NATIONAL OPEN UNIVERSITY OF NIGERIA

SCHOOL OF SCIENCE AND TECHNOLOGY

COURSE CODE: CHS 324

COURSE TITLE:
INTRODUTION TO STANDING ORDERS

CHS 324 INTRODUTION TO STANDING ORDERS.

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CHS 324 INTRODCTION TO STANDING ORDERS.

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CHS 324 INTRODUCTION TO STANDING ORDERS

COURSE GUIDE

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1.0 INTRODUCTION

Introduction to standing orders is a 2.0 unit course for 300 level student offering B.Sc community health.

Standing orders is a book meant to guide actions in a way to ensure a uniform standard of treatment and handling all other health related situations. These provide basis for better training, monitoring and evaluation of all primary health care activities through out the country to improve the quality of health care delivery. Standing orders also provides legal backing for the health workers when properly used. The purpose underlying the study of standing orders is to develop greater capacity in client/patient management at community and health facility levels.

2.0 OBJECTIVES

At the end of this unit, the learner should be able to:

- Define the term standing orders
- Enumerate the purpose for use of standing orders.
- Identify other inclusions in the standing others
- Trace the evolution of standing orders
- Explain the two-way referral system

3.1 DEFINATION OF STANDING ORDERS

FMOH/NPHCDA, (1995) Defined standing orders as a set of specific guidelines arrange by symptoms which defined how clients with different conditions should be cared for. They are designed to be used by community health workers and should also be adhere to by Doctors

and other health workers in primary health care settings. Unless there is a valid medical reason to deviate form them.

3.2 PURPOSE FOR THE USE OF STANDING ORDRES

The purpose for the use of standing orders include.

- Gives these health workers legal protection in their primary heath care assignments.
- Provide a systematic framework for history taking and physical examination.
- Enable the health workers treat less common easily forgotten and more serious conditions.
- Maintain a high and uniform standard of health care.
- Minimize unnecessary, often – time consuming and expensive laboratory investigations.
- Provide a framework for evaluation of care and staff performance.

3.3 OTHER INCLUSIONS IN STANDING ORDERS.

Odunsi (1994), stated that the discrepancies in the findings and actions boxes of some of the conditions in the standing orders, prompted the review of the second edition. The review also gave the opportunity to include sections on

- Mental health
- Acute respiratory infection
- Management of diarrhea diseases and
- HIV/AIDS in the current standing orders.

It is hoped that the community health workers training institutions all over the country and the supervising officers will encourage the health workers to use their standing orders in the community as expected, so that the trial and error type of clients management will be a thing of the past.

3.4 EVOLUTION OF STANDING ORDERS.

Primary health care was defined by world health organization in its conference held in Alma – atta in USSR in 1978. Nigeria launched a national health policy in October 1988, the bedrock of the policy was primary health care which form the integral part of the national health care system. Primary health care was also identified as key to national health care system. Nigeria government made some attempts to persuade doctors to serve in the disadvantaged areas of the country

bur failed because of medical education that does not equip doctors with the skills to work with a community. Another reason is lack of social amenities such as water, electricity and schools to rural areas. Lastly, there is still a lingering belief that in some states doctors face discrimination in appointments and posting to comfortable stations. There are five times more nurses than doctors, however studies indicate nurses, like doctors were ill – equipped to deliver primary health services and a major adjustment in the curriculum was required. Although this was done, it did not succeed in removing the overwhelming bias towards hospital base or individual health care services. In 1978 a new breed of PHC workers was introduce to man the PHC services. These were community health officers, supervisors, assistance and aides. In 1987, the names "assistants" and "aides" were changed to community health extension workers. These personnel will be architects of community participation – a prerequisite for transforming a community from its traditional past to the age of science. Hence there were no doctors, no nurses, on pharmacists, no psychiatrists and no dentists, a community health worker was meant to be every thing in delivering integrated, primary health care services. It was at this time that different categories of health workers were assigned the responsibility of drawing the standing orders to be used by community health workers and it serve as legal document for carrying out their PHC assignments. The first edition was published in 1989, the second 1991 and the third 1995 (Ransome Kuti et al 1991).

3.5 REFERRAL SYSTEM

Explain the importance of 2-way referral system as in management of clients

- Definition of 2-way referral system
- The importance of referral system
- Reasons for referral
- Conditions needing referral
- 2-way referral form.

4.0 CONCLUSION

Standing orders is a guide for community health workers to ensure uniformity in delivering integrated PHC services. Other areas such as mental health, acute respiratory infections, management of Diarrhea diseases and HIV/AIDS have been included in the current edition, standing orders have undertaken revision from first to second edition and to the third edition in order to improve the standard of

living of all Nigerians, promote good health, enlongate life span and enhance the quality of all our lives.

5.0 SUMMARY.

Standing orders have been defined and purpose for the use of standing orders such as uniformity of care, provision of legal protection, frame work for history taking and physical examination, also for staff evaluation of performance have been explained. Recent inclusions in the standing orders have been identified and evaluation of standing orders discussed and type of cases to be referred identified.

6.0 TUTOR MARKED ASSIGNMENT

1a Define standing orders

1b State the purpose for the use of standing orders.

7.0 REFERENCES AND FURTHER READINGS,

1. FMOH and NPHCDA, (1995), Standing order for community health officers and community health extension workers. Training and manpower development division pp 1-5.

2. Odunsi P.Y. (1994), Acknowledgement to the third edition, standing orders review committee in standing orders published by training and manpower development division Nigeria 1995.

3. Ransome – Kuti et al (1991) strengthening primary health care at local Government level. The Nigerian experience: Academic press Ltd. Lagos. Pp 1-10

4. FMOH, (1990), Guide lines and training manual for the development of primary health care in Nigeria pp 106 - 108

CHS 324 INTRODUCTION TO STANDING ORDERS

TABLE OF CONTENETS

1.0 INTRODUCTION

Since you have gone through unit one, you have acquired the general overview of the background use of the standing orders. This unit is about the layout format of standing orders which explains the components of standing orders and various sections of the standing orders.

2.0 OBJECTIVES

At the end of this unit learner should be able to:

- Describe the components of the standing orders
- Identify the various sections of the standing orders
- Explain the sections of the standing orders e.g. maternal and child health including family planning. Treatment of common conditions in adult and appendix.

3.1 COMPONENTS OF STANDING ORDERS

The standing orders encompasses the following areas, the preface to the third edition, acknowledgement to the third edition, table of contents, introductions, instructions, acknowledgement to the first edition, acknowledgement to the second edition preface to the second edition and index.

3.2 VARIOUS SECTIONS OF STANDING ORDERS

The various sections of the standing orders include: maternal and child health including family planning. The child health aspects deals with child first visit, new born babies, well child revisit and various problems affecting children including school health services. Maternal health deals with prenatal visit, labour and delivery, post natal problems family planning include first visit for contraceptive,

contraceptive follow-up visit schedule, methods of contraception and infertility.

Adult health – Deals with adult first visit and all problems affecting adults.

Appendix – Other things covered in standing orders but not found in maternal and child health including family planning and adult health are in appendix.

4.0 CONCLUSION

In this unit you have learn the layout format for the standing orders which include the components of standing orders and various sections of the standing orders.

5.0 SUMMARY

The components of standing orders such as the preface, acknowledgement introduction, instructions and index were identified. The various sections of the standing orders like maternal and child health including family planning, adult health and conditions in appendix were identified and discussed for proper use of standing order.

6.0 TUTOR MARKED ASSIGNMENT

Identify the various components of maternal health and briefly explain each.

7.0 REFERENCES

1. FMOH and NPHCDA, (1995), Standing order for community health officers and community health extension workers. Training and manpower development division pp 1-5.

2. FMOH, (1990), Guide lines and training manual for the development of primary health care in Nigeria pp 106 – 108.

3. NBTE, (2003) National Diploma and High National Diploma in community Health Curriculum and course specifications plot B, Bida Road, Kaduna pp 25

CHO 324 INTRODUCTON OF STANDING ORDERS

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1.0 INTRODUCTION

This unit enlightens the learner what to do when he/she encounters a health condition to be managed with the standing orders. It follows step to step in management of client's condition to it logical conclusion. It also entails on what to do in high risk conditions, follow up and referrals. It also describe the clinical manifestations of various conditions and what to do.

2.0 OBJECTIVES

At completion of this unit the learner should be able to:

- List the steps in the use of standing orders
- Describe the use of standing orders for different clients situation e.g. first visit, follow up and emergency.
- Explain "at risk" register
- Select cases for the at risk register.
- Identify conditions in children and adult that can that put them in grave danger.
- Explain the symptomatology of long term high risk conditions and conditions that can put a child in grave danger.

UNIT 1 STEP IN THE USE OF STANDING

- Obtain the complain and write down
- Look up the client's problem or complain in the index or table of contents and turn to the appropriate page.
- Ask all questions as listed in the history box.
- Perform all the examinations as listed in the appropriate box.
- Assemble and record all significant information including negative ones.
- From list of findings, select the box containing all significant findings related to the particular client.
- Locate the action corresponding to the selected group of findings and manage the clients complaint as stated.
- It may be necessary to refer to more than one section of the standing orders to completely manage the problems with which the client presents.
- Take appropriate action based on your findings.
- Each case turns to medication page for the appropriate drug dosage.
- Whenever course of medicine or injection is due to finish review the clients condition. This is a good way to successfully evaluate your work.

UNIT 2 MANAGEMENT OF CLIENT WITH DIFFERENT CONDITIONS

- Every client should have the complete examination listed under the FIRST VISIT at fist contract with the health facility. This examination should be omitted only when there are emergency problems and should be done at next visit.
- Every opportunity should be taken to manage problems of all members of the family present in the clinic.
- It is important that all referred cases should be followed up when they return. This is for continuity of care as well as a learning process for health workers.
- Inform all clients to return to the health facility immediately if their condition gets worse.
- Health education is one of the most important aspect of client's care and must receive health education in some of the following areas:
  - Breast feeing
  - Nutrition
  - Child spacing
  - Personal hygiene
  - Immunization
  - Clients presenting condition

- STDs/HIV/AIDS

- Follow up visits are an important part of good client care and allow you to pick up clients who may not be responding well to treatment if client is getting worse you should refer.
- If client has multiple problems, they should be followed up more frequently than what the standing order prescribe for any one of the problems. This is because a client with multiple problems is usually more ill and is more apt to develop complications.

UNIT 3 COMMON CONDITION AFFECTING CHILDREN AND ADULTS

Which can put them in grave danger FMOH. (1996). Listed the following conditions which ban be given priority attention according to standing orders.

- Signs of shock
- Severe respiratory distress
- Signs of severe local injury: profuse bleeding, deep loceration. Displaced or open fracture or sever burns.
- Profuse or prolong diarrhea with signs of dehydration
- Hemoglobin below 5gm%
- Stiff neck
- Abdominal pain with marked regality. Or marked tenderness
- Generalized oedema
- Fever over 40^0c
- No urine in the last 24hours
- Unconscious or delirious patients.

UNIT 4 CONDITIONS REQUIRING FOLLOW UP OVER A LONG PERIOD OF TIME

- Malnurished children
- Tuberculosis client
- Epileptic client
- Clients with leprosy
- Anaemic patients with hemoglobin under 7.5gm%
- Physical, social and mental handicapped
- AIDS client and their children.

3.6 SYMPTOMATOLOGY OF AT RISK CASES

Both conditions that can put a patient in grave danger and long term high risk factors were discussed including their signs and symptoms.

3.7 FOLLOW UP AND REVIEW CASE

This is seeking the assistance of the physician or supervising officer in the clinic when uncertain about the management of the client in order to ensure effective client care and to improve the skills of the health workers. Consistently instruct the client to return for necessary follow up as indicated in the standing orders unless there are other indications for earlier follow up. Such indications may be due to:

- Health worker **assessment** of client's condition
- Client for one reason might have difficulty following instruction. This ensures staff evaluation of performance and effectiveness.

4.0 CONCLUSION

This unit was able to discuses the use of standing orders. Other areas such as follow up and review of patients conditions were discussed. It also identified conditions that can put person in grave danger and long term high risk factors.

5.0 SUMMARY

Steps in the use of standing orders were identified and ways of management of clients with different conditions were highlighted, follow up visits and review of managed cases of people with short/long term high risk factors were also discussed symtomatology of all the disease in the at risk register will enumerated.

6.0. TUTOR MARKED ASSIGNMENT

a. Identify high risk short term conditions affecting people in your community.
b. How will you use standing order to manage such conditions.

7.0 DEREFERENCES

1. FMOH and NPHCDA, (1995), Standing order for community health officers and community health extension workers. Training and manpower development division pp 1-5.

3. FMOH, (1996) Curriculum for community Health officers, training and manpower division, pp 27-29.

2. FMOH, (1990), Guide lines and training manual for the development of primary health care in Nigeria pp 106 - 108.

CHS 324: INTRODUCTION TO STANDING ORDERS

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CHS 324 INTRODUCTION TO STANDING DRDERS

COURSE MATTERIAL

The main components of the course are:

1. The course guide
2. Study Units
3. References/Further Readings
4. Assignments
5. Presentation schedule

STUDY UNITS

The study units in this course are as fellows:

Module 1 Historical background of standing order

Unit 1 Definition of standing orders.

Unit 2 Purpose for the use of standing orders

Unit 3 Evolution of standing orders

Unit 4 Other inclusions in the standing orders

Unit 5 The referral system

Module 2 layout format of standing orders

Unit 1 Components of standing orders

Unit 2 Preface and acknowledgement to first, second and third edition of standing orders

Unit 3 Instructions

Unit 4 Maternal and child health including family planning section

Unit 5 Adult health and appendix

Module 3 procedure for use of standing orders

Unit 1 Steps in the use of standing orders

Unit 2 Management of clients with different conditions

Unit 3 Short term high risk factors in children and adult

Unit 4 Long term high risk conditions in children and adult.

Unit 5 Symptomatology of identified conditions in unit 2 and 3

1.0 INTRODUCTION

Introduction to standing orders is a second semester course for 300 level students offering B.Sc Community Health. It is a two unit degree course.

Standing order is a book meant to guide actions in a way to ensure a uniform standard of treatment and handling all others health related situations. These provide basis for better training, monitoring and evaluation of all primary health care activities through out the country to improve the quality of health care delivery. Standing order also provides legal backing for the health workers when properly used. The purpose underlying the study of standing order is to develop greater capacity in client/patient management at community and health facility levels.

2.0 OBJECTIVES

At the end of this unit, the learner should be able to:

- Define the term standing order
- Enumerate the purpose for use of standing orders.
- Identify other inclusions in the standing others
- Trace the evolution of standing orders
- Explain the 2-way referral system

MODULE 1 HSITORICAL BACKGROUD OF STANDING ORDERS

UNIT 1 DEFINITION OF STANDING ORDERS

FMOH/NPHCDA, (1995) Defined standing orders as a set of specific guidelines arranged by symptoms which defined how clients with different conditions should be cared for. They are designed to be used by community health workers and should also be adhere to by Doctors and other health workers in primary health care settings. Unless there is a valid medial reason to deviate form them.

The standing orders as a concept present, as much as possible, the best treatment for each condition listed as a result of many years of field testing, they are practical and relevant to the setting in which community health worker operate. By strictly adhering to the standing orders, the workers is acting under the authority and legal auspices of the physician at al times. For any sign or symptom that the client is likely to complain of, the standing orders begin with a short write-up designed to cue the worker on important aspects of the complaint. This is followed by suggested history and examination, then a list of the likely groups of findings indicating both signs and symptoms. For each group, there is a set of actions including health education, further investigation, treatment and follow up necessary for good client's care. Every attempt has been made to ensure simplicity, clearity and ease of use. The more commonly occurring findings have been placed first.

The uniformity of care which the standing orders provide makes evaluation easier, since it is a set of standard for care which can be applied to each case. This evaluation can be used to ensure that workers are following the standing orders and thus maintaining a high standard of care. It can also be used to evaluate the adequacy of overall care for each client and also to determine areas that need strengthening or change.

The standing orders do not replace clinical judgment and thought by the worker. The health worker must still elicit the important points of history and physical examination necessary to treat the client and decide which group of findings and corresponding actions are appropriate in each case. Strictly, speaking, these are protocols as they delineate the data base required and the decision to be made to manage a client sign or symptom.

The standing orders like the rest of primary health care concept, depend on well trained, committed and dedicated health workers for its effectiveness. The standing orders are therefore complemented by course work development to be used by schools of health technology, community health officers training institutions and B.Sc community health programmes. The continued and proper utilization of standing orders, for both training and practice, will ensure the sustenance of a high standard of health care deliver in the country.

UNIT 2 PURPOSE FOR THE USE OF STANDING ORDER

To be objective in the use of standing orders, the following purposes have been formulated for the use of standing orders:

- It gives the health worker legal protection in their primary health care assignments.
- Provide a systematic framework for history taking and physical examination.
- Enable the health worker treat less common, easily forgotten and more serious conditions.
- Maintain a high and uniform standard of health care
- Minimize unnecessary, often times expensive and time consuming laboratory investigation
- Provide a framework for evaluate of care and staff performance.

UNIT 3 EVOLUTION OF STANDING ORDER

Primary Health Care was defined by world Health Organization in its conference held in Alma-atta in USSR in 1978. Nigeria launched a National Health policy in October 1988, the bedrock of the policy was primary health care which form the integral part of the national health care system. Primary

health care was also identified as key to national health care system. Nigerian government made some attempts to persuade doctors to serve in the disadvantage areas of the country but failed because of medial education that does not equip doctors with the skills to work with a community. Another reason is lack of social amenities such as water, electricity and schools to rural areas. Lastly, there is still a lingering belief that in some states doctors face discrimination in appointment and posting to comfortable stations. There are five times more nurses than doctors, however studies indicate nurses, like doctors well ill-equipped to deliver primary health services and a major adjustment in the curriculum was required. Although this was done, it did not succeed in removing the overwhelming bias towards hospital based or individual health care services. In 1978 a new breed of PHC workers was introduce to man the PHC services. There were community health officers, supervisors, assistants and Aides in 1987, the names assistant and Aids were changed to community health extension workers. These personnels will be architects of community participation. A pre requisite for transforming a community from its traditional past to the age of science. Hence there were no doctors, no nurses, no pharmacist, no psychiatrists and no dentists, a community health worker was meant to be everything in delivering integrated primary health care services. It was at this time that different categories of health workers were assigned the responsibility of drawing the standing orders to be used by community health workers and it serve as legal document for carrying out their PHC assignments. The first edition was published in 1989, the second 1991 and third 1995 (Ramsome Kuti et al 1991).

UNIT 4 OTHER INCLUSIOIONS IN THE STANDING ORDERS

Odunsi (1994), FMOH/NPHCDA (1995), identified the following inclusions in the third edition of the standing orders: mental Health, Acute respiratory infection, management of diarhoea diseases and HIV/AIDS.

Mental Health inclusion is the changes in alertness and behaviour which means that the client does not act normally. He may be drowsy or unconscious or give a history of fainting. Big changes such as unconsciousness or delirium are easy to identify. Small changes such as drowsiness and decrease alertness are not easily notice. If the client is not alert or is drowsy, it may not be noticed easily. The client may not receive treatment and could come back later in more serious conditions. Therefore careful observation of the client is important.

All children are born with varying types of temperament, they display a range of behaviours when growing up. These behaviours vary form child to child. They may be described as abnormal when they last beyond the expected age or when they occur in a higher degree than expected allowing

for individual variability. Sometimes such abnormal state may be caused by problems during pregnancy, problems of neglects, strange environment, heredity and various other factors, when detected early some children may receive help and improve. Example of such behaviours include bedwetting, excess crying, tantrums, sleeping difficulties, restlessness, poor attentions span, destructives behaviour, bizarre, hallucinations, irrational speech, frequent asthmatic attack.

Dizziness or slight headache due to inadequate blood or oxygen supply to the brain. Conditions that affect the blood circulation are slow pulse, pounding rapid pulse, abnormal blood pressure severe anaemia. All may produced dizziness. The centre for balance is in the inner ear. So ear problems too can cause dizziness. Vertigo (disturbance of movement) is like dizziness but is related to the body's ability to maintain its balance and may be a sign of middle ear infection, meningitis, gastric disturbances, nerve damage and occasionally drugs or alcohol.

Violence to others or to self sometimes people become suddenly aggressive and violent to either other people or to themselves. This violent out burst is unprovoked. Frequently such violence may be as a result of severe emotional experiences. If nothing is done immediately, there may be damage to life and property.

Abnormal Beliefs, experiences and behaviour (Delusions, Hallucinations etc)

Sometimes somebody may suddenly become restless, offoid, suspicious and even confused. He may think that people are after him. He may complain of seeing strange people or things. He may even become hostile and aggressive even to those who are concern about his welfare. The condition may have come after a fever due to malaria, typhoid or viral infection or it may have happened because the individual have been drinking alcohol excessively for sometime or has taken drugs such as Indian hemp. Sometimes the reason may not be obvious.

Withdrawal/Over Activity/Abnormal Speech

Fever, low blood sugar, head injury or other factors may cause sudden change of mood, abnormal speech with strange contents, excessive fear, restlessness, sweating, aggressiveness confusion and even loss of consciousness.

Anxiety: - is usually manifested by physical and psychological signs in certain people whom they are exposed to particular circumstances. It is a normal reaction to over bearing situations but sometimes the reaction may

become excessive or persistence, even when the circumstance that provoked it has passed away. Drugs, disturbances in order parts of the body such as the heart and thryroid may also bring on the reaction.

Depression: - is thought to have occurred when a person become fearful and moody. He may have problem falling asleep and on sleeping may have unpleasant or disturbing dreams. He may wake up earlier than usual and is unhappy. The appetite may be poor and over a period of time, there would be weight loss. The person may lack energy, interest and drive to carry out normal household chores of relatives and friends. They may be frequent expression of being and never seem to find cure for their complaints. They tend to worry a lot that things might go wrong and after some times these complaints may make them remain sad and unable to enjoy life. Fed up with life finding, life not worth living or wanting to end it all.

There may even be attempt to commit suicide by taking poison, overdose of medication, banging, jumping into the traffic or river, cutting the wrist etc. the problem may develop as a result of recent stressful life problem such as death of a close relative, loss of job, accident, marital problems, loss of property through theft, fire, flood, problems at work. Some times there may not be any obvious cause.

Persistent complaints of ache, crawling sensation, heat in the body etc

Persistent and long standing complains of body aches, crawling or peppery sensation, heat in the head, tightness in the chest, pain in the neck, shaking of body heart beating fast and loud, poor sleep etc. may be given by some people such clients also have the habit of visiting many doctors, traditional healers spiritual churches etc. and never seem to find cure for their complaints. The turn to worry a lot that things may go wrong after some times these complaints only make them remain sad and unable to enjoy life.

Sudden loss of consciousness with or without jerking of lmbs

Client may suddenly become unconscious at any time or place. The whole body or parts of it such as the arms, may jerk or shake, the teeth may clench. The person then fall down and at times urinates on himself. After a while he will wake up but may develop headache and confusion for some times. Later, he becomes full aware of his environment. This situation may be due to a condition called epilepsy.

Acute Respiratory infections

Home care for acute respiratory infections has been included in the third edition of the standing orders. This is the management of cough or

common cold at home. It also applies to the care of a child with pneumonia receiving out patient treatment. Advise the mother or caretaker on the supportive treatment to give the child. Teach her the signs that mean that she should seek help from a health worker or bring the child back to the clinic. The danger signs include: Fast breathing, difficult breathing or sever lower chest in drawing. Poor feeding or inability to suck and child becoming more ill. Note that ARI is not a contraindication to immunization. Any child presenting with cough/difficult breathing and not already immunized, is eligible for immunization and should receive it.

Management of diarrhoea diseases

Diarrhoea is passage of three or more loose or watery stools in a 24 hour period. A loose stool is one that would take the shape of the container into which it is passed. Infants who are exclusively breast feed normally pass several soft or semi liquid stools each day, for them diarrhea is an increase in stool frequency or liquidity considered abnormal by the mother. Acute watery diarrhea is one that begins acute and lest less than 14 days without visible blood. Acute diarrhea causes death by loss of water and essential salts from the body and it kills children more easily than adults. In the adults diarrhea can be defined as waterly or very loses stool which occur more often than normal (usually more than three times a day). Diarrhoea kills by loss of water and essential salt from the body. Therefore salt sugar solution is the most important treatment. If you can give a client with very severe diarrhea or cholera fluids to drink, he will not die.

ASSESSEMTN OF DEHYDRTION

1. Look at condition	Well, alert,	Restless, irritable	*Lethargic or unconscious, floppy
Eyes	Normal	Sunken	Very sunken and dry
TEARS	PRESENT	ABSENT	ABSENT
Mouth and Tongue	Moist	Dry	Very dry
Thirst	Drink normally, not thirsty	*Thirsty, drinks eagerly	*Drinks poorly or not able to drink
2 FEEL Skin pinch	Goes back quickly	*Goes back slowly	*Goes back very slowly
3DECIDE	This clients has no sign of dehydration	If client has two or more sign, including at least one * sign there is some dehydration	If client has two or more signs including one * sign there is severe dehydration
4 TREAT	According to standing order on diarrhea	Weigh the client and treat according to section on diarrhea	Weigh the client and treat according to section on diarrhea

Source: Federal ministry of Health training and manpower development division 1996.

MANAGEMENT OF DIARRHOEA AND DEHYDRATION

Salt Sugar Solution

Age	Amount of SSS to give after each loose stool	Amount of SSS pupae for use at home
Less then 24months	50 – 100ml	500ml/Day
2 – 10 years	100 – 200ml	1000ml/Day
10 years	As much as wanted	2000ml/Day

FLUID TREATMETN OF MODERATE DEHYDRATED

AGE	Less than 4 moths	4-11 months	12-24 months	2-4 years	5-14 years	15 years or older
WEIGHT (kg)	Less than 5	5-7.9	8-10.9	11-15.9	16-29.9	2200-4000
ORS in m/s	200-400	400-600	600-800	800-1200	1200-2200	2200-4000

FLUID MANAGEMETN OF SERVERE DEHYDRTION

Start iv fluids immediately. If the patient can drink gives ORS by mouth while the drip is set up. Give 100ml/kg ringer's lactate solution (or not available normal saline) divided as follows:

Age	**Fluid Treatment**	**Fluid Treatment**
Infants less than 12 months	First give 30ml/kg body weight 1hour.	Then give 70m/kg body weight in 5 hours.
Older	First give 30ml/kg body wt. in 30 mins.	Than give 70ml/kg body weight in two and half hours.

Reassess every 1-2 hours. If dehydration not improving, give the iv fluid more rapidly. Also give ORS (5ml/kg/hour) as soon as client can drink.

WHAT TO DO IF IV THERAPY IS NOT AVILABLE

If iv Therapy is not available at the facility but can be given nearby (ie with in 30 min), the child could be sent immediately for iv treatment. If the child can drink, the mother should be provided with ORS solution and shown how to give with during the journey.

Findings	**Action**
Diarrhoea with severe dehydration	1. ORS orally or by naso-gastric tube: 20 ml/kg body weight per hour x 6 hours maximum 2. It abdomen becomes swollen, ORS should be given more slowly until it is less distended 3. Review every hour, if no improvement refer immediately.

Source – FMOH/NPHCDA 1995 PP 200

HUMAN IMMUNO – DEFICIENCY VIRUS (HIV)/ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

Acquired Immune Deficiency Syndrome (AIDS) is caused by infection with the Human Immuno Deficiency Virus (HIV). It is transmitted through sexual intercourse, parenterally such as with blood transfusion, sharing of injection needles and other skin piercing materials and from mother to child. Early infection by HIV is symptomless and a person can stay infected for up to ten years before manifesting signs and symptoms, he can transmit the HIV to others. It may take a further 5-10 years before a person with HIV infection start showing signs and symptoms of AIDS

FINDINGS	**ACTIONS**
If two or more of these signs and symptoms are present (i) Progressive unexplained weight loss (=10% of body weight) Or (ii) Weakness (more than 1 month) Or (iii) Persistent fever (more than one month) Or (iv) Persisten diarrhoe [more than one month] Or (v) Cough (more than 1 month) Or (vi) Oral thrush (more than one month) Or (vii) Painful genital ulcer: Or (viii) Generalized lymphodenopathy Or (ix) Skin rashes (more than 1 month)	1. Think of HIV infection 2. Confirm contact address 3. Manage under strict confidentiality. 4. Observe universal precautions with blood and other fluids. 5. Manage any life threatening presenting conditions e.g. dehydration 6. Counsel and refer immediately.

UNIT 5 THE REFERRAL SYSTEM

The referral system is the process where a health worker transfer some of his responsibilities temporally or permanently to another health worker or

facility and expect a feed back. Referral cannot be complete unless there will be a feed back for continuity.

FMOH (1990). Identified referral at three levels, namely village, health facility and district levels. At village level, one can identify patients to be transferred using the following cretcria:

- Illness not covered by the standing orders
- Illness not responding to treatment with in the specified time in the standing orders.
- Illness rapidly getting worst, and
- Illness one is in doubts of:

Use pictograph, referral form in patients requiring further treatment and followed by up all referrals

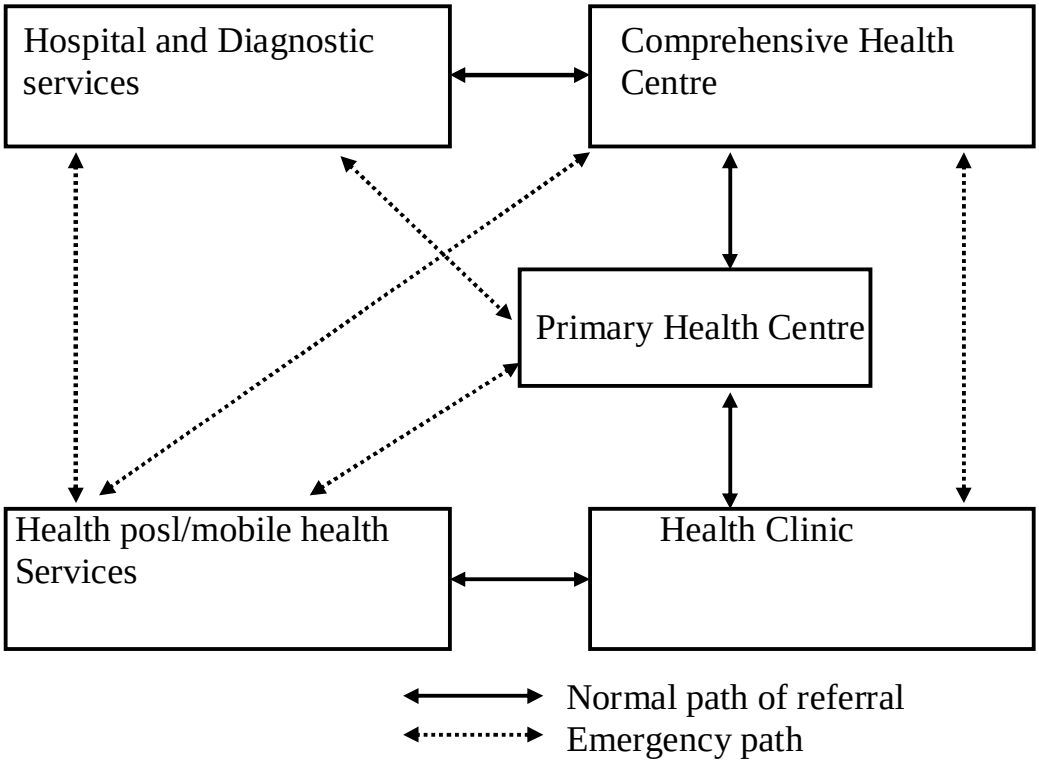
Health Facility Level

- Accept referrals from the village level
- Communicate follow up information for patient care to VHW/TBAS
- Identify illness to be referred using the following criteria:
  - Illness not covered by the standing orders
  - Illness not responding to treatment within the specified time in the standing orders
  - Illness getting worse
  - Illness one is in doubt of
- Use the 2-ways referrals form for case being referred to the district level
- Follow up cases referred to the districts level or higher health facility.

District Level

- Accept referrals from village/facility level
- Communicate follow-up information for patient care to the village, facility and district levels.
- Identify patents to be referred using the following criteria:
  - Illness not covered by the standing orders
  - Illness not responding to treatment with in the specified time in the standing orders.
  - Illness rapidly getting worse
  - Illness one is in doubt
- Use 2-way referral forms for cases referred to the LGA, compressive health centres or higher levels of health care.
- Follow up cases referred to the comprehensive health centre or other higher levels of health care.

2-Way Referral System



Source FMOH 1990 pp 117

Referring a Child to Hospital

A referral should only be made if you expect the child will actually receive better care at another facility. In some cases, giving the child the best care you have available is better than sending the child on a long trip to a referral hospital that may not have the supplies or the expertise to care for the child.

When referring a child to the hospital the following steps are recommended.

i. Explain to the mother that her child needs treatment in a hospital. Obtain her agreement to take the child. If she says that she does not want to take the child, identify her reason. Help calm her fears and solve other difficulties she may have.
ii. Discuss with the mother how she can travel to the hospital
iii. Administer the first does of antibiotic and any other treatment such as paracetamol ORS/SSS, anitmalaria if indicated. Do not delay referrals, if these medicines cannot be given promptly.

- If you only have an oral antibiotic, give the antibiotic only if child is able to drink and can safely swallow the antibiotic.

- If there is a long referral time, give additional doses of antibiotic or ORS/SSS for the mother to give en route (at the appropriate dosing schedule)
- If referral is uncertain, given the mother full 5 days course of the antibiotic.

iv. Make sure the mother keep young infant warm during transportation

v. Give another treatment that may be needed, such as treatment for fever, wheezing or suspected cerebral malaria.

vi. Complete the two way referral form and give the mother to take with her to the hospital. Tell her to give it to the health worker who sees her child and bring back the detachable end of the form.

2-WAY REFERRAL FORM

To …….. Date ……..
From ……. Personal No.
Clint's Name …….
Address: …….
Age: …… Sex: ……..
This family/patient had been receiving treatment for: …….
From: …….. To …….
Reasons for referral: ……..
History: ……..
Temperature: …… Pulse: ……. Resp: ……
B/P: …… Height: …… Weight: ……...
Findings: ……...
Other problems: ie. Allergies: ……...
…….....
Treatment given: ……...
Time: …….. Dose: ……....

Immunization

1. BCG:...……. 2. DPT: …...…….
3. Polio Vacc: ……... 4. Measles Vacc:…….
5. Tetanus Toxoid: ……6. Yellow fever Vacc:…….
7. Hepatitis Vacc:. …….
8. Others: ……...

Enclosures: ……...
e.g x-ray, urine, blood group, genotype, place let me know if there is further information you need.

Thank you.

Please complete the slip below ad return to referring officer for continuity Name of officer referring: ……....
Designation: ……..
Date: ……..

……
Signature

Please tear below and return to the referring officer.

PHC No: ……

Patient's Name: ……

Findings: ……...

Diagnosis: ……

Treatment Given: ……...

Further instructions: ……

Name: ……...

Designation: ……...

Signature: ……...

Date: ……...

Source: FMOH: (1996) Curriculum for community Health officers pp 85

WHEN REFERRAL IS DIFFICULT OR IMPOSSIBLE

The best possible treatment for a child with a very severe illness is at a hospital, if the hospital is able to provide adequate assassinate and treatment.

Sometimes referral is impossible. Distance to the hospital might be too far, the hospital may not have the equipment or staff to care for the child or adequate transport might not be available. Occasionally, parents refuse to take a child to the hospital, inspite of the effect of the health worker to explain the need for referral. If this is so, then the health worker should do what ever he can to help the family care for the child, this may mean having the child stay in or near the health centre to be reviewed several times a day, or arranging for visits at home.

Findings	**Action**
i. Severe cough with difficulty in breathing. ii. High fever with stiff neck iii. Sepsis	Age less than 2 months 1. Benzyl penicillin 6 hourly for 48 hours; follow with procaine penicillin x 5 days Or 2. Benzyl penicillin 6 hourly for 48 hours followed with contrimaxazole x 8days 3. Chloroquine x 3day 4. Continue breast feeding 5. Small frequent fluids (5m/lkg 1 hourly) 6. Clear blocked nose with plastic syringe. 7. Keep warm 8. Review hourly **Age 2months to 5 years**

	1. Chloramphenicol by mouth or by nasogastric tube x 8 days Or 2. Benzypenicillin for 48 hours followed with procaine x 5 days 3. Chloroquine x 3days 4. Paracetamol x 3days 5. Encourage fluids (3-4ml/kg/hour) 6. Clear blocked nose 7. Keep calm and warm 8. Review hourly.

4.0. CONCLUSION

Standing orders is a guide for community health workers to ensure uniformity in delivering integrated PHC services. Other areas such as mental health, acute respiratory infections, management of dirrhoea diseases and HIV/AIDS have been included in the current edition. standing orders have undertaken revision from first to second edition and to the third edition in order to improve the standard of living of all Nigerians, promote good health, elongate life span and enhance the quality of all our lives. The two referral system have also been explained to help in management of patients condition.

5.0. SUMMARY

Standing order have been defined and purpose for the use of standing orders such as uniformity of care, provision of legal protection frame work for history taking and physical examination, also for staff evaluation of performance have been explained. Recent inclusions in the standing orders have been identified, evolution of standing order discussed, and two way referral system explained.

6.0. TUTOR MARKED ASSIGNMENT

(a) Define standing order
(b) State the purpose for the use of standing order

7.0. REFERENCES AND FURTHER READINGS

1. FMOH and NPHCDA, (1995), Standing order for community health

officers and community health extension workers. Training and manpower development division pp 1-5.

2. Oduns: P.Y. (1994), Acknowledgement to the third edition, standing orders review committee in standing orders published by training ad manpower development division Nigeria 1995.

3. Ransome – Kuti et al (1991) strengthening primary health care at local Government level. The Nigerian experience: Academic press Ltd. Lagos. Pp 1-10.

4. FMOH, (1990), Guide lines and training manual for the development of primary health care in Nigeria pp 106 - 108

MODULE 2 – LAY OUT FORMAT OF STANDING ORDERS

1.0. INTRODUCTION

Since you have gone through unit one, you have acquired the general overview of the background use of the standing orders. This unit is about the layout format of standing orders which explains the components of standing orders and various sections of the standing orders.

2.0 OBJECTIVES

At the end of this unit the learner should e able to:

- Describe components of the standing orders
- Identify the various sections of the standing order
- Explain the sections of the standing orders e.g. maternal of child health including family planning. Treatment of common conditions in adult and appendix.

UNIT 1 COMPONENTS OF STANDING ORDER

The standing orders is made up of different parts which include preface to the third edition, acknowledgements, introduction, instructions and different sections of the standing orders which include maternal and child health including family planning, treatment of common conditions in adult and appendix 1-22b. Acknowledge to the first and second edition and preface to the second edition are also included in the standing orders. The last component of the standing orders is the index.

UNIT 2 PREFACES AND ACKNOWLEDGEMENT TO VARIOUS EDITIONS OF STANDING ORDERS

Preface to third edition.

Was written by Dr. A. O.O Sorungbe Executive director NPHCDA in August 1995. He stated that the last three years have witnessed the continuous review of the standing orders. During the period, three highly respected Nigerians had been appointed ministers of health. The NPHCDA recognizes the commitment and dedication of all the distinguished Nigerians to the pursuit and attainment of the goal of health for all Nigerians by the year 2000 and beyond. He stated that expanded programme on immunization was reviewed and renamed the national programme on immunization (NPI). As the immunization services serve as the key to child survival, so the national primary health care programme serves as the bed-rock of the national health system.

The then minister of Health, Dr. I.C. Maduike, often proclaims his support for the national primary health care programme and the publication of these standing orders are a testimony to his words. These documents will

provide legal cover and technical competence to all primary health care workers who use them at LGA level in the country. In the spirit of health for all, the PHC programme aims to serve as many Nigerians as possible, especially those in the peripheral communities. The standing orders will boost both the coverage and quality of care if utilized properly by all concerned. This is while it is mandatory for the standing orders to be used by all appropriate institutions in the training of various cadres of community health workers. It is also mandatory for the cadres of community health workers to use the standing orders in their daily practices.

He concluded that the vision for production of these standing orders was to improve the standard of living of all Nigerians, promote good health, elongate life span and enhance the quality of all our lives. It is therefore hoped that those who use the standing orders, use them with appropriate vision, dedication and commitment to their duties.

Acknowledgement to the third edition

The acknowledgement to this edition was written by Dr. P.Y Odumsi, chairperson standing orders reviewing committee in January 1994. He stated that the discrepancies in the findings and actions boxes of some of the conditions in the standing orders prompted the review of the second edition. The review also gave the opportunity to include the sections on mental health, acute respiratory infection. Management of diarrhea diseases and HIV/AIDS in current edition of the standing orders. It is hoped that the community health workers training institutions all over the country and the supervising officers will encourage the health workers to use their standing orders in the community as expected, so that the trial and error type of clients management will be a thing of the past. He express his gratitude to the former minister of health and human services, Prof. Olikoye Ransome Kuti and others who encouraged the initial review of the standing orders and for those that provides financial and moral support. He expressed his appreciation to Dr. Makanjuola and his team for developing the mental health section, Dr. (MRS) Abiola Tilley Gyado and her team for reviewing the sexually transmitted diseases/HIV/AIDS components, Dr. (MRS) M.D. Adejeji and her team for reviewing the acute respiratory infection section and Miss Rodman for her enormous contribution in the development of the standing orders. He also acknowledged those that got the work typed expeditiously and the reviewing committee for bringing this work to fruition.

Reface to the second edition

The preface to the second edition of the standing orders was written by Dr. E.O. A Ekunwe, chairperson standing orders review committee in October 1989. He stated that that community health work has come a very long way since the first draft of the standing orders were written by a team

under the direction of Prof, O. Ransome Kuti. Its practitioners have metamorphosed from family health workers to community health workers. He also stated that the curricula work has become extensive and formalized for various institutions were set up to train all cadres of community health practitioners. The setting of health care has changed dramatically as the doctor is no longer on hand or within easy reach to give medical back-up. This, coupled with the extended and familized curriculum, has made it necessary and possible to give greater responsibility for case management to community health workers.

As a reserve of drug policy which emphasizes few safe, effective and less costly drugs, the drug treatment in the second edition was streamlined and all trade names excluded. With the use of the standing orders will make health care available to people where hey live and work and one can only hope that it will continue and increase.

Acknowledgement to the second edition

Adesola Jinubu coordinator, standing orders committee in 1989 expressed her profound gratitude to all the people who made the protocol possible especially the FMOH, BSS coordinating unit for financial and moral support. She owe a special debt of thanks to Prof. O. Ransome Kuti, Prof. A. Mabadeje and Dr. (MRS) E. Ekunwe of the College of Medicine, Mrs. O.O Ogundane of Lagos University Teaching Hospital, Pharmacy Department and Dr. B. Showenimo, Chief Pharmacist, Lagos state ministry of Health, for toiling arduously and patiently over the pharmacopedia of the protocol.

Special thanks to the corps graphic avtists of 1980/81 service year who did the lustrations in the protocol. She also expressed appreciation over the efforts, hard work and patience of all the typists over the preparations of the protocols. The messengers and all members of the standing orders committee, as well as all community health workers are acknowledged.

Acknowledgement for the first edition

This acknowledgement was written by Dr. O. Ransome Kuti and family health project team. They gave thanks to Dr. (Mrs.) T. Mcmoli of the Lagos University Teaching Hospital, Department of ophthalmology, who assisted in the designing of the standing orders for the eyes. They also thanked Dr. Nicholas Cunningham of the mount sanai school of medicine, who went over the standing orders in details and made many valuable suggestions on how to improve them. Their thanks also went to Dr. Cecile de sweerner for her suggestions. Dr. (Mrs.) M.A Oyediran of the department of community health, College of Medicine, University of Lagos and Barbata Adams, family planning nursing consultant were acknowledged for their

contribution to development of standing orders. The consultation and assistance provided by the department of international health, the Johns Hopkins University, under a grant form United State Aid for international department can not be left out.

Special thanks to Dr. (Mrs.) A. Okoisor, department of obstetrics and gynecology and lyn Gilbect, nursing consultant to the family health project Dr. E. Ekunwe department of peadiatrics, LUTH for many hours which they spent in making suggestions for the revised version. Gratitude should also be expressed to Miss I. Y. Doherty for her faithful secretariat assistance during the revision of these standing orders.

We would like to thank the many nurses in the family health clinic and those who went through the family training courses, for their suggestions as they actually used them, even as they were being developed and revised. Their suggestions have been important in helping to simplify. Clarify and generally improve the standing orders. We however take full responsibility for the contents of the standing orders.

UNIT 3 INSTRUCTIONS

The standing orders present, as much as possible, the best treatment for each condition listed. As a result of many of field testing, they are practical and relevant to the setting in which community health workers operate. By strickly adhering to the standing orders, the worker is acting under authority and legal auspices of the physician at all times. For any sign or symptom that the client is likely to complain of, the standing orders begins with a short write-up designed to cue the work on important aspects of the complaint. This is followed by suggestion history and examination, then a list of the likely groups of findings (both signs and symptoms). For each group, there is a set of actins including health educations, further investigations, treatment and follow-up necessary for good clients care. Every attempt has been made to ensure simplicity, clarity and ease of use. The more commonly findings have been placed first.

If the findings represent a complicated or life threatening problem, the standing orders specify that the client be referred either to the next level referral centre or to the nearest hospital as appropriate. The uniformity of care which the standing orders provide makes evaluation earlier, since is a set standard for care which can be applied to each case. This evaluation can be used to ensure that workers are following the standing orders and this maintaining a high standard of care. It can also be sued to evaluate the adequacy of over all care for each client and also to determine areas that need strengthening or change. The standing orders do not replace clinical judgment and thought by the worker. The health worker must still elicit the important points of history and physical examination necessary to treat the

client and decide which group of findings and corresponding action are appropriate in each case. Strictly speaking, these are protocols as they delineate the data base required and the decision to be made to manage a clients signs and symptoms.

The standing orders, like the rest of PHC concept, depend on well trained, committed and dedicated health workers for its effectiveness. These standing orders are therefore, complemented by the curricula development for use by various training institutions. The continuous and proper utilizations of these orders, for both training and practice, will ensure the sustenance of a high standard of health care delivery in the country.

UNIT 4 MATERNAL AND CHILD HEALTH INCLUDING FAMILY PLANNING

a. Child Health

This section is for children 0-12 years ad include child first visit new born babies, well children revisit and other conditions affecting children.

Child First Visit

The child first visit is a very important one and should always include: screening for health problems, growth monitoring and promotion health education about nutrition, immunization and protection from illness and other conditions as relevant to the family, mothers should be encouraged to bring their children for visits while they are well-monthly in the first two years of life and every 3 months until at the age of five years, and subsequently when necessary. This section has history box and examination and abnormal finding if detected.

New Born Babies

The new born is a neonate from birth until he is 4 weeks old (28days). If the baby has just been born, the most important thing to check is weather he is breathing and his heart is beating. Is he hearing difficulty in breathing or is he blue? Rapid breathing during the neonate period is 60 or more breaths per minute. The normal newborn hearth rate is about 160/minute by the time the baby is nearly a moth old the rate is about 140/min.

Jaundices can be dangerous, if it is not promptly and properly treated, it may lead to severe brain damage.

Diarrhoea, vomiting and acute respiratory infection are particularly damagerous in a new born, because such babies become very sick and die very quickly.

All problems of the neonate are treated under new born babies standing orders.

Well Child Revisit

The well child re-visit is the routine clinic attendance for the child that is well. It is a chance when the child receive routine immunization and the mother is relaxed to listen to health talk on growth monitoring and promotion, personal hygiene, immunization came of the child, child spacing etc.

Problems Affecting Children

Most of problems affecting children are included in children standing order:

i. **Fever:** – is rectal temperature of 38^0c (100.4^0f), oral or anilla of 37.5^0c (99.1^0f) or above. It is a sign of infection and or dehydration. A normal temperature in the morning does not necessarily mean that there is no fever. All clients with history of fever should be treated and encouraged to drink plenty of fluids. High fever should be treated as emergency.

ii. **Cough:** - is usually a symptom of irritation or blockage of the air passage. It is forceful pushing of air out of the lungs. Difficult breathing is when the child is making an additional effort to breath, is breathing too fast or hearing noisy breathing. The most severe difficult breathing can be seen by looking for chest indrawing below the ribs as the child breaths in. lower chest indrawing indicates severe pneumonia.

Fast breathing means a respiratory rate of 60 and more per minute for an infant less than 2months of age, respiratory rate of 50 and above per minute for an infant aged 2-12 months and for a child 12months 5years, a respiratory rate of 40 and above per minute. The most common causes of difficult breathing are pneumonia, asthma, mucus plucked, adenoids, aspiration of foreign body or heart disease.
Aspirin or kerosene poisoning is also a cause of fast breathing.

iii. **Digrrhoea:** - as stated in other inclusions.

iv. **Vomiting:** - is throwing up of the contents of the stomach. The common causes of vomiting are gastro-enteritis, meningitis, ear infection, liver disease and severe abdominal problem.

v. **Pallor (low hemoglobin)/jaundice**

Anaemia is defined as a hemoglobin below 10grams (68%). At this level of hemoglobin, the child is almost always pale. The impotent causes of annaemia are malaria, bleeding from any part of the body, inadequate iron or folic acid in the diet, worm infestation, Sickle cell anaemia, glucose 6-phosphorus dehydrogenese deficiency (G6PD).
Jaundies is recognized by the presence of yellow eyes, palm of hands, soles of feet and nails. It may be accompanied by passage of deep yellow urine and in some case, the stools are pale. The important causes

are sickle cell disorders, Glucose -6- phosphorus dehydrogenese (G6PD) deficiency, disorders of the liver aid anything that causes destruction of the red blood cells.

vi. Measles

The rash is made up of macules (flat spots) and papules (raised spots) which often appear in little groups. The illness begins like a severe cold accompanied by cough, sore eyes and koplik's spots (white spots in the mouth). The rash appear on the fourth day of the onset of the illness. It is severe illness because of the frequency with which complications occur especially in poorly nourished children.

WHO in (1994), stared that measles is common disease in children throughout the world. Despite a global measles vaccine coverage of 78%, measles remains one of the reading causes of childhood death in developing countries. In 1994 alone WHO estimate 45 million cases and 1-12 deaths from measles. Most deaths follow complications such as pneumonia, croup and diarrhea and are also frequently associated with malnutrition. In addition measles may result in order long term health problems including blindness, deafness, chronic lung disease, poor growth and recurrent infections.

vii. Weight loss or failure to thrive

All children under 5year attending the clinic should have their weight charted on the growth chart. Failure to gain weight should alert the health worker who should not postpone action until weight has actual been lost. However as long a child is gaining weight steadily even if below the lower line, he is probably healthy and may require regular observation

viii. Abdominal pain

The important cause of abdominal pain are gastro-enteritis (vomiting and diarrhea) malaria, intestinal worms, infection, appendicitis, rupture of intestine (often form typhoid), sickle cell crisis and intestinal obstruction. Vomiting with out diarrhea or with constipation are signs of very serous problems when they occur with abdominal pain.

An abdominal hernia is when a part of the gastro-intestinal tract protudes through a gap of weakness in the abdominal wall. Abdominal hernias can be found on the umblicus, groin and scrotum.

ix. Anal problems

ANUS is the terminal end of the alimentary canal. Common problems affecting the anus include fissures, redness and prolapse. Anal fissure is

painful lineal sores of margin of anus. In rectal prolapse, the rectum turns inside out and protrude out of the anus as a pink mass. It is common in children who are poorly nourished and having frequent diarrhea.

x. Head Problems

The head contains the brain and vital centres for life; the sense structure for hearing, seeing, smelling and tasting.

Injuries and infections to the head are a great danger because of large blood and nerve supply which it contains and the possibility of damage to the brain.

xi. Skin Problems

Poor hygiene, nutrition and housing are major determinates of the range and severity of skin diseases. Water for bathing is particularly important. Some appear to affect only the skin (ring worm). Some appear to only affected body in ternally (pyoderma). Others affect many of the body system and generally are more important (measles, leprosy, diabetese, HIV/AIDS, jaundice).

xii. Eye Problems

A child's eye can be infected by bacteria or viruses, they can be injured, or a foreign body may get into them. Sometimes, they become disease because the child is not getting enough vitamin A in his food if these conditions are not prevented or treated early, they may make him blind. This is why eye conditions are so important.

xiii. Nose Problems

The nose is an organ for breathing and for the sense of smell. Diseases or injuries in the throat or sinuses can affect the nose. Also injuries to the nose can affect the throat. If the nose is blocked, an infant will have difficulty in breathing when sucking, so may not feed well. You should think of foreign object if there is discharge form only one side of the nose.

If the child has a nose bleed, he may swallows the blood, so it is difficult to know how much bleed has occurred.

xiv. Heart Problems

Chest and heart problems usually mean there is some interference with the supply of oxygen reaching the blood stream, (hypoxia).

Changes in pulse and respiratory rate are often important signs of heart disease. Blueness of the lips, or fingernails, clubbing of the fingers,

cough or pain in the chest are other signs to watch carefully for. Congestive heart failure is when the heart is too weak to pump all the blood and some of it back up into the lungs. This shows up as moist sound in the chest on both sides and is accompanied by difficult breathing or cough. There is often swelling of the abdomen and legs as well. The client may complain of difficult in breathing and the need to sleep propped up at night.

xv. Arms and legs problems

Deformities of the arms and legs, if present since birth are not correctable. New deformities on swelling may be due to bruises, fractures or a dislocation. It is important to test for normal movement of the part wherever there is history of injury swelling or deformity. Internal bleeding may also cause swelling. Swelling of the joint may be due to sprain of the tendons surrounding the joint. Sickle cell disease may also be a cause of pain in the arms, legs and hip bone. Tuber culosis can occur in the joints. Polio can seriously affect one or both legs or arms, first causing weakness then wasting or paralysis. Diabetes melius may cause tingling sensation and numbness of the fingers and toes, foot ulcer that fail to heal and black discolouration of toes and feet (Gangrene).

xvi. Neck Problem

Nodes of lumps on the neck are usually caused by infection in the ears, mouth, or on the scalp. They can also be caused by tuberculosis, leukemia, or other childhood malignancies. Lumps right in the centre or front of the neck are not nodes (for example goiters). Stiff neck is best examined when this patient is lying flat on his back. An attempt is made to bend the client's neck such that touches the chest. In the child this can be done very carefully. When the neck is stiff, the procedure is difficult ad painful far the client and we tends to bend his knees to over come the pain. This is positive kernig's sign.

xvii. Ear Problem

The most common ear problem is middle ear infection, usually presenting with pain in the ear, dullness or redness of the drum with perforation and drainage of pus or fluid. It is important to examine the bone behind the ear if it is tender, it means the infection has spread to the mastoid process. (mastoiditios) This is a danger sign because it can spread to the menninges. The other major complication is deafness which can be tested by clapping your hands behind a younger child to see if he will turn and look.

xviii. Throat Problems

A red throat may be caused by viral or bacterial infections. It may be combined with nasal congestion and middle ear infections especially in young children. The tonsils normally enlarge during childhood, but unless they obstruct breathing or show evidence of inflammation or pus, no treatment is needed. Dirty, grey pus or an adherent membrane may indicate diphtheria and this requires urgent treatment.

xix. Mouth/dental problems

Many common problems of the mouth are due to poor oral hygiene and poor nutrition. The most common complaint is pain and may be from tooth, gum or lining of the mouth the pain may or may not accompany by swelling either. Inside the mouth or on the face. The condition of the mouth is also a reflection of the clients general health, so it should be inspected as part of the physical examination.

xx. Urinary and genital problem

The common problem which affect the urinary tract are infections sores in the genitalia and bilharzias. The findings in urinary infections are frequent and painful micturation, blood in urine and in children over 4years old, bed-wetting. In addition the urine always look cloudy and contains protein and may contain blood. Tuberculosis of the kidney or bladder manifests the same as tuberculosis else where n the body, i.e. weight loss ad night sweat.

Blood in urine is a sign of schistosomiasis. Although bilharzia is a common cause of blood in urine, the symptom can also occur in tuberculosis of the kidney and bladder hence, it is important to assess thoroughly. Blood can also be found in urine in sickle disorders. Protein discharge or physical activity. If it is physical activity, it will disappear in a day or two. This is why children with protein in the urine with no other findings are brought back in 3 days and their urine re-examined before treatment is started. However, it can also be a sign of severe kidney disease or urinary track infection. Little girls get urinary, tract infections more easily and more frequent than boys. These infections often recur and may become chronic, causing failure to thrive and sometimes kidney damage. Fluids are very important in treating infections, therefore fluids should be encouraged. If the kidneys are not working well or if the child is dehydrated, there will be a decrease in the frequency or amount of urine. Other conditions that may give rise to urinary and genital problems are diabetes melilus G6PD – deficiency, sickle cell disease.

xxi. Acquired Immune Deficiency Syndrome

As per other inclusions

Other aspects of symptomatology of AIDS include: pulmonary Tuberclosis, Herpes Zosters, Hepatosplemomegaly, Kaposis Sarcoma, Anaeimia, Septicaemia, genital discharge delayed wound healing, herpes simplex, failure to thrive and repeated common infections.

xxii. Passing Worms

Most children have worms. In cities and towns, ascaris (round worm) is the most common. Heavy round worm infestation produced abdominal pain, vomiting, constipation and sometimes obstruction of the intestine. Hookworm infestation is more common in rural areas where heavy infestation cause blood in stool, aneamia, malnutrition. Severe truchuris (whip-worm) infestation causes bloody diarrhea, abdominal pain, anaemia and prolapsed of the rectum. Thread worm also lives in the intestine and cause itching around the anus.

xxiii. Burns

Burns may be caused by boiling water, hot oil, chemicals or fire. Serious burns cause shock because of the pain and the large amount of fluid that may be lost. The area of body surface affected is important in deciding the seriousness of the burns. This approximately shows the proportion of child body surface.

Part	**percentage of body surface**
Head (front and back	20%
Chest and abdomen	15%
One arm	10%
Back	15%
Buttocks (each)	3%
One leg	15%

Source – FMOH 1995 pp 80

xxiv. Convulsion

Convulsion is common in infants and young children. They may be due to high fever from any cause, head injury, tumor or sometimes infection of the brain or the spinal cord. Tepid sponging the child with high fever is a good way of presenting convulsion. Convulsion that occur in association with fever in children aged 6months to 6years, due to a cause other than brain problem, is called febrile convulsion

xxv. Oedema

Oedema is abnormal collection of third in the tissue resulting in swelling. Oedema may be generalized or localized. One foot or finger, generalized oedema is most noticeable on the parts of the body which are lowest at that time e.g. legs when standing, kidney disease, liver disease and kwashiorkor. Oedema may also be due to a reaction to toxin, drug or insect sting. Ascitis which is fluid in the abdominal cavity may accompany oedema.

xxvi. Poisons

A poison is a toxic substance which may enter the body through swallowing, breathing, absorption through the skin or mucous membrane or infection. Poison may be accidental, suicidal or homicidal. An over dose of medicinal drug may act as poison e.g. too much asprin or chlonoqnine.

xxvii. School Health Services

The school health services are essential in maintaining the health status of members of school community, and should be available to every one for as long as they are in the school community.

School health services afford the opportunity for:

- Personal health care
- Screening of school food vendors.
- Environmental health care
- Community mobilization
- Advocacy

Personal Health Care includes health screening for all new comers, regular health inspection and treatment of minor ailments.

Environmental care - Collaborate with school authorities, parents – teachers Associations, state and local government Education Authorities on.

a. **Building**
   i. It is the safety of the children taken into consideration when inspecting the school building?
   ii. Are desk and chairs adequate for students?
   iii. Class rooms – are they spacious, well ventilated and well illuminated? Are the black board well placed and maintained?

b. **Provision of water**

Is the water clear, safe and potable? Available all the times? Is it tape or well water?

c. **Provision of lavatories**
Are the facilities adequate for the children and their teachers? Are they clean? In good condition? Blocked? Deplorable condition?

d. **Refuse disposal**
What method is used? (Bins is recommended) How many? Any lids? Are the bins empted regularly? Any flies around the bins? Any offensive odour form the bins?

e. **Cafeteria**
Is it adequate for students and teachers? Is it kept clean? Is it spacious with adequate entrance and exit? Well ventilated and illuminated?

f. **Potential Hazards**
Any uncovered pits? Naked electrical wires? Stagnant pools of water? Broken glass windows and doors? Chemicals carelessly kept?

Community mobilization

With assistance of the principal, form a health education committee for the school to:

(a) To advice on recreational and social actionties as means of social, physical and mental development
(b) Advice on provision of incentives for healthy competition
(c) Facilitate the training of teachers in simple primary health care services.

Advocacy

The health worker in collaboration with school authorities, should seek political support for the school health services from the state, local government, community and parents/teachers association.

B. MATERNAL HELATH

The maternal health section of the standing order deals with pregnancy, labour, delivery and problems the woman and baby have after delivery.

i. First Prenatal Visit

Good antenatal care is the first step to effective care of the infant at the first prenatal visit, it is important to discover any medical and obstetric problems the mother may have and determine if she is able to deliver the baby safely. The mothers nutritional practices must be stressed. Tetanus immunization will protect both mother and the infant from tetanus. The new regiment of

tetanus toxoid for women in the reproductive age should be followed.

The first prenatal visit should be followed by return prenatal visits, so that the women have 3-4 contacts with the facility before delivery.

ii. Labour and Delivery

Normal labour is the onset of regular uterine contractions and retractions, resulting in delivery of a live baby. It is divided into three stages namely: First stage, which is manifested by regular uterine contractions, dilatation of the cervix and presence of show. The normal first stage does not last for more then 18hours and is much shorter in women who have had babies before.

The second stage occurs form when the cervix is fully dictated to the expulsion of the baby. This does not last for more than one hour but could be shorter in women who have had babies before.

Third stage is from the delivery of the baby to the complete expulsion of the placenta. It lasts for about half an hour and it is accompanied by blood loss which should not be more tan 300mls.

iii. Postnatal Problems

The post natal period is the 6-8 weeks following delivery. This is the time that lactation is well established and the return of the uterus and other reproductive organs to the condition they whe before pregnancy.

iv. Vagina Bleeding

When it is not a menstrual period, is always an important sign. It may be a sign of abortion, ectopic pregnancy or local cervical or vagina irritation or injury.

v. Breast problems

The breast are strongly affected by the hormones in the body. Events such as pregnancy, child birth, menstruation and menopause cause important changes in the breast. Every woman should be taught to examine her breast each month, at end of the menstrual period, in order to detect lumps which might be tumors.

C. FAMILY PLANNING (MALE AND FEMALE)

Family planning section of the standing order deals with first visit for contraception, contraceptive follow up visit schedule,

intra-uterine contraceptive device problems, hormonal contraceptive problems and infertility in female and male.

i. First visit for contraception

The first visit to the clinic for contraception is when a woman or man decide to seek advice on contraceptive methods for the following reasons:

a. The need to space child births.
b. To stop having children
c. Medical
d. Social and cultural.

For the individual man or man, the ideal is a service in which the person is offered a choice of methods. Having heard about the advantages and possible disadvantages of each, they are decide which method they prefer. What matters in the end is not the number of people offered contraceptive methods, but the number who go on using it successfully and this depends on what the user feels about it. The user feelings may be influenced by the atmosphere of the clinic. Therefore, the staff should establish a friendly relationship with man or woman so that he/she feels welcome.

ii. Contraceptive follow-up visit schedule

Intra-uterine contraceptive device (IUCD) - Has follow up visit in 6weeks after insertion. The second follow up visit 3 month after the first follow up visit and the third visit 6 months after second follow up visit. Yearly visit should be one year after their follow up visit and every year after that during the time that the woman wears the IUCD. At each visit various examinations are undertaken.

Oral contraceptive (oc) – first follow-up visit is when client has taken the contraceptive pill in the first packet and is on brown pills. Subsequent visits are three months after the first follow up visit when the client is taking the brown pills in her fourth packet of pills. Yearly visit one year after client began to take the pills and every year afterwards. Various examinations are undertaken at each visit.

The diaphragm – first follow up visit one week after fitting the diaphragm. This is follow by a brief history taking and advice subsequent visits are for spermicidal cream supply or to buy new diaphragm when necessarily, then yearly visits and examination as provided for other contraceptives.

Medroxy progesterone acetate (depo-provera)
First follow up visit 3 months after first injection. Subsequent visit every three months to receive injection and yearly visit. Examinations are conducted.

Spermicidal foam and tablets – first follow up visit two weeks after first supply, then monthly and yearly. Examinations are conducted and supply made.

Condoms - Follow up visit as need be for advice and supply.

iii. Intra uterine contraceptive device problems

The IUCD may be complicated by prolong menstrual bleeding during the first 3-6 months after insertion. Cramping pain in the lower abdomen is also common during the first few months after IUCD insertion and during the first three menstrual periods. Women who wear the IUCD experience back ache. A woman wearing an IUCD can stop having menstrual periods for many reasons including pregnancy, menopause in the older women, nervous tension, malnutrition and tuberculosis. Four explanations are possible for absence of the vagina threads, explosion, pregnancy, upward migration and uterine perforation.

iv. Hormonal contraceptive problems

Hormonal contraceptive can cause headache as side effects, women who have migraine headaches might find that they get work when they use hormonal contraceptives. The oral contraceptive cause a decrease in menstrual bleeding where the injections may give rise to heavy bleeding irregular menstrual flow and prolong spotting. Both types may occasionally give rise to amenorrhea as well as a raised blood pressure.

v. Infertility

A couple is considered infertile if they have not had a pregnancy after one year of unprotected sexual intercourse. The first visit for infertility is very important, it may be possible to discover an easily cause for the infertility by taking a careful history and performing a good examination. Infertility in women may be due to:

a. Hormonal problem: if her menstrual cycle is normal, her hormones are probably normal.
b. A physical problem: an abnormality in any of the female organ can cause infertility

c. Infection: An infection in the vagina or cervix can affect sperm movement, tubal infection can cause blockage of the tubes and a uterine infection can prevent implantation of the fertilized egg.

d. Poor general health and age over 40 years.

e. Sexual habit: the most favourable position of sexual intercourse. For conception is with man on top and woman lying on her back. The woman should remain lying down for ½ hour after sexual intercourse. Sexual intercourse should be encouraged during the woman's fertile period, mid way between her menstrual period (day 10 to day 18). They should have intercourse ever other might during this period. Infertility in man may be due to blockage of the tubes, chronic illness, mumps after puberty, congenital malformation including undecended testes, low or absent sperm count. Infertility affects approximately 15% of couples many of who have medical history to suggest the likely hood of reproductive disorder. 30% of infertility in couples is caused by male factor alone, in another 20% both partners have detectable abnormalities. Thus a male factor plays a prominent role in about 50% of reproductive disorders. Antibodies against sperm, injury to the testicle, disorder of the hormone production and varicocele plays a part in male infertility.

UNIT 5 ADULTH HEALTH

This section is for children above 12 years and adults. It deals with adult first visit, problems affecting adults and drug schedule.

Adult First Visit

This is the most important visit because it is at this time that the clients decide whether or not they will continue to use the clinic. The registration visit often takes a long time. So the client should be assured that subsequent visits are not likely to take long time. They should be helped to understand the importance of prevention and early treatment of diseases conditions, in order that they can remain healthy.

There are common health problems which a person may not be able to detect early, therefore it is necessary to perform the following procedures on every clients, weight, hemoglobin estimation, blood pressure, urine test and stool examination.

i. General body pain

General body pain may be due to malaria or other infectious diseases. Usually the back and leg muscle are affected. Sickle cell disease may cause swelling and pains of the hands and feet. Pain that seem to be mainly in the chest in more likely to be caused by lower respiratory

treat infections or heart diseases. Pain should be relieved because it add to the clients exhaustion and can produce shock. Back ache may be a problem of the kidney or abdominal infection.

ii. Headache

Headache is a common complaint among adults and may be caused by nervous tension or a simple cold, malaria, sinus infection, high blood pressure, ear infection and eye problems. Serious disease e.g. meningitis, brain abcess and typhoid.

iii. Loss of appetite

This is a common complaint. The examiner needs to look carefully for other signs in order to discover the cause. Depression, gastro-entelities, fever infections diseases including tuberculosis may be causes of poor appetite. Worm infestations and kwashiorkor, early pregnancy causes loss of appetite. If it is associated with general weakness occasionally is the first sign of hepatitis or liver infection.

iv. Patches of the skin (Leprosy)

Leprosy is a chronic communicable disease of human beings, caused by mycobacterium leprae. It affects the nerves, skin, mucus membrane, eyes and other organs. It is curable but the disease may cause deformity and disability in a small proportion due to nerve damage. To detect and treat early will prevent deformity and disability in a small proportion due to nerve damage. To detect and treat early will prevent deformity and disability.

v. Sexually transmitted disease

Sexually transmitted diseases (STDs) are got by sexual contacts, there may be genital, ero-genital or ano-genital contacts. Over 20 diseases are now known gonorrhoea, syphilis, AIDS, chanchoid, herpes and genital warts. Most of these can be prevented if condom is used.

a. Urethras discharge is the commonest presenting complaint of STD in males, sometimes with dysuria or urethra discomfort. For practical purpose STD related urethritis is subdivided in to gonococcal urethritis caused by gonorrhea and non gonococal urethritis (NGU) which is usually caused by Chlamydia trachomatis.

STD – related vagina discharge is a change in colour, odour and or an increase in the amount of vagina secretions due to vagina or cervical infection. Vagina discharge may be accompanied by puritis, genital

swelling, dysuria, lower abdominal or back pain (PID). The most common are yeast infection, Chlamydia, gonorrhea, herpes, trichomoniasis and bacteria vaginosis.

b. Genital ulcer

Genital ulcerations are common cause of consultations in tropical countries. Genital ulcer may be painful or painless and are frequently accompanied by inguinal lymphadenopathy. Painless indurated lesions are attributed to syphilis. Painful, easily bleeding sores are attributed to chancroid, the presents of vesicular lesions or superficial erosion indicated probable hepatic infection.

c. Lower abdominal pain in women

STD – related pelvic infections are major cause of infertility, recurrent infections, ectopic pregnancy and chronic pain. Pelvic inflammatory disease is a general name for pelvic infections in women.

d. Genital warts (condylomata acuminata)

Genital warts are single or multiple, soft, fleshy painless growths around the anus, vuluo-vagina area, penis, urethra or perineum, or there may be flat warts, difficult to detect. All women with anogenital warts must have pap smear:, all sexually active women should have pap smear.

e. Swollen scrotum

STD – related epididymitis and orditis, if not treated properly may lead to infertility. Swollen scrotum is an increase in size of ht scrotal sac, accompanied by oedema and erythema. Sometimes there is pain, urethra discharge or urinary tract symptoms. Acute unset of unilateral swollen scrotum may be due to trauma or testicular torsion, testicular tumor, vascular abnormalities or inguinal hernia requiring immediate referral.

iv. Scabies

Scabies is caused by itch mite. It usually penetrates the skin creating visible papules vesicles and small linear burrous, which contain mites and their eggs. Common site of infections include the flexor surfaces of the wrist, webbing between fingers, anterior axillay folds, the external genitalia and the inner aspects of the upper thigh complications include excoriation and secondary infection due to scratching.

v. Pediculosis

Peiculosis is caused by crab lice, phthirius pubis which usually infest the hairy part of the body, pubic and prenatal areas of the thigh, legs, fore arms, axillae and the chest. Less frequent eye lashes, eyebrows and beard. Typical crab lice are transmitted through sexual or close body contact. Crab lice takes blood meal from the skin in the public are resulting in it chin and excoriation. Second any infection may occur.

vi. Opthalmia neonatorum

Opthalmia neonatorum is an infection with discharge from the conjunctiva in newborn. It can lead to blindness especially when caused by gonorrhea or Chlamydia.

vii. Abnormal blood pressure

Blood pressure refers to the pressure of the blood neither in the arteries of the body. When the left ventricle of the heart contracts, blood is forced out into the aorta and travels through the large auteries to the smaller vessels. The diastolic pressure is the arterial pressure at the lowest level of the pulsation, that is, during the heart's resting phase and is normally between 70-90 mmHg. Blood pressure usually increases slightly with age as the blood vessels become less elastic. Women turn to have lower blood pressure than men of the same age. The normal systolic blood pressure for young adults is 100-120 mmHg and for old ages 120-140 mmHg. Pregnancy affects the blood pressure in most cases by lowering it and a rise may indicate toxemia of pregnancy. An abnormal high blood pressure is referred to as hypertension; hypothension refers to abnormally low blood pressure and lead to shock in extreme cases.

viii. Weakness or fatigue

Weakness or fatigue is a common problem. Often, its cause with be some interference with one of the body's basic needs; Fresh air or oxygen, nourishing food or some particular vitamins or rest, interference with body functions, blood circulation and breathing. It is important to find out if other problems are present with the weakness or fatigue so that they can be treated.

Appendix

All other inclusions in the standing order not found in maternal and child health including family planning and adult health are in the

appendix. They include reasons for referral, IEC for tuberculosis. The tuberculin tests, sensation test for skin patches, sputum test for adults, management of diarrhea and dehydration, risk assessment in women who are sexually active. Universal precaution rationale against AIDS and other blood related diseases. Immunization schedule, home care for cute respiratory infections, when referral is difficult, the child with diarrhea and severe dehydration, temperature equivalents, the two way referral form, JCHEW kit. The national tuberculosis and leprosy control programme basic regimen, sexually transmitted infections reporting form (STD-05), guide lines on laboratory procedure, instructions for condom users, types and management of snakes.

4.0 CONCLUSION

In this unit you have learn the layout format for the standing orders which include the components of standing orders and various sections of the standing orders.

SUMMARY

The components of standing orders such as the preface, acknowledgement introduction, instructions and index were identified. The various sections of the standing orders like maternal and child health including family planning, adult health and conditions in appendix were identified and discussed for proper use of standing order.

6.0 TUTOR MARKED ASSIGNMENT

Identify the various components of maternal health and briefly explain each.

7.0 REFERENCES

1. FMOH and NPHCDA, (1995), Standing order for community health officers and community health extension workers. Training and manpower development division pp 1-5.

2. FMOH, (1990), Guide lines and training manual for the development of primary health care in Nigeria pp 106 – 108.

3. NBTE, (2003) National Diploma and High National Diploma in community Health Curriculum and course specifications plot B, Bida Road, Kaduna pp 25

4. FMOH, (1996), Curriculum for community officers, training and manpower division, pp 27-29.

MODULE 3 PROCEDURE FOR THE USE OF STANDING ORDERS

1.0 INTRODUCTION

This unit enlighten the learner what to do when he/she encounters a health condition to be managed with the standing orders. It follows step to step in management of client's condition to it logical conclusion. It also entails on what to do in high risk conditions, follow up and referrals. It also describe the clinical manifestations of various conditions and what to do.

2.0 OBJECTIVES

At completion of this unit the learner should be able to:

- List the steps in the use of standing orders
- Describe the use of standing orders for different clients situation e.g. first visit, follow up and emergency.
- Explain "at risk" register
- Select cases for the at risk register.
- Identify conditions in children and adult that can that put them in grave danger.
- Explain the symptomatology of long term high risk conditions and conditions that can put a child in grave danger.

UNIT 1 STEP IN THE USE OF STANDING

- Obtain the complain and write down
- Look up the client's problem or complain in the index or table of contents and turn to the appropriate page.
- Ask all questions as listed in the history box.
- Perform all the examinations as listed in the appropriate box.
- Assemble and record all significant information including negative ones.
- From list of findings, select the box containing all significant findings related to the particular client.
- Select the action corresponding to the selected group of findings and manage the clients complaint as stated.
- It may be necessary to refer to more than one section of the standing orders in order to completely manage all the problems with which the client presents.
- Take appropriate action because on your findings.
- Each case turns to medication page for the appropriate drug dosage.

- Whenever course of medicine or injection is due to finish, review the clients condition. This is a good way to successfully evaluate your work.

UNIT 2 MANAGEMENT OF CLIENT WITH DIFFERENT CONDITIONS

- Every client should have the complete examination listed under the FIRST VISIT at fist contract with the health facility. This examination should be omitted only when there are emergency problems and should be done at next visit.
- Every opportunity should be taken to manage problems of all members of the family present in the clinic.
- It is important that all referred cases should be followed up when they return. This is for continuity of care as well as a learning process for health workers.
- Inform all clients return to the health facility immediately if their condition gets worse.
- Health education is one of the most important aspects of client's care and each client must receive health education in some of the following areas:
  - Breast feeing
  - Nutrition
  - Child spacing
  - Personal hygiene
  - Immunization
  - Clients presenting condition
  - STDs/HIV/AIDS
- Follow up visits are an important part of good client care and allow you to pick up clients who may not be responding well to treatment if client is getting worse you should refer.
- If client has multiple problems, the should be followed up more frequently than what the standing order prseribe for any one of the problems. This is because a client with multiple problems is usually more ill and is more apt to develop complications.

UNIT 3 COMMON CONDITION AFFECTING CHILDREN AND ADULTS WHICH CAN PUT THEM IN GRAVE DANGER

FMOH. (1996). Listed the following conditions which can be given priority attention according to standing orders.

- Signs of shock
- Severe respiratory distress

- Signs of severe local injury: profuse bleeding, deep laceration. Displaced or open fracture or severe burns.
- Profuse or prolong diarrhea with signs of dehydration
- Hemoglobin below 5gm%
- Stiff neck
- Abdominal pain with marked regality, or marked tenderness
- Generalized oedema
- Fever over 40^0c
- No urine in the last 24hours
- Unconscious or delirious patients.

UNIT 4 CONDITIONS REQUIRING FOLLOW UP OVER A LONG PERIOD OF TIME

- Malnurished children
- Tuberculosis client
- Epiteptic client
- Clients with leprosy
- Anaemic patients with hemoglobin under 7.5gm%
- Physical, social and mental handicapped
- AIDS client and their children.

UNIT 5 SYMPTOMATOLOGY

Symtomatology is the study of signs and symptoms of a disease

- Signs of shock include, low blood pressure, fast weak pulse, cold clammy skin, sweating rapid breathing and collapse
- Severe respiratory distress is presented with chest indrawing difficult breathing flaying of nostrils and sometimes with cough.
- Signs of severe local injury include, profuse bleeding deep laceration displace or open fracture and severe burns.
- Profuse or prolong diarrhea with dehydration. Signs and symptoms include, increase thirst lost of skin electricity, eager to drink or drink poorly, lethargy or floppy limbs, depressed anterior fontanel and scanty urine in the last 24hours.
- Hemoglobin below 5gram% indicate severe anemia with pallor and general body weakness.
- Stiff neck indicate meningitis which is presented with severe headache convulsion in children, positive kernign's signs and projectile vomiting.
- Abdominal pain with marked rigidity indicate acute abdomen which is accompany by vomiting, inability to pass stool, there is marked tenderness.

- Generalize oedema may indicate anemia or kidney disease, there is protein in urine and the person is weak. It may also be a sign of malnutrition.
- Fever over 40^0c indicates hyperpyrexia followed by fast breathing and the body is hot, children may request for more water to drink and this can lead convulsion in children 0-6years.
- No urine in the last 24hours indicate severe dehydration or anemia.
- Unconscious or delirious patients this are people who are very ill and may go in to coma state.
- Malnourished children present with lost of weight, failure to thrive oedema, wasting and occasionally lost of appetites
- Tuberculosis patients have cough for more than three weeks, chest pain, difficult breathing, heamatypsis (cough with blood) and loss of weight, night sweating.
- Epileptic clients present with aura signs, convulsion and jerking of body muscle. In children they may be twisting of the mouth and inability brick the eye.
- Client with leprosy, the cardinal signs include skin patches, lost of skin sensation and enlargement of the nerves.
- AIDS clients and their children. People with AIDS present with the following signs, progressive unexplained weight loss, prolonged diarrhea, prolong fever, prolong cough, lymphadenopaty, pulmonary tuberculosis, herpes zoster, hepatosplenomegaly, oral thrush, kaposi's sarcoma, anaemia, septicaemia, Genital discharge, delayed wound healing, failure to thrive, repeated common infections.

4.0 CONCLUTION

This unit was able to discuses the use of standing orders. Other areas such as follow up and review of patients conditions were discussed. It also identified conditions that can put person in grave danger and long term high risk factors. The unit finally described the symptomatology of such conditions.

5.0 SUMMARY

Steps in the use of standing orders were identified and ways of management of clients with different conditions were highlighted, follow up visit and review of managed cases of people with short/long term high risk factors were also discussed symtomatology of all the disease in the at risk register were enumerated.

6.0. TUTOR MARKED ASSIGNMENT

a. Identify high risk short term conditions effecting people in your community.
b. How will you use standing order to manage such conditions.

7.0 DEREFERENCES

1. FMOH and NPHCDA, (1995), Standing order for community health officers and community health extension workers. Training and manpower development division pp 1-5.

3. FMOH, (1996) Curriculum for community Health officers, training and manpower division, pp 27-29.

2. FMOH, (1990), Guide lines and training manual for the development of primary health care in Nigeria pp 106 - 108.