the bus.

Some of the women or church organizations “adopt” a certain ward in a psychiatric hospital. Once a month they have a tea party in the ward. By involving the community during the period of hospitalization, the patient gradually adapts to life in the community.

Patients are allowed to attend church gatherings in the community and after the service they join in having tea with the other members of the congregation.

In many psychiatric hospitals members of the community are members of the sport club of the hospital.

The strongly-felt need for community involvement led to the establishment of mental health societies. By means of mental health education these societies provide a preventative service.

Curative services are provided at different clinics for patients for consultation with the psychiatrist, the psychiatric nurse and the social worker.

Hostels, protective workshops as well as day care centres are also provided for mentally handicapped persons. Most of these institutions are financed by donations from the community, for example the Pumla and Pumelela Day Care Centres for black mentally retarded children.

Hence, there are strong indications that members of the community should be sensitive to the needs of their fellow men. Without the help and the involvement of the community it will not be possible to fulfill the concept of “a healthy mind in a healthy body.”

CONCLUSION

It is quite obvious from the discussion that community involvement is not really a new concept. In South Africa we have many examples of community involvement especially in our smaller communities.

It is the responsibility of the community health nurse to promote community involvement. Because of her relationship with the public at all levels of community life, whether through schools, prisons, private homes, institutions, clinics and factories. She is in an ideal position to do so. A tremendous challenge — is she prepared to meet it?

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defining their role in the supervision of the clinic midwife. If doctors are to adapt easily to this situation, they must be introduced to the concept of the Comprehensive Health Programme as medical students.

BASIC PRINCIPLES

Certain basic principles must be established before details are considered.

1. The primary health care unit in this structure is the midwife, not the medical officer. It is not valid use of the doctor's time, nor does it increase patient confidence in the midwife's ability, for the doctor to see all the patients at a peripheral antenatal clinic.

2. The doctor's task must be to provide training for, and supervision of, the midwife, so that she can successfully detect the high risk patient, in the antenatal, intrapartum, or postpartum periods. Such patients should then be transferred timely to the base hospital, or referred to the doctor on one of his regular weekly or fortnightly visits. She should be able to manage patients with normal pregnancies without his assistance.

3. Monitoring the midwife's work under these circumstances is only possible if a high standard of clinical notekeeping is maintained, both in the clinic and in the base hospital. This implies that each patient must have a maternity case record which will form a satisfactory record of her whole pregnancy, including her confinement and puerperium. Such a record should accompany her to the hospital if she is referred there for delivery. It must also be adequately completed and returned to the clinic when she is discharged. This is the only way of ensuring good communications, and thus enabling a high standard of patient care in a community obstetric programme. Good communications can only be achieved if hospital staff recognise the clinic as an integral part of the obstetric service, and they frequently need considerable re-education in this regard. The supervising doctor must be prepared to discuss adequately completed charts with the medical and nursing staff concerned. He should also be prepared to arrange clinic visits for hospital staff, and even to organise the rotation of hospital nursing staff through the clinics.

4. During his clinic visits, the doctor should also be prepared to pay attention to incidental problems such as equipment, transport, and water supplies.

METHODS OF SURVEILLANCE

Referrals

The records of all patients referred from each clinic to the hospital should be critically reviewed at fortnightly or monthly intervals. Such a review should take place against a background of a clear management protocol for each condition encountered in that obstetric population. The objects of this examination of patients' records should be to:

(a) test and modify where necessary, management protocols,
(b) detect inadequate management of patients, whether or not this resulted in morbidity or perinatal mortality,
(c) detect unnecessary transfers and referrals, and
(d) detect patients who have been exceptionally well managed.

Any findings should be discussed with the whole clinic staff when the charts are returned to the clinic. Changes in management protocols can be worked out, the reasons for failure in management identified and corrected, and the necessary encouragement and praise shared when tasks have been well done. The midwives' participation in decision-making in this way improves understanding and the level of trust between clinic and base hospital staff. It also incidentally usually means that better decisions are made by the medical staff when improving management protocols.

A similar review should be made of patients referred at the clinic for the doctor's assessment, each patient's problem thus forming a teaching opportunity.

Random Patient Review

With the clinic midwives' knowledge, antenatal patients or patients in labour at the clinic, who have been previously assessed by her, are reassessed by the supervising doctor. This method enables him to monitor the accuracy of her observations, from screening the heart and lungs to pelvic assessment, and will help him to determine the details and direction of further practical training in technique which the midwife may require. It also incidentally allows assessment of the standards of aseptic technique pertaining in the clinic, and whether the equipment is adequate in quality and quantity.

Clinic Antenatal Record Review

Time can be profitably spent in examining all the antenatal records of patients attending the clinic. This is especially so if a method of problem-orientated antenatal notekeeping is employed. A suitable method is described elsewhere. This method of notekeeping enables the medical officer to see immediately whether a high risk factor has been detected, and whether appropriate action has been taken. Where such factors have been missed, or the correct action has not been indicated, he can write it into the chart, at the same time discussing the patient with the clinic staff, thus ensuring that the patient's problem is correctly dealt with at her next visit.

Clinic Perinatal Mortality and Morbidity Meetings

These should be organised on a regular basis, the number of meetings per year depending upon such factors as the number of patients delivered at the clinic. Where numbers are small, a meeting for staff from a group of clinics may be valuable. The senior nursing staff at each clinic should be encouraged to do the background work, gathering the case records of all stillbirths, neonatal deaths, and babies with low APGAR scores, as well as any maternal deaths. This review should include all patients transferred to the hospital during the period in question, as well as those delivered in the clinic. As far as is possible, learning from these patients should take place by peer review, the midwives themselves being encouraged to identify the factors which lead to mortality or morbidity, and to suggest where treatment could have been improved. This affords the doctor the opportunity of observing how much of his instruction has been understood, and whether it is being applied in problem solving.
Regular Formal Inspections

These should be carried out with the senior nursing officer of the health ward. Special attention should be given during such inspections to the standard of aseptic technique, the maintenance of equipment, the organizational aspects of antenatal, intrapartum and postnatal care, and the adequacy of communications and transport arrangements. They should not simply involve the inspection of general clinic cleanliness and drug records, but should be a forum for discussion between the medical and nursing authorities and the clinic staff, directed at achieving a better standard of service and improved working conditions.

DISCUSSION

Five methods of surveillance of the clinic midwife's work have been detailed. Each has slightly different aims. Use of all five will result in adequate monitoring of the following areas of her work:

1. The indications she employs for referring patients, and her management of patients at risk.
2. The standard of her clinical observations and technical ability.
3. The unrecognized problems which pass through her antenatal clinic.
4. Her ability to recognize and learn from her mistakes.
5. The nursing and organizational standards of the service she offers.

It is the author's experience that the use of all five methods can result in the development of a service of considerable excellence.

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INTRODUCTION

The black population of South Africa consists of several different ethnic groups, each with its own historical identity. Seven of these groups have homelands. They are the Xhosa of Ciskei, the Zulu of KwaZulu, the Swazi of Kangwane, the Changana/Tonga of Gazankulu, the Basotho of Qwa-Qwa, the North Sotho of Lebowa, and the Venda of Venda.

The Xhosa of Transkei and the Tswana of Bophuthatswana, two former homelands, became independent during 1976 and 1977 respectively.

All the homelands have their own health and welfare departments. During March 1970 the control of all hospitals in the homelands was transferred to the Department of Bantu Administration and Development. The Department of Health remained responsible for all health services in the homelands, and acted as agent to render the service on behalf of the Department of Bantu Administration and Development.

HISTORICAL BACKGROUND

The first medical services in the homelands were mostly provided by mission hospitals, and until recently...