COMMUNITY HEALTH

(MODULES I – V)

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MODULE OUTLINE

	MODULE	Unit	Hours
YEAR I			
SEMESTER 1 (Y1S1)	Community Health I	Introduction to Community Health	12
		Health Education	10
		Nutrition	18
		Primary Health Care & Community Based Health Services	20
		TOTAL	60
SEMESTER 2 (Y1S2)	Community Health II	Introduction to Environmental Health and Pest Control	10
		Waste Management and Housing	10
		Water Supply and Food Hygiene	10
		TOTAL	**30**
YEAR II			
SEMESTER 3 (Y2S1)	Community Health III	Epidemiology	10
		Demography	10
		Occupational Health and Safety	10
		TOTAL	**30**
SEMESTER 4 (Y2S2)	Community Health IV	Communicable Diseases	20
		Non-Communicable Diseases	10
		TOTAL	**30**
		COMMUNITY ATTACHMENT	**240**
YEAR III			
SEMESTER 5 (Y3S1)	Community Health V	Disaster Management	15
		Drug and Substance Abuse	15
		TOTAL	**30**

References

1) Glanville H DE, RSF Schilling and CH Wood (1980) - Occupational health, Nairobi: AMREF
2) Government Publications and Policy documents
3) Gupta, C. B and Gupta, V - An introduction to statistical methods, 21st Edition, Mumbai: Viska
4) Harper, W. M. (19910 Statistics, 6th edition; Edinburgh: Prentice Hall
5) King'oriah, G. K. (2004) Fundamentals of Applied statistics, Nairobi: JKF
6) Kothari, C. R. (2003) Research Methodology- Methods and Techniques. New Delhi: New Age International
7) Kothari, C. R. (2004) Research Methodology - Methods and Techniques; 2nd Edition. New Delhi: New Age International (P) Limited Publishers
8) Lucas AO & HM Gilles (2003). Short text book of Public Health Medicine for the Tropics 4th edition Arnold. (ISBN: 0340759887)
9) Manson, E. J. and Bramble, W. J. (1997) Research in Education and the Behavioural Sciences: Concepts and Methods; Chicago: Brown & Benchmark.

10) Mbeche, I. (2004) "Sampling Methods" In Ngau, P. and Kumssa, A. (Eds) *Research Design, Data Collection and Analysis: A training manual*; United Nations Centre for Regional Development Africa Office
11) McKenzie, J. F., Pinger, R. R. and Kotechi, J. E. (2008). An Introduction to Community Health, 6th Edition; Boston, Toronto: Jones and Bartlett Publishers
12) Moore, D.S. and McCabe, G.P. (2003) *Introduction to the practice of statistics,* 4th Ed. New York: W.H. Freeman and Co.
13) Mugenda, M.O. and Mugenda, A.G. (1999), *Research methods: Quantitative and qualitative methods.* Nairobi. Acts press
14) Relevant and authentic Internet Sources
15) Relevant Professional Journals
16) Relevant University Publications
17) Rukungu G.K. Ed (2001) Environmental health for East African Rural health series No. 16, Nairobi: AMREF
18) Shubhangini A Joshi (2002) Nutrition and dietetics, India, Delhi: Tata MC-Graw-Hill
19) UN, UNICEF and WHO publications
20) Wood, C.H. and De Glanville and J. P. Vaughan(1997) community health, Nairobi: AMREF
21) Wood, C. H. (2008) Community Health 3rd Edition, Nairobi: AMREF
22) Yount, R. (2006) Research Designs and Statistical analysis for Christian Ministry Research Foundations, 4th Edition

MODULE: COMMUNITY HEALTH I

MODULE OBJECTIVE

This module is designed to enable the student acquire knowledge, skills and attitude to acquire competence necessary for the implementation of community health programs, community nutrition program and environmental aspects of health.

UNIT I: INTRODUCTION TO COMMUNITY HEALTH

UNIT OUTLINE

	Topics	HRS
1.	Introduction to Community Studies	1
2.	Leadership and Social Institutions	1
3.	Introduction to Community Health	1
4.	Natural History of Disease, Disease Prevention and Surveillance	1
5.	Community Mobilization and Empowerment	2
6.	Community Participation, Advocacy and Partnerships	2
7.	Community Organization and Organizations	2
8.	Health Promotion	2
	TOTAL	12

Topic 1 – Introduction to Community Studies

Objectives

At the end of the topic the learner will be able to": -

1) Define basic concepts in community health
2) Describe characteristics of a community
3) Identify types of communities
4) Discuss factors that hold communities together
5) Discus theories governing study of communities

1.0 DEFINITION OF COMMUNITIES

- A community is a set of interactions, i.e., human behaviors that have meaning and expectations between its members. Such actions must be based on shared expectations, values, beliefs and meanings between individuals (Bartle, 2005)
- According to Fellin (2001), a community is social unit with one or more of the following three aspects:
  (i) A functional spatial unit meeting sustenance needs
  (ii) A unit of patterned interaction
  (iii) A symbolic unit of physical and/or psychological collective identification
- This means that a given community can be identified by one or all of the following - presence of geographic space, meaningful social interactions and common cultural ties (Hardcastle et al, 2009).
- A community is a group of people who are located in a particular space in a defined geographical area, have shared values and interact with a social system
- A community has four components - people, location in space, social interaction and shared values
- Communities have **boundaries** that encapsulate the identity of that community. The manner in which the boundaries are marked depends entirely upon the specific community in question (what holds them together = boundaries)
- The boundaries can be physical or abstract
  - E.g. some like national or administrative boundaries may be statutory and enshrined in law or some may be physically expressed by a mountain range, water body, etc.
  - Some other boundaries may be racial e.g. blacks, whites, Asians

- May be based on a language e.g. Francophone and Anglophone
- Religious boundaries – Muslims, Christians

- Community is an entity to which one belongs which is greater than kinship and within it an individual acquires fundamental experience of social life outside the home

Other Definitions

1) A group of people sharing characteristics and interests that live within a larger society, from which those features distinguish it.
2) A community can be conceived in three dimensions as a:
   a) Place where the physical environment is thought of as natural or as artificial;
   b) Group of people, like a population. Communities however differ in the size of their populations and in the social characteristics of their inhabitants
   c) Social system - a community as a system can be considered as the totality of interactions among subsystems (health, education, economy, religion, family and communication), because every community has a variety of behavioural rules that satisfy local needs through the specialization of functions and of the people that make up these subsystems.
3) The community as a whole which has three key components namely function, structure and culture
4) A dynamic social group, that exists prior to the intervention of the researcher that shares problems and interests in a specific space and time
5) A group of people that shares a common territory, a set of common resources, and a common culture, that interacts frequently, and that considers themselves as part of a social group defined as a community

2.0 CHARACTERISTICS OF MEMBERS OF A COMMUNITY

1) Learn a particular culture and that culture governs that particular community. Culture has a set of beliefs and rules and governing their institutions
2) Have particular ways of doing things
3) Show commitment to a common body of symbols.
4) Believe they make a similar sense of things either generally or with respect to specific and significant interests

3.0 THEORIES GOVERNING STUDY OF COMMUNITIES

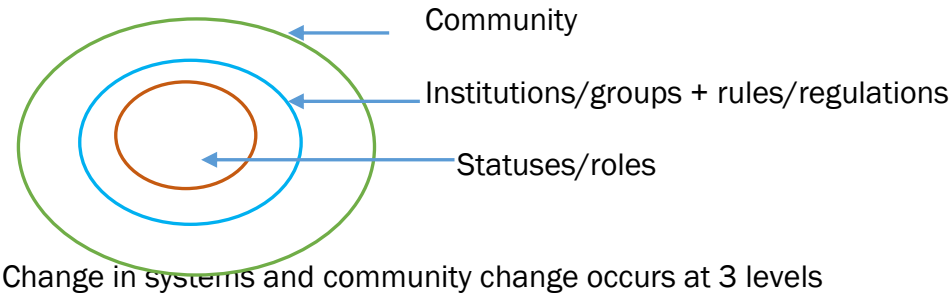
- Theories are a set of explanations about a phenomenon and it is developed from observations that could be formal or informal
- Formal – researches carried out and results put together
- Informal – observe and form an opinion or explanation
- The theories include: - *theory of social systems, theory of structural determinism, theory of interpretivism and theory of Symbolism*

3.1 Theory of Social Systems (Network)

- Views a community as a **system** made up of **subsystems** of statuses and roles, institutions and regulations
- It is a meta-system composed of other systems such the language system, technological system, political systems etc. created by human beings themselves
- A community is a particular type of social system distinguished by the following characteristics
  i) People involved in the system have a sense and recognition of the relationships and areas of common concerns with other members.

ii) The system has longevity, continuity and is expected to persist
iii) Its operations depend considerably on voluntary cooperation, with a minimal use (or threat) of sanctions or coercion
iv) It is multi-functional (system is expected to produce many things and to be attuned to many dimensions of interactions)
v) The system is complex, dynamic and sufficiently large that instrumental relationships predominate
vi) There is a geographic element associated with its definition and basic boundaries

- System
  - Components are statues and roles; institutions/groups and regulations
  - Sub systems are closely related with one another and form the big system
- Status – individual's position in any social group e.g. family, church, organization
- Roles – manner in which an individual behaves as he/she occupies his/her status that has been assigned to him/her
- Institution/groups



- Change in systems and community change occurs at 3 levels
  i) Individual
  ii) Interrelation (groups)
  iii) Structures/rules/regulations
- Individual - human being

a) Cognitive domain - Brain – critical thinking (make individual to think critically)
b) Emotional domain
   - Involve one's emotions in accepting change and feel the necessity to accept change
   - What kind of emotion is required to bring about change
   - What are the safe levels of emotions
   - How to utilize emotions for the benefit of the system or community
c) Behavioural domain
   - Is all about actions of individuals thus changes in cognitive and emotional domains is useless unless they evoke behaviour change
   - Individuals must cat in their right way to encourage development
   - Key stake holders will be important in giving direction and change - think of opinion leaders

Think of appropriate examples among the communities in Kenya.

3.2 Theory of Structural Determinisms

- E. Durkheim is the proponent and is related to the social theory
- Views a community as a **social structure**
- Social determinism theory holds the view that **structure determines** behaviour e.g. if one designates a particular structure as a classrooms then that determines what will happen in there
- If the structure is used for something else or for a different purpose then judgment will be made that normality had been suspended either through the imposition of another structural form or through pathological breakdown of structural order
- This view implies a consensus of meaning and a compliance with structure
- It describes communities in terms of their **constituent institutions** e.g. ceremonies

- Looks at communities in terms of **interests**
- Since structure determines behaviour it would follow that people located in that social structure will behave in similar ways. They would perceive things and issues similarly and would attach similar meanings to things. This implied uniformity
- Structure (religion, school, government, group) → meaning
- Uniformity is a **construct** hence you cannot expect uniformity leading to development of another theory – the theory of interpretivism

> Think of appropriate examples among the communities in Kenya.

3.3 Theory of Interpretivism

- Study of structure gave way to study of believe and knowledge in order to understand the functioning of communities
- It is now believed that a community masks the differences within itself by using or imposing a common set of symbols
- Members of a community display commonality in ways of behaving among its members e.g. at a political rally different people have different feelings
- In order to understand how a community functions there is need to interpret functions and the symbols held in common by the members
- We assume symbols have same meaning but that has been proved not to be so leading to emergence of the theory of symbolism

> Think of appropriate examples among the communities in Kenya.

3.4 Theory of Symbolism

- Is a recent theory advanced by Antony Cohen (1985)
- A community is defined as a group of people who have something in common with each other which **distinguishes them in a significant** way from members of other recognized groups
- What is held in common is the **symbol** and determines the boundary or group e.g. language, flags and names
- This sense of community difference is referred to as **boundary** and if it sums up the identity of the community e.g. Kamba or luhya sums up the language, naming and culture
- Cohen argues that not all community boundaries or components are objectively clear. They may be thought of existing in the minds of those that are thinking about them (beholders) therefore they may be perceived in different terms not only by the people outside the community but also those within the community
- Therefore this theory views a community as a **boundary expressing symbol** i.e. to say the community itself is a symbol with a boundary. We understand the community to be something but what it means to the members is very different
- As a symbol the community is held in common by its members but its meaning varies with its members unique orientation to it
- People's experience and understanding of their community depends on their orientation to its symbolism therefore different people will differ from each other in certain respects in their interpretations of the phenomenon they are oriented to
- Symbolism theory further holds the view that most symbols do not have visual or physical expression but are rather ideas

> Think of appropriate examples among the communities in Kenya.

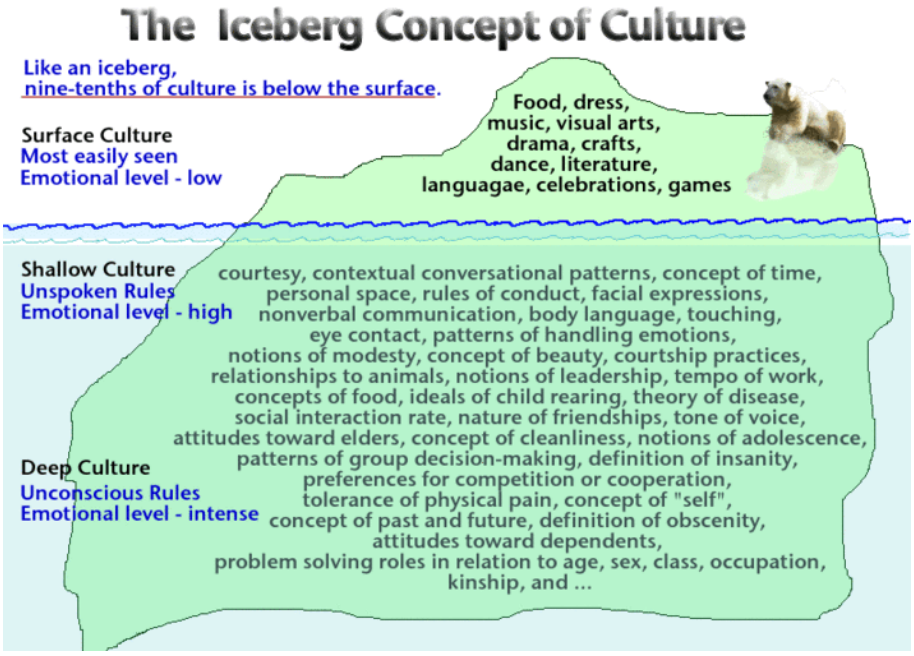
Application of Theory of Symbolism

- Because community members attach various meanings to symbols then they can only be understood by seeking the members experience
- Members of a community display commonality in ways of behaving though they may recognize important differences among themselves
- Symbols are a uniting factor in communities
- In a community, members are continuously trying to understand other people's behaviour and this is done by reconstructing other people's behaviour based on interpretation of what one witnesses (symbols)
- Communities can therefore no longer be adequately described in terms of institutions and components. These are symbols to which various members attach their own meanings – marriage, church, chief, women or youth group

4.0 FACTORS THAT HOLD COMMUNITIES TOGETHER

- Factors that enhance cohesiveness and remove individualism in communities include **culture**, **authority**, **social organization** and **benefits**
  1) Culture
     - A culture is a way of life of a group of people--the behaviours, beliefs, values, and symbols that they accept, generally without thinking about them, and that are passed along by communication and imitation from one generation to the next.
     - Culture is
       - Collective programming of the mind which distinguishes members of one group/category of people from another
       - Is a complex phenomenon which includes deep rooted values and manifestations that can be observed
       - Is cultivated behaviour that is the totality of a person's learned, accumulated experience which is socially transmitted, or more briefly, behaviour through social learning
       - Sum of total of the learned behaviour of a group of people that are generally considered to be the tradition of that people and are transmitted from generation to generation

Diagram 1.1: Iceberg of Culture



- Culture refers to the cumulative deposit of knowledge, experience, beliefs, values, attitudes, meanings, hierarchies, religion, notions of time, roles, spatial relations, concepts of the universe, and material objects and possessions acquired by a group of people in the course of generations through individual and group striving.
- Culture consists of patterns, explicit and implicit, of and for behaviour acquired and transmitted by symbols, constituting the distinctive achievement of human groups, including their embodiments in artefacts
- The essential core of culture consists of traditional ideas and especially their attached values; culture systems may, on the one hand, be considered as products of action, on the other hand, as conditioning influences upon further action.

Manifestations of Culture

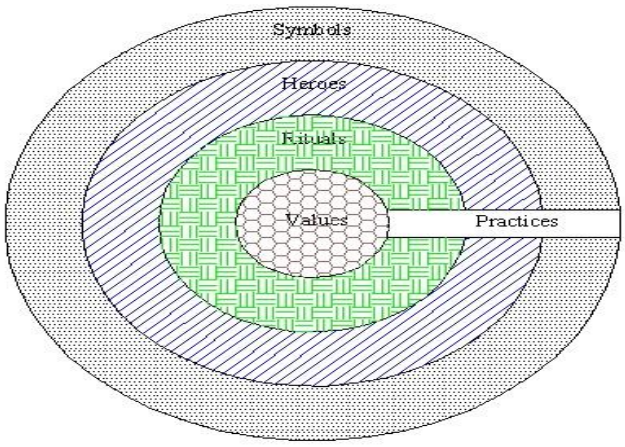
- Cultural differences manifest themselves in different ways and differing levels of depth
- Symbols represent the most superficial and values the deepest manifestations of culture, with heroes and rituals in between.
- Symbols, heroes, and rituals are the tangible or visual aspects of the practices of a culture. The true cultural meaning of the practices is intangible; this is revealed only when the practices are interpreted by the insiders.

Symbols

- Symbols are words, gestures, pictures, or objects that carry a particular meaning which is only recognized by those who share a particular culture
- New symbols easily develop, old ones disappear
- Symbols from one particular group are regularly copied by others. This is why symbols represent the outermost layer of a culture.

Values

- The core of a culture is formed by values
- A value is something whose importance is fully understood, accepted and cherished for its own sake by the community members
- Values are broad tendencies for preferences of certain state of affairs to others (good-evil, right-wrong, natural-unnatural). Many values remain unconscious to those who hold them. Therefore they often cannot be discussed, nor can they be directly observed by others. Values can only be inferred from the way people act under different circumstances
- Values can be seen as the ultimate organizing principles that direct and control the way human energies are expressed in activity and for this reason they are referred to as **psychological skills of society**
- People disagree about values or the importance of these values. If these disagreements spread to other members, factions are likely to develop thus polarizing a particular community
- Outward-directed manifestations include physical symbols, rituals and heroes



Rituals

- Are actions that are always done at a fixed time and in the same way as part of the community
- This includes particular ceremonies, song and dance etc.
- Some communities are more ritualistic than others
- Rituals are collective activities, sometimes superfluous in reaching desired objectives, but are considered as socially essential. They are therefore carried out most of the times for their own sake (ways of greetings, paying respect to others, religious and social ceremonies, etc.).

Heroes (Heroines)

- Heroes are persons, past or present, real or fictitious, who possess characteristics that are highly prized in a culture. They also serve as models for behaviour
- Heroes are persons admired by many people because of their qualities.
- In some communities there is hero worship but for other communities they admire without worshiping that person
- Hero worship involves admiring someone excessively and placing him/her above the natural human being

Aspects of Culture

1) History-time period and conditions under which a group migrated or immigrated.
2) Social Status Factors – education, occupation, income
3) Social Group Interaction Patterns: Intra-group (within group relations) and Inter-group (between-group relations)
4) Value Orientation – standards by which members of a culture judge their personal actions and those of others.
5) Language and Communication: Verbal and Nonverbal
6) Family Life Processes – gender roles, family dynamics
7) Healing Beliefs and Practices – attitudes and beliefs about health.
8) Religion – spiritual beliefs and practices
9) Art and Expressive Forms – art, music, stories, dance, etc.
10) Diet/Foods – preferred food eaten by groups.
11) Recreation – activities, sports for leisure, etc.
12) Clothing – types, styles, and extent of body coverings

Layers of Culture

- People even within the same culture carry several layers of mental programming within themselves
- Different layers of culture exist at the following levels
  i) National level - associated with the nation as a whole
  ii) Regional level - associated with ethnic, linguistic, or religious differences that exist within a nation
  iii) Gender level - associated with gender differences (female vs. male)
  iv) Generation level - associated with the differences between grandparents and parents, parents and children
  v) Social class level - associated with educational opportunities and differences in occupation
  vi) Corporate level- associated with the particular culture of an organization. Applicable to those who are employed

2) Authority
   - This is the power
     i) Give orders and make others obey
     ii) Make decisions or take action
     iii) Influence people because of inspiring respect or having special knowledge

- How authority is exercised in a community determines whether or not divisions occur
- Authority could be given (from above), elected or imposed
- Leaders that hold communities together tend to share some characteristics
  i) They are dedicated to the survival of the community
  ii) They are courageous and optimistic
  iii) They show high levels of perseverance in times of challenges
  iv) Take responsibility over their decisions and actions
  v) Have an inner motivation and achievement drive
  vi) They are emotionally stable and mature
  vii) Have a high level of self-efficiency (ability to learn to be successful)
  viii) Emotional intelligence (awareness of their feelings as well as others and use that to the advantage of the community)

3) Social organization
   - Is about the way people and other resources are arranged into a working order
   - Social organization that promote cohesiveness of the community are those that promote: -
     i) A feeling of togetherness where members of the community are concerned with each other's welfare
     ii) Cultural enclosure - this is where the culture of the people is sheltered from external influence to some extent. This could be done through limited physical and emotional interaction between the community members and outsiders (what are the disadvantages of sheltering the culture?)

4) Benefits
   - Benefits could be real or perceived physical, spiritual, psychological and emotions outcomes of participation in that community
   - Whatever members expect to gain from their community determines the cohesiveness of the community especially the degree to which members perceive the benefit to fulfil their identified need
   - Social needs are determined by the social values of that particular community

5.0 COMMUNITY STRUCTURE

- Community is "subsets of actors among whom there are relatively strong, direct, intense, frequent or positive ties."
- Community is a set of actors interacting with each other frequently thus a set of people without interaction is NOT a community e.g. people waiting for a bus at station but don't talk to each other
- Communities are networks of individuals with common problems or interests that 'get together' (either physically or virtually) and collaborate to identify common solutions, explore new ways of working, and share good practices and ideas
- Communities may be formal (*Communities of Practice* or COPs) or informal (*Communities of Interest* - COIs)
- Formal communities
  - Mainly deal with explicit knowledge and often align with organizations, projects or activities
  - Are a means to bring domain specialists with different skills together, e.g. engineers and marketers dealing with the same product portfolio
- Informal communities
  - Host individuals that share a common interest or passion – which may be either work-related or non-work-related
  - Members typically belong to different parts of the organization, may know little about each other, and have no other common interests outside of this area

- Work-related COIs may e.g. be looking for disruptive innovation ideas, while other groups may deal with more casual topics like language learning or photography

6.0 TYPES OF COMMUNITIES

- Based on what binds people together
  i) Interest - communities of people who share the same interest or passion
  ii) Action - communities of people trying to bring about change
  iii) Place - communities of people brought together by geographic boundaries
  iv) Practice - communities of people in the same profession or undertake the same activities.
  v) Circumstance - communities of people brought together by external events/situations

- Different types of communities include: -
  1) Cultural communities
     - Members are united primarily by ties of a common cultural traditions (culture)
       - E.g. Ethnic groups (Luo, Luhya, Borana, Rendile e.t.c) or racial groups (Africans, Asians, Europeans e.t.c)

  2) Religious communities
     - Members united by obedience and reverence[1] to a common supreme entity, a common set of beliefs and code of conduct e.g. Christians, Muslims, Hindus, Bahai's

  3) Ecological communities
     - There are 2 types
       a. Administrative locality community
          - Members are united by administration boundaries e.g. country, district, division, location
       b. Natural habitation community
          - Members centred by habitation and usage of a common natural resource
          - Examples – Mau forest community, Water body e.g. Migingo, Mountain, Forest
  4) Communities of Interest
     - Members united by similar interests e.g. Sports, Business, Profession

  5) Institutional communities
     - Formed due to affiliation to a particular institution e.g. working, attendance of regular activities in that particular institution e.g. Egerton, KMTC

  6) Immigrant communities
     - Formed due to displacement and eventual placement as a result of manmade or natural disaster or due to search for a better livelihood; moving away from something
     - Examples – settlement schemes, IDPs and green card holders

[1] Respect/worship

Topic 2 Leadership and Social Institutions

Objectives

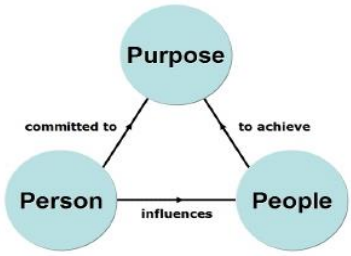
At the end of the lesson the learner shall be able to: -

1) Discuss the role of leadership and social institutions in community health services

1.0 COMMUNITY LEADERSHIP

1.1 Introduction

- Community Leadership is about channeling our collective experience, skills and energy to drive positive social change and enable our communities to thrive
- A leader is "a person who influences a group of people towards the achievement of a goal"
- A mnemonic for this definition would be 3P's - Person, People and Purpose



- A leader by its meaning is one who goes first and leads by example, so that others are motivated to follow him
- To be a leader, a person must have a deep-rooted commitment to the goal that he will strive to achieve it even if nobody follows him!
- Leadership is the art of organizing people and managing the process that enables people to set individual and collective goals as well as priorities in life
- Leadership
  - i) Facilitates creation of appropriate structures of operation and governance
  - ii) Help in mobilization, organization and guidance in resources
  - iii) Influence the community to reach identified goals
- Effectiveness in leadership has been attributed to persuasion skills, leadership styles and personal attributes of the leader.

1.2 Assigning leadership

i) Constituency of electorates
ii) Nomination
iii) Institutional appointment
iv) Situational leadership
v) Manipulation or self-imposition

1.3 Characteristics of a Good Leader

1) Honesty and trustworthy (probity)
2) Ability to delegate
3) Communication skills
4) Motivation
5) Sense of humour
6) Confidence
7) Commitment
8) Patience
9) Perspective
10)
11) Persuasive

1.4 Leadership styles

	Style	Characteristics
1.	Dictatorial leadership	• Characterized by orders and instructions directed at the people who are expected to comply without questioning
2.	Consultative leadership	• Promotes individual thinking and initiative • Useful when brain storming on issues
3.	Laissez-Faire	• Leaves people to do whatever they want at their own time and convenience • Leader has no control (leader by name)
4.	Democratic or Enabling leadership	• Promotes participatory decision making • Each person is considered equal and opinion of each accepted and considered in the process of decision making

2.0 SOCIAL INSTITUTIONS

2.1 Introduction

- An institution is an organized system of social relationships which embodies certain common values and procedures and meets certain basic needs of society(Horton)
- Social institutions have been created by man from social relationships in society to meet such basic needs as stability, law and order and clearly defined roles of authority and decision making
- Every organization is dependent upon certain recognized and established set of rules, traditions and usages
- Social institutions are formal cultural structures devised to meet basic social needs(Landis)
- Social institutions
    - Are well-established and structured patterns of behaviour or of relationships of group of people that is accepted as a fundamental part of a culture
    - Are a complex, integrated set of social norms organized around the preservation of a basic societal value
    - Structures and mechanisms of social order and cooperation governing the behaviour of a set of individuals within a given human collectively.
    - Are a set of organized beliefs, rules, and practices that establishes how a society will attempt to meet basic needs.
    - Are socially approved system of values, norms, and roles that exists to accomplish specific societal goals

2.2 Elements of Social Institutions

- A Group of People
- United by common interests
- Having material resources
- Having norms
- Fulfil some social need

2.3 General functions of Social Institutions

1) Institution satisfy the basic needs of society
2) Institution define dominant social values
3) Socialization
4) Institutions establish permanent patterns of social behaviour
5) Preservation of social order
6) Institutions support other institutions
7) Institutions provide roles for individuals

2.4 Types/Classification of Social Institutions

a) Primary or Basic Types of Social Institutions
   1) Family
   2) Government
   3) Economy
   4) Education
   5) Religion
b) Secondary social institutions
   1) Mass media
   2) Science
   3) Professional
   4) Health institutions

2.5 Primary Social Institutions

1) Family

- A fundamental social group in society typically consisting of one/two parents and their children
- Two or more people who share goals and values, have long-term commitments to one another, and reside usually in the same dwelling place
- Functions of Family
   i) The control and regulation of sexual behaviour
   ii) To provide for new members of society (children)
   iii) To provide for the economic and emotional maintenance of individuals
   iv) To provide for primary socialization of children
   v) To provide a sense of identity or belonging among its members
   vi) To transmit culture between generations
- Types of Family - patrilocal or matrilocal family, nucleus family, consanguine family, conjugal family and patriarchal or matriarchal family
- Mates Selection - exogamy, endogamy, polygamy, monogamy, polyandry and group marriage

2) Economic Institutions

- Economic Institutions are
   - the set of norms related to production of goods and services
   - an aspect of theoretical and particle
   - very important for almost all Groups
- Economic growth and development has changed the pattern of interaction of people all over the world
- Functions of Economic Institutions
   i) Provide methods for the production of goods and services
   ii) Provide methods for the distribution of goods and services
   iii) Enable society's members to consume goods and services which are produced.
   iv) To Control and regulate goods and services.
   v) Division of labour

3) Political Institutions (Government)

- Set of norms pertaining to the distribution of power and authority concerning the management of control of society to bring order in life.
- A sociologist is interested in Politics because it deals with political behaviour, public opinions, public relations, pressure groups etc...

- Weber: Defines the state as an authority that maintains a monopoly on the use of violence in its territory
- Structure of Government 1. Executive 2. Legislative 3. Judiciary
- Functions of Government
  i) The Institutionalization of norms (Laws)
  ii) The enforcement of laws
  iii) The adjudication of conflict (Court)
  iv) Provide for the welfare of members of society
  v) Protection of Society from external threat

4) Educational Institutions

- Refer to the set of norms centred round the teaching and learning aiming at the adjustment of individuals to the environment
- Education is synonyms with Socialization
- Education can be formal or informal education
- Functions
  i) Transmitting culture
  ii) Preparation for occupational roles
  iii) Evaluating and selecting competent individuals
  iv) Transmitting functional skills for functioning in society.
  v) To minimize the cultural lag in society
  vi) It increase social mobility in society

5) Religious Institutions

- Religious Institution is the system of believers and practices influencing human events where man is helpless to explain them.
- Supernaturalism and sacredness are the two main elements of Religious Institution
- Religion is the "opium of the people"—it masks domination and diverts workers from rebelling against exploitation (Marx)
- Weber: Classified religions by their approach to salvation:
  - Ascetic religions require active self-mastery; mystical religions require passive contemplation.
  - Other-worldly religions require focus on the next life (e.g., heaven); this-worldly religions require focus on earthly life.
- Religion provides social solidarity and collective conscience; it expresses and celebrates the force of society over the individual (Durkheim)
- Functionalist theory:
  - Functions of religion include providing meaning for life, reinforcing social norms, strengthening social bonds, and marking status changes (e.g., marriage).Dysfunctions, according to some, include justifying persecution.
- Functions of Religion
  i) Providing solutions for unexplained natural, phenomena
  ii) Supplying a means for controlling the natural world
  iii) Religion tends to support the normative structure of the society
  iv) Furnishing a psychological diversion from unwanted life situations
  v) Sustaining the existing class structure
  vi) Religion serves as an instrument of socialization
  vii) Religion may both promote and retard social change.

2.6 Secondary Social Institutions

Discuss the role of mass media and science in community health services

Topic 3 - Introduction to Community Health

Objectives

At the end of the lesson the learner will be able to:-
1) Define community health and population health
2) Describe key aspects of community health
3) Discuss the foundations of community health

1.0 BACKGROUND – PUBLIC HEALTH

- "**Health care** is vital to all of us some of the time, but **public health** is vital to all of us all of the time"
- PH is approach to medicine concerned with the health of the community as a whole
- It is what we do collectively as a society to ensure the conditions in which people can be healthy
- Public health is defined as
  - An effort organized by society to protect, promote and restore the people's health through the application of science, practical skill and collective actions (Boyles, 2003)
  - A health science concerned with safeguarding and improving the physical, mental, and social well-being of the community as a whole
  - The practice of preventing disease and promoting good health within groups of people, from small communities to entire countries
  - The science of protecting & improving the health of communities through education, promotion of healthy lifestyles & research for disease and injury prevention
- The three main public health functions are
  1) Assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities
  2) Formulation of public policies designed to solve identified local and national health problems and priorities
  3) Assure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services
- Public health professionals monitor and diagnose the health concerns of entire communities and promote healthy practices and behaviours to ensure that populations stay healthy
- Public health professionals try to prevent problems from happening or re-occurring through implementing educational programs, developing policies, administering services, regulating health systems and conducting research in contrast to clinical professionals (e.g. clinicians) who focus primarily on treating individuals after they become sick or injured
- It is a field that is concerned with limiting health disparities (fight for health care equity, quality, and accessibility)
- Field of public health is highly varied and encompasses many disciplines including Health education; Behavioural sciences; Environmental health; International health; Public health policy, MCH/FP, Demography, Biostatistics; Epidemiology; Nutrition; Health service management

2.0 DEFINITION OF COMMUNITY HEALTH

- Community health refers to the health status of **a defined group of people** and the actions and conditions to promote, protect, preserve and improve their health.
- It is concerned with the health of the **whole population** and the **prevention** of diseases
- Involves establishing health status, planning and management of community level services (promotive, preventive, curative and rehabilitative)
- Individuals who make up a community live in a somewhat localized area under the same general regulations, norms, values, and organizations. For example, the health status of the people living in a particular town, and the actions taken to protect and improve the health of

these residents, would constitute community health. However with expanding global economies, rapid transportation, and instant communication, communities alone no longer have the resources to control or look after all the needs of their residents or constituents thus the term "**population health**" has emerged

- Population health differs from community health only in the scope of people it might address. People who are not organized or have no identity as a group or locality may constitute a population, but not necessarily a community
- A population could be a segment of a community, a category of people in several communities of a region, or workers in various industries. The health status of these populations and the actions and conditions needed to protect and improve the health of a population constitute population health.

Compare and contrast community health and public health

3.0 PRACTICE OF COMMUNITY HEALTH

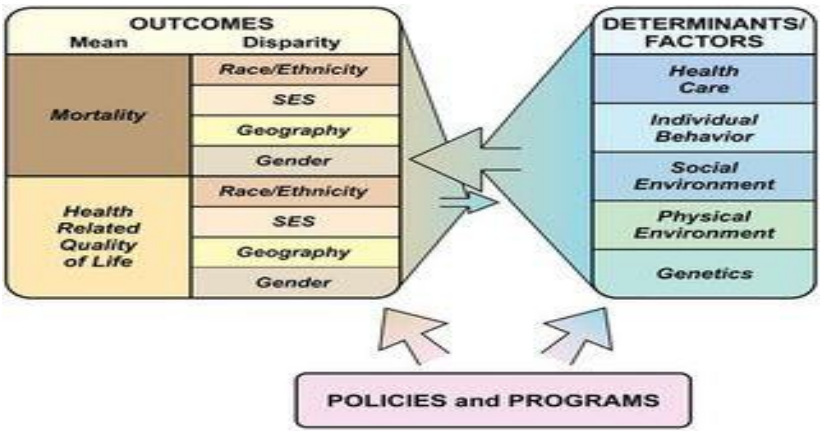
- Community health practice is carried out through health promotion, health protection and health services

3.1 Health Promotion

- Includes educational, social, and environmental supports for individual, organizational, and community action
- Seeks to activate local organizations and groups or individuals to make changes in behaviour (lifestyle, self-care, mutual aid, participation in community or political action) or in rules or policies that influence health
- Communities employ health promotion strategies in mental and social health, and recreation and fitness

3.2 Health Protection

- Revolves around environmental health and safety
- Community health personnel identify environmental risks and problems and take the necessary actions to protect the community or population
- Protective measures include the control of unintentional and intentional injuries; vector control; safe air, water and food for consumption, proper waste disposal; and safety of residential, occupational, and other environments
- Protective measures are often the result of educational programs, including self-defence classes; policy development, such as the Public Health Act; Food and Poisons Acted, Safe Drinking Water Act or the Clean Air Act; environmental changes, NEMA Act;



3.3 Health Services

- Communities differ in several ways and they are less autonomous and more dependent on support from outside the community
- Organizations that can assist communities and populations are classified into governmental, quasi-governmental and non-governmental groups
- Such organizations can also be classified by the different levels where they operate i.e. international (world), national, regional and local

Governmental health agencies

- Funded primarily by taxes
- Managed by government officials
- Have specific responsibilities outlined by the governmental bodies that oversee them
- Examples - The World Health Organization (WHO), The U.S. Department of Health and Human Services; Ministry of Health

Quasi-governmental health organizations

- Have some official responsibilities
- But they also operate in part like voluntary health organizations
- May receive some government funding, yet they operate independently of government supervision
- Examples - Kenya Red Cross (KRC)

Nongovernmental health agencies

- Funded primarily by private donations or, in some cases, by membership dues. The thousands of these organizations all have one thing in common
- They arose because there was an unmet need for them
- Examples
  - Voluntary health agencies
  - Professional health organizations and associations – KMA, KCOA,
  - Philanthropic foundations – Chandaria Foundation, Lion's Club, Bill and Belinda Gate's Foundation,
  - Service organizations – Aga Khan Foundation
  - Social organization – Abagusii Welfare
  - Religious organizations – Catholic Church, Adventists Church, Methodist,

4.0 FOUNDATIONS OF COMMUNITY HEALTH

- Foundations of community health include
  1) The history of community health practice,
  2) Factors that affect community and population health
  3) Tools of community health practice - Epidemiology, community organizing, health promotion and disease prevention, Planning, management, and evaluation

4.1 History of Community Health Practice

- Is as old as civilization as recorded evidence of concern about health is found as early as 25,000 B.C., in Spain, where cave walls included murals of physical deformities
- Earliest records were those of the Chinese, Egyptians, and Babylonians
- As early as the twenty-first century B.C. the Chinese dug wells for drinking

- Between the 1st and 2nd centuries B.C. records show that the Chinese were concerned about draining rainwater, protecting their drinking water, killing rats, preventing rabies, and building latrines
- Many writings from 770 B.C. to the present mention personal hygiene, lifestyle, and preventive medical practices. Included in these works are statements by Confucius (551–479 B.C.) such as "Putrid fish ... food with unusual colours... foods with odd tastes ... food not well cooked is not to be eaten
- Archaeological findings from the Nile river region as early as 2000 B.C. indicate that the Egyptians also had environment health concerns with rain and waste water.
- In 1900 B.C. Hammurabi, the king of Babylon, prepared his code of conduct that included laws pertaining to physicians and health practices
- During the years of the classical cultures (500 B.C.–500 A.D.),
  - Greeks were interested in men's physical strength and skill, and in the practice of community sanitation
  - Romans built upon the Greek's engineering and built aqueducts that could transport water many miles (remains of these aqueducts still exist)
  - Romans did little to advance medical thinking, but hospitals emerged from their culture

- In the Middle Ages (500–1500 A.D)
  - Health problems were considered to have both **spiritual causes and spiritual solutions**
  - The failure to account for the role of physical and biological factors led to epidemics of leprosy, the plague, and other communicable diseases
  - The worst of these, the **plague epidemic** of the fourteenth century, also known as the Black Death, killed 25 million people in Europe alone

- During the Renaissance (1500–1700 A.D.)
  - Growing belief that diseases were caused by environmental, not spiritual, factors
  - Time when observations of the sick provided more accurate descriptions of the symptoms and outcomes of diseases
  - Epidemics were still rampant

- The 18th century
  - Characterized by industrial growth, but workplaces were unsafe and living conditions in general were unhealthful
  - Important events –
    - 1796 Dr. Edward Jenner successfully demonstrated the process of vaccination for smallpox
    - 1798, in response to the continuing epidemics and other health problems in the United States, the Marine Hospital Service (now U.S. Public Health Service) was formed

- The first half of 19th century
  - Saw few advances in community health practice
  - Poor living conditions and epidemics were still concerns
  - Better agricultural methods led to improved nutrition
  - 1850 marks the beginning of the *modern era of public health* in the United States
    - Lemuel Shattuck drew up a health report for the Commonwealth of Massachusetts that outlined the public health needs of the state
    - This came prior to the work of Dr. John Snow, who removed the handle of the Broad Street pump drinking well in London, England, in 1854, to abate the cholera epidemic

- The second half of the 19th century
  - Proposal of Louis Pasteur of France in 1859 of the germ theory
  - German scientist Robert Koch's work in the last quarter of the century showing that a particular microbe, and no other, causes a particular disease.
  - The period from 1875 to 1900 has come to be known as the *bacteriological era of public health.*

- The 20th century
  - 1900 and 1960 - the health resources development era.
    - Growth of health care facilities and providers
    - Birth of the first voluntary health agencies
    - National Association for the Study and Prevention of Tuberculosis (now the American Lung Association) was founded in 1904 and the American Cancer Society in 1913.
    - The government's major involvement in social issues began with the Social Security Act of 1935. The two world wars accelerated medical discoveries, including the development of penicillin. In 1946, Congress passed the National Hospital Survey and Construction Act (Hill-Burton Act) to improve the distribution and enhance the quality of hospitals.

  - 1960–1975- - *social engineering era*
    - Passage of amendments to the Social Security Act that set up Medicare (payment of medical bills for the elderly and certain people with disabilities) and Medicaid (payment of medical bills for the poor)

  - 1976 – 1999 - the *health promotion era* (1974–1999)
    - It was recognized that the greatest potential for improving the health of communities and populations was not through health care but through health promotion and disease prevention programs.
    - The U.S. government created its "blueprint for health" a set of health goals and objectives for the nation. The first set was published in 1980 and titled *Promoting Health/Preventing Disease: Objectives for the Nation*. Progress toward the objectives has been assessed on a regular basis, and new goals and objectives created in volumes titled *Healthy People 2000*, and *Healthy People 2010*. Other countries, and many states, provinces, and even communities, have developed similar goals and targets to guide community health.

4.2 Factors that Affect Community and Population Health.

- There are **four categories** of factors that affect the health of a community or population
- Because these factors will vary in separate communities, the health status of individual communities will be different

1) Physical factors
   a. Geography – altitude, latitude and climate (parasitic diseases)
   b. Environment (availability of natural resources)
   c. Community size (overcrowding)
   d. Industrial development (pollution)

2) Social and cultural factors
   a. Cultural – arise from guidelines (explicit or implicit) that individuals inherit form being part of a particular society. The main aspects include beliefs, traditions and prejudices . Examples - smoking in public places, availability of ethnic foods, racial disparities)
   b. Social – arise form interaction of individuals or groups within the community
      i. Economy (employee health care benefits)
      ii. Politics (government participation)
      iii. Religion (beliefs about medical treatment)
      iv. Social norms (drinking on a college campus)
      v. Socioeconomic status (number of people below poverty level)

3) Community organization
   - The way in which a community is able to organize its resources directly influences its ability to intervene and solve problems, including health problems.

- Community organizing "is a process through which communities are helped to identify common problems or goals, mobilize resources, and in other ways develop and implement strategies for reaching their goals they have collectively set
- Examples – availability of health agencies (local health department, voluntary health agencies) and ability to organize to problem solve (lobby city council).

4) Individual behaviour
   - Behaviour of the individual community members contributes to the health of the entire community
   - It takes the concerted effort of many—if not most—of the individuals in a community to make a program work
   - For example health-enhancing behaviours like exercising, getting immunized, and recycling wastes).

4.3 Tools of Community Health Practice

- Much of the work of community health revolves around three basic tools:
  1) Epidemiology - the study of the distribution and determinants of diseases and injuries in human populations
  2) Community organizing - as bringing people together to combat shared problems and increase their say about decisions that affect their lives
  3) Health education - involves health promotion and disease prevention (HP/DP) programming, a process by which a variety of interventions are planned, implemented, and evaluated for the purpose of improving or maintaining the health of a community

5.0 DETERMINANTS OF COMMUNITY HEALTH

- Many factors combine together to affect the health of individuals and communities
- The determinants of health include:- social and economic environment, physical environment, and person's individual characteristics and behaviours
- The context of people's lives determine their health, and so blaming individuals for having poor health or crediting them for good health is inappropriate
- Individuals are unlikely to be able to directly control many of the determinants of health.
- Some of the determinants include
  1) Social and economic environment
     - Income and social status - higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health
     - Education – low education levels are linked with poor health, more stress and lower self-confidence
     - Health services - access & use of services that prevent & treat disease influences health
     - Social support networks – greater support from families, friends and communities is linked to better health. Culture - customs and traditions, and the beliefs of the family and community all affect health
  2) Physical environment
     - Safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health
     - Employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions
  3) Personal characteristics
     - Genetics - inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses
     - Personal behaviour and coping skills – balanced eating, keeping active, smoking, drinking, and how we deal with life's stresses and challenges all affect health
     - Gender - Men and women suffer from different types of diseases at different ages.

Topic 4 – Natural History of Disease, Disease Prevention and Surveillance

Learning outcomes

At the end of the lesson the learner shall be able to
1) Explain the history of medical services in Kenya
2) Describe the levels of disease prevention

1.0 DETERMINANTS OF COMMUNITY HEALTH

- Many factors combine together to affect the health of individuals and communities
- The determinants of health include: -
  1) The social and economic environment,
  2) The physical environment, and
  3) The person's individual characteristics and behaviours
- The context of people's lives determines their health, and so blaming individuals for having poor health or crediting them for good health is inappropriate
- Individuals are unlikely to be able to directly control many of the determinants of health.
- Some of the determinants include
  a) Social and economic environment o Income and social status - higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health
     - Education – low education levels are linked with poor health, more stress and lower self-confidence
     - Health services - access and use of services that prevent and treat disease influences health
     - Social support networks – greater support from families, friends and communities; Culture - customs and traditions, and the beliefs of the family and community all affect health
  b) Physical environment
     - Safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health
     - Employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions
  c) Personal characteristics
     - Genetics - inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses
     - Personal behaviour and coping skills – balanced eating, keeping active, smoking, drinking, and how we deal with life's stresses and challenges all affect health
     - Gender - Men and women suffer from different types of diseases at different ages

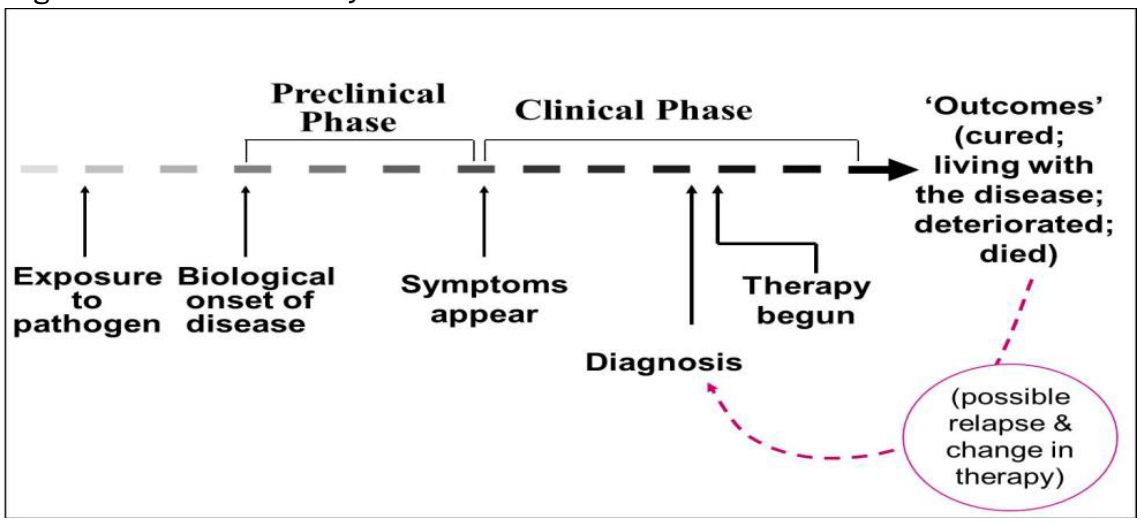
2.0 CAUSES OF DISEASE

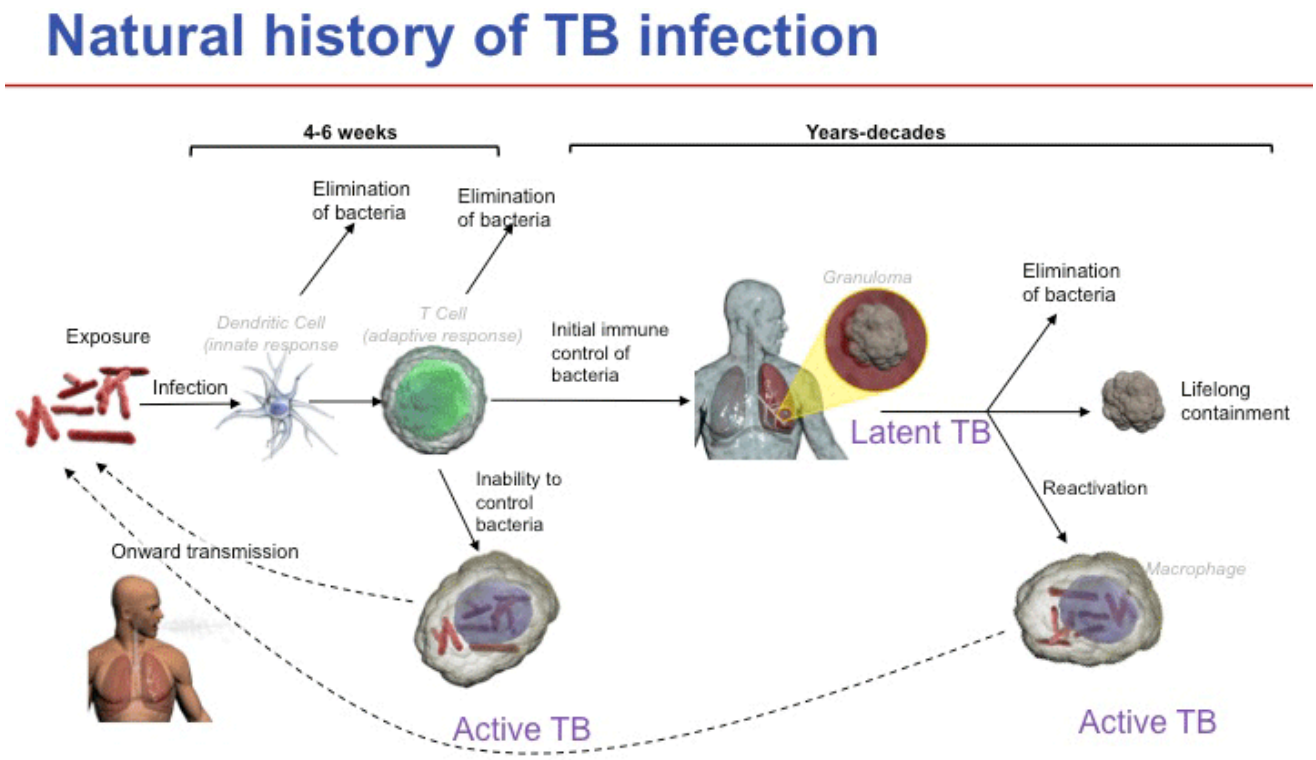
- What are the causes of Disease?

3.0 NATURAL HISTORY OF DISEASE

- Life cycle or natural history of a particular disease varies from individual to individual, and different diseases but four common stages manifest
  i. Stage of susceptibility
  ii. Stage of pre-symptomatic disease
  iii. Stage of clinical disease
  iv. Stage of diminished capacity/disability/death/chronicity

Diagram 4.1: Natural History of Disease





4.0 DISEASE PREVENTION

4.1 Introduction

- Prevention is the most effective, affordable way to reduce risk for and severity of chronic *disease*
- Preventable diseases continue to impose a high burden of premature mortality, and unfortunately, simple and cost-effective preventive and curative interventions are underused.
- Disease prevention applies to measures taken to prevent diseases before they occur as well as measures taken to prevent disease progression
- There are 4 levels of disease prevention - primordial, primary, secondary and tertiary

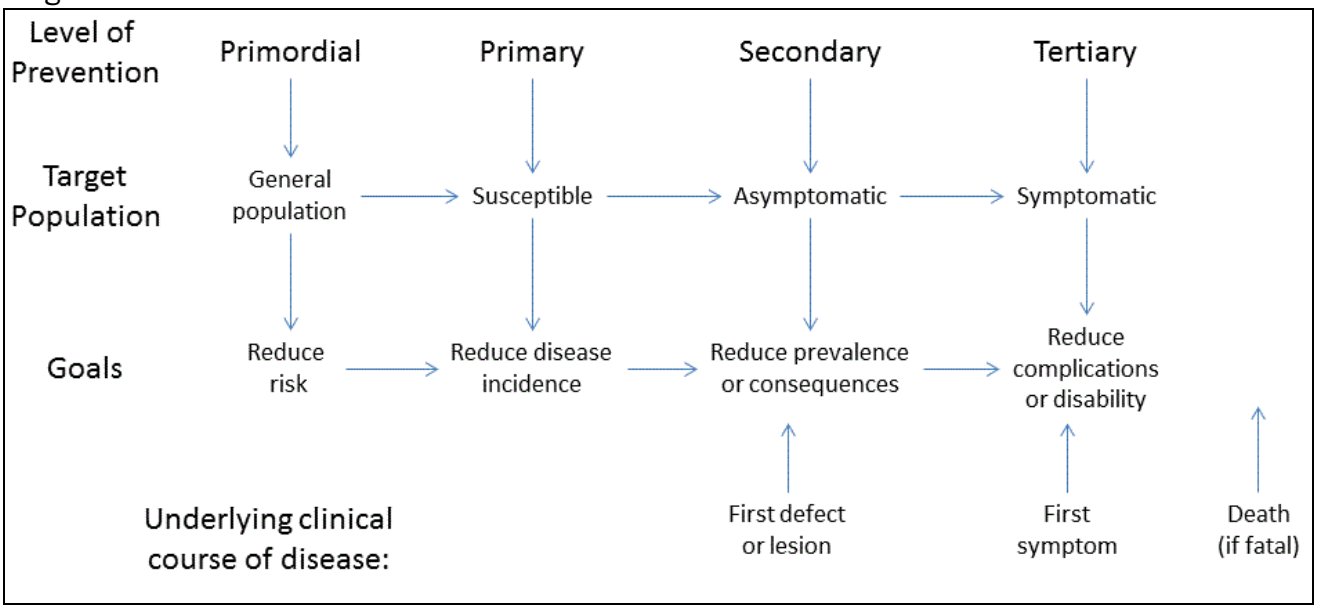
4.2 Primordial Level

- Primordial prevention is defined as **prevention emergence or development of risk factors** themselves, beginning with change in social and environmental conditions in which these

factors are observed to develop, and continuing for high risk children, adolescents and young adults

- This is a relatively new concept receiving special attention in the prevention of chronic diseases. For example, many adult health problems (e.g. obesity, hypertension) have their early origins in childhood, because this is the time when lifestyles are formed
- Responsibility lies on the government. professional and non-governmental organizations, industry, hospitals, health clinics, health practitioners and health-care workers
- The main intervention – is through individual and mass education
- Examples of National policies and programmes on nutrition involving the agricultural sector, the food industry, and the food import-export sector, prenatal nutrition, improving sanitation
- Many adult health problems (e.g., obesity, hypertension) have their early origins in childhood, because this is the time when lifestyles are formed (smoking, eating patterns, physical exercise). Efforts are directed towards discouraging children from adopting harmful lifestyles

Diagram 4.2: Levels of Disease Prevention



4.3 Primary Level (Primary Prevention)

- Measures of prevention undertaken during the phase of pre- pathogenesis (phase of susceptibility)
- Entails measures taken to prevent diseases before they occur
- Strategies emphasize general health promotion, risk factor reduction, and other health protective measures
- Strategies include **health education** and **health promotion** programs designed to foster healthier lifestyles and environmental health programs designed to improve environmental quality
- Some approaches involve active participation (e.g. regular tooth brushing and flossing to prevent dental caries) or passive (adding fluoride to the municipal drinking water to harden tooth enamel and prevent caries
- Primary prevention generally targets specific causes and risk factors for specific diseases, but may also aim to promote healthy behaviours, improve host resistance, and foster safe environments that reduce the risk of disease, for instance, thorough cleaning of operating rooms to prevent post-operative infection
- Involves two sub-steps
  i) Health Promotion
    - Steps undertaken to improve the level of general health and wellbeing so that conditions for initiation of disease process are prevented
    - Steps are not specific for any disease or a group of diseases

- Includes – improvement in the overall socio-economic status of the population, – health education, feeding programmes for mothers and children, promotion of breast feeding, promotion of small family norms, education, motivation for healthy lifestyle.

ii) Specific Protection
- Measures to prevent the initiation of specific diseases or a group of diseases
- Examples – Immunization to protect against specific diseases, fortification of foods with specific nutrients (as salt with iodine), use of condoms to protect against sexually transmitted diseases (STDs), use of helmets to protect against head injuries

- Two types of strategy

i) Population strategy
- Advantages - radical large potential for population, behaviourally appropriate
- Disadvantages - small benefits to individual, poor motivation of subject, poor motivation of physician, benefit to risk ratio may be low

iii) High risk strategy
- Advantages - appropriate to individuals, subject motivation, physician motivation, benefit to risk ratio is favourable
- Disadvantages - high screening costs, temporary effects, limited effect, behaviourally inappropriate
- Other examples – immunization, avoidance of substances (e.g. drugs), public health education about good nutrition, exercise, stress management, and individual responsibility for health; chlorination and filtration of public water supplies; and legislation requiring child restraints in motor vehicles, general health promotion strategies taken at home, working places and in institutions e.g. promotion of good nutrition, provision of basic needs (food, clothing, shelter), recreation facilities and prevention of accidents; screening of populations

What strategies has the government employed to facilitate primary intervention? Discuss using specific examples

4.4 Secondary Level (Curative Level)

- Include all actions undertaken at the stage of early pathogenesis (asymptomatic disease) with a view to halt the progress of disease at its earliest, incipient stage, by "early diagnosis and prompt treatment"
- Entails early detection of disease followed by prompt intervention
- It is important in preventing complications, disabilities and communicability of disease
- Secondary prevention focuses on early detection and swift treatment of disease
- Its purpose is to cure disease, slow its progression, or reduce its impact on individuals or communities
- A common approach to **secondary prevention is screening for disease**,
- Examples of "Screening for disease" for breast cancer (using mammography) and cervical cancer (using Pap smear), medical examinations of school children, of industrial workers and various disease screening camps
- Non-invasive computerized test e.g. ECG_2, CT_3 scan for the early detection of heart disease; CT scans to look for calcium deposition in the arteries; mammography for breast cancer detection; eye tests for glaucoma; blood tests for lead exposure; occult blood tests for colorectal cancer; the Pap test for cervical concrete breath test for Helicobacter pylori, the bacterium implicated in duodenal and gastric ulcers; and the Prostate-Specific Antigen(PSA) test for prostate cancer
- Screening is performed to detect disease early so prompt treatment can be initiated e.g. treatment of hypertension and diabetes to prevent complications and removal of skin cancer lesions as they occur

- Protects healthy members of the community against certain diseases

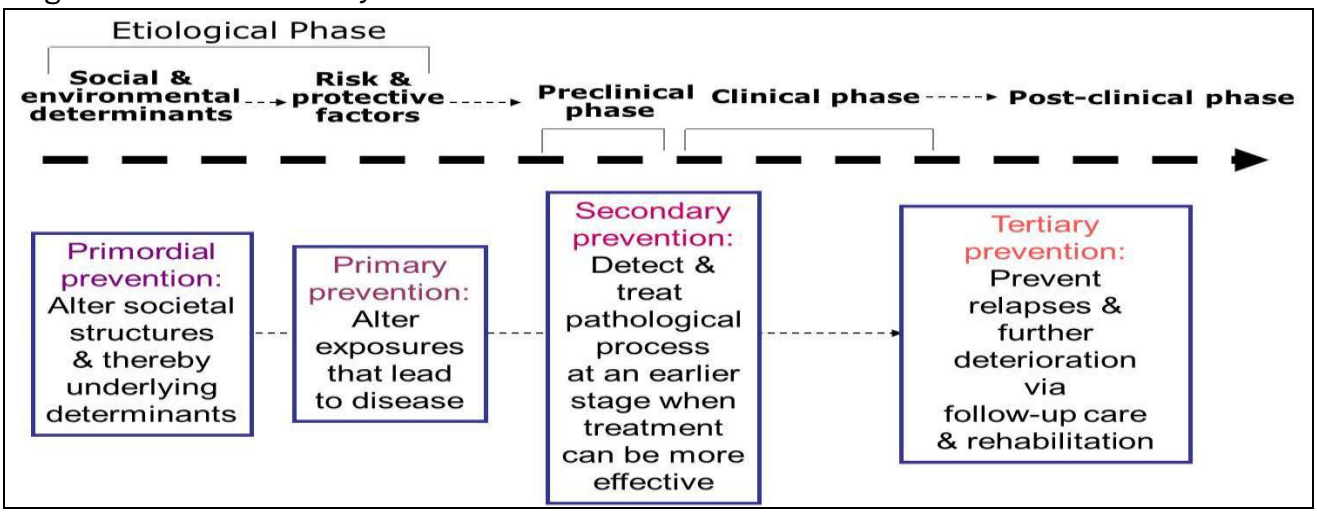
> What strategies has the government employed to facilitate secondary/curative intervention? Discuss using specific examples

4.5 Tertiary Level (Rehabilitative Intervention)

- Consists of attempts made to improve the quality of life of an individual after a disease has occurred and caused damage to the person
- Include all measures undertaken when the disease has become clinically manifest or advanced, with a view to prevent or delay death, reduce or limit the impairments and disabilities, minimize suffering and to promote the subject's adjustment to irremediable conditions
- Involves both therapeutic and rehabilitative measures once disease is firmly established
- Has two types of approaches
  i) Disability limitation
     - Measures to prevent the occurrence of further complications, impairments, disabilities and handicaps or even death
     - Example: – Application of plaster cast to a patient who has suffered Colle's fracture, is done to prevent complications and further disability like mal-union or non-union; Complete rest, morphine, oxygen and streptokinase is given to a patient of Acute MI, to prevent death or complications like arrhythmias / CHF
     - Sequence with which a disease turns into a handicap is as follows
       a) Disease - a pathological process and its manifestations which indicate a departure from the state of perfect health
       b) Impairment - the actual loss or damage of a part of body anatomy or an aberration of the physiological functions that occurs consequent to a disease
       c) Disability - the inability to carry out certain functions or activities which are otherwise expected for that age / sex, as a result of the impairment
       d) Handicap - This is the final disadvantage in life which occurs consequent to an impairment or disability, which limits the fulfilment of the role a person is required to play in life.

  ii) Rehabilitation
     - Rehabilitation stands for the combined and coordinated usage of all the available medical, social, educational and vocational measures, for training the person to the highest level of functional ability
       a) Medical rehabilitation - done through medical/surgical procedures to restore the anatomy, anatomical functions and physiological functions to as near normal as possible
       b) Vocational rehabilitation - includes steps involving training and education so as to enable the person to earn a livelihood
       c) Social rehabilitation - involves steps for restoration of the family and social relationships
       d) Emotional and Psychological rehabilitation - involves steps to restore the confidence, personal dignity and confidence.
          - Examples - treatment of diabetics to prevent complications; management of chronic heart disease patients with medication, diet, exercise, and periodic examination; improving functioning of stroke patients through rehabilitation by occupational and physical therapy, nursing care, speech therapy, counselling, and so forth, and treating those suffering from complications of diseases such as meningitis, multiple sclerosis, or Parkinson's disease.
          - May involve modification of working and home environments and funding affected persons to start IGAs

Diagram 4.3: Natural History and Levels of Disease Prevention



What strategies has the government employed to facilitate tertiary/rehabilitative intervention? Discuss using specific examples
What is are the Roles of Clinicians in Disease Prevention?

5.0 SURVEILLANCE

- Disease surveillance is an information-based activity involving the collection, analysis and interpretation of large volumes of data originating from a variety of sources.
- Surveillance is
  i) The ongoing, systematic collection of data related to health events; their verification, analysis, interpretation, and the dissemination of information to those who need to know in order to reduce morbidity and mortality & to improve health (WHO)
  ii) Ongoing systematic collection, analysis, and interpretation of health data essential to the planning, implementation, & evaluation of public health practice, closely integrated with the timely dissemination of the data to those who need to know (CDC)

Topic 5: Community Mobilization and Empowerment

Objectives

At the end of the lesson the leaner will be able to:
1) Discuss factors promoting and hindering community empowerment and participation
2) Discuss the process of participation, empowerment and mobilization
3) Discuss challenges to community empowerment, mobilization and participation

1.0 PRINCIPLES[2] OF COMMUNITY HEALTH

- These include community participation, empowerment, community organization, mobilization, health promotion, advocacy and health education (next unit), community development

2.0 COMMUNITY MOBILIZATION (CM)

2.1 Definition

- Community mobilization is the
  a) process of engaging a group of people in **joint action** in order to achieve **societal goals** through **self-reliant efforts** (Dale, 2000)
  b) a capacity building process through which community members, groups or organizations plan, carry put and evaluate activities on a participatory and sustained basis to improve their health and other conditions either on their own initiative or stimulated by others
  c) process through which **action is stimulated** by a community itself, or by others, that is planned, carried out, and evaluated by a community's individuals, groups, and organizations on a **participatory** and sustained basis to **improve health**
- It can be described as an "outside-in" process
- Mobilizing the community begins when
  i) Concerned citizens or groups organize to take a stand
  ii) Community change is determined
  iii) The public is concerned about the problem(s)
  iv) There is a need for collaboration among the community groups and individuals;
  v) The community at large is involved in the situation;
  vi) Emerging community leaders are recognized and encouraged; and
  vii) The efforts for change are sustained

2.2 Objectives

- Create awareness, Build local organizations, Strengthen peoples' analytical capacity, Promote peoples' confidence, Mobilize underutilized or non-utilized resources, Establish linkages, Building Leadership, Increase Civic Engagement and Enhancing Member Participation

2.3 Who to Consult and Involve In Community Mobilization

- Kings, chiefs, traditional healers, religious leaders, political leaders, women leaders, village celebrities, village elders, youth leaders and professionals

[2] a fundamental source or basis of something; a fundamental truth or proposition that serves as the foundation for a system of belief or behaviour or for a chain of reasoning; an accepted or professed rule of action or conduct: a fundamental basis of a system of thought or belief; is some kind of basic truth that helps you with your life

2.4 Strategies and Models

Introduction

- Overall goal of CM is to bring about **planned social change** through full participation of people in the community
- Different strategies can be used to stimulate the needed action (strategy = process by which individuals, groups or communities arrive at a chosen object)

The main strategies include

- Can be implemented at 3 levels namely general (extension, community development), intermediate and specific strategy
- Main strategies include
  i) Power strategy – ability of members to assume power and influence decisions
  ii) Self-help strategy – efforts made to assist the community to change through volunteer efforts
  iii) Communication strategy – communicate problems of the community to the larger society compelling assistance
  iv) Political strategy – develop viable political organizations

Models of Community Mobilization

	Model	Explanation/description
1.	Induced social action model	Used by outside agents to bring change to the community Involves stages such as exploration, organization (set nucleus or initiating set), training, discussion group decision making, planning for social change action, evaluation and subsequent action
2.	Spontaneous social action model	Idea conceived by a single individual within the community who induces changes and other take the change
3.	Quasi stationary equilibrium model	Work is done in groups particularly in crises situations Involves 3 steps of unfreezing (changes old habits), moving (taking on new habits) and freezing (cementing the change)
4.	Social advocacy model	A disadvantaged segment of the community needs to be organized and mobilized to gain power and resources In line with principle of democracy and social justice
5.	Diffusion of innovations model	Occurs due to technological changes which communities have to take on board

2.5 Community Mobilization Plan

- Defines the overall program goals and objectives
- Elements of CMP
  1) Background information
  2) Program goal
  3) Program objectives
  4) Community action cycle (community mobilization process)
     a) Sensitization and clearance
     b) Unity organizing
     c) Mobilizer training
     d) Management training
     e) Participatory assessment
     f) Defining priorities and problems
     g) Community action plan

h) Community project design
i) Negotiation
j) Implementation
k) Monitoring and evaluation
l) Completion ceremony
m) Repeat the cycle

5) Monitoring and evaluation plan
6) Management plan
7) Budget

Diagram 5.1: Community Mobilization cycle

2.6 Identification and Mobilization of Resources

1) Financial
2) Human
3) Material
4) Time

- Explain how these resources are identified and mobilized
- State the significance of the resources in community mobilization

2.7 Institutions for Community Mobilization

1) State/government - political and administrative organizations
2) Civil society – NGOs, CBOs, trade unions, lobby movements, self-help groups, youth groups
3) Market oriented/based institutions

2.8 Outcome of Community Mobilization

- The principal outcome is **PARTICIPATION**
- Others include honour and respect, acceptance and support, beneficial engagement, shange attitudes, behaviour and practice, secure input from the community, resources, communication, Influence acceptance, Effective participation and unity

2.9 Conflicts

- Diverse groups, strategic disagreement, competition between groups, unreasonable expectations, lack of common understanding, goal conflict, poor communication skills, unclear/unfair expectations, power-plays and manipulation

2.10 Barriers to Mobilization

1) Personal characteristics - perceived sensitive issues, social fear or shyness, feelings of inadequacy, fear of conflict or consequences of action taken and attitude
2) Role characteristics - role conflict, role overload and poor leadership
3) Community characteristics - Economically disadvantaged, an aging population, too few volunteers, shortage of human resource, cultural aspects, leadership and resources

2.11 Major Challenges in Community Mobilization

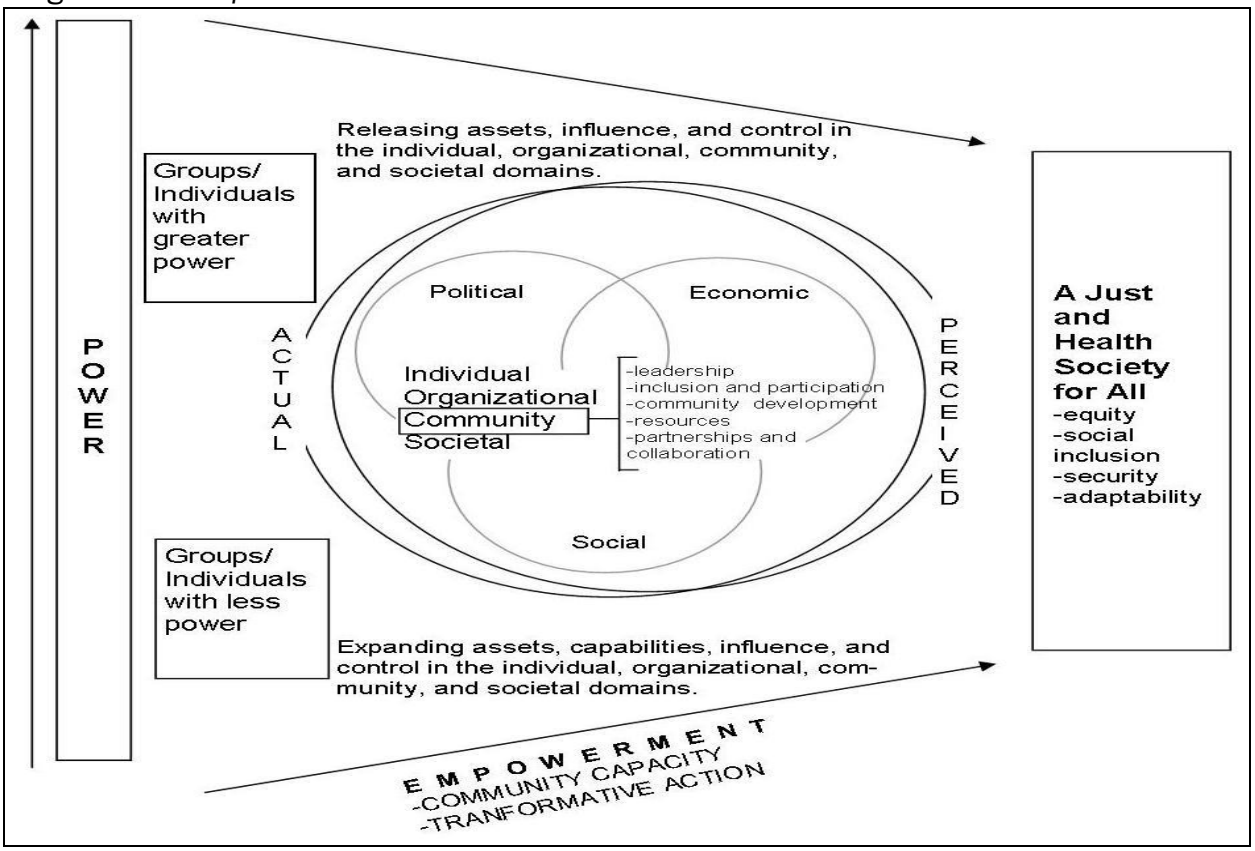
1) Traditional mind-sets and attitudes
2) Involvement of many people slows progress
3) Absence of skills to manage different levels of professional & non-professionals involved
4) Balancing of community standards with internationally acceptable standards
5) Reluctance by qualified professionals to take up community programmes
6) Hidden selfish motives

3.0 EMPOWERMENT

3.1 Introduction

- Empowerment is the primary goal of community mobilization focusing mostly on the disadvantaged people with the expectation that they will attain more equal conditions in society
- Empowerment is the process whereby people
  - acquire more influence over factors that shape their lives (increase control over their lives)
  - gain control over the factors and decisions that shape their lives by increasing their assets and attributes and build capacities to gain access, partners, networks and/or a voice, in order to gain control
  - **re-negotiate power** in order to gain more control
- Addresses the social, cultural, political and economic determinants that underpin health, and seeks to build partnerships with other sectors in finding solutions
- "Enabling" implies that people cannot "be empowered" by others; they can only empower themselves by acquiring more of power's different forms (Laverack, 2008)
- It assumes that people are their own assets, and the role of the external agent is to catalyse, facilitate or "accompany" the community in acquiring power

Diagram 5.2: Empowerment



3.2 Concepts in Empowerment

1) Communication
   - Plays a vital role in ensuring community empowerment

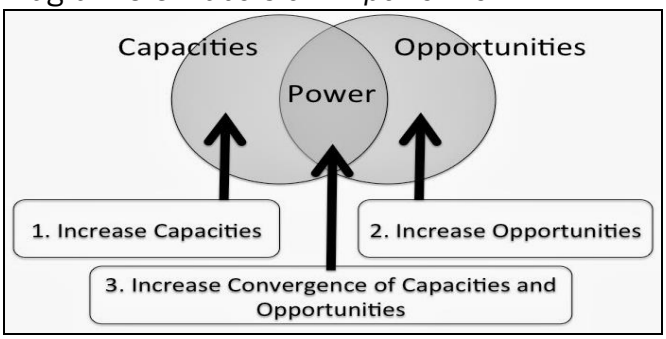
2) Social and Political change
   - CE is more than the involvement, participation or engagement of communities
   - Community ownership and action that explicitly aims at social and political change
   - CE recognizes that if some people are going to be empowered, then others will be sharing their existing power and giving some of it up (Baum, 2008)
   - Power is a central concept in community empowerment and health promotion invariably operates within the arena of a power struggle

3) Participatory approaches in communication
   - Encourage discussion and debate result in increased knowledge and awareness, and a higher level of critical thinking

4) Critical thinking
   - Enables communities to understand the interplay of forces operating on their lives, and helps them take their own decisions.

5) Globalization
   - Local and global are inextricably linked thus action on one cannot ignore the influence of or impact on the other

Diagram 5.3: Facets of Empowerment



3.3 Principles of Effective Empowerment

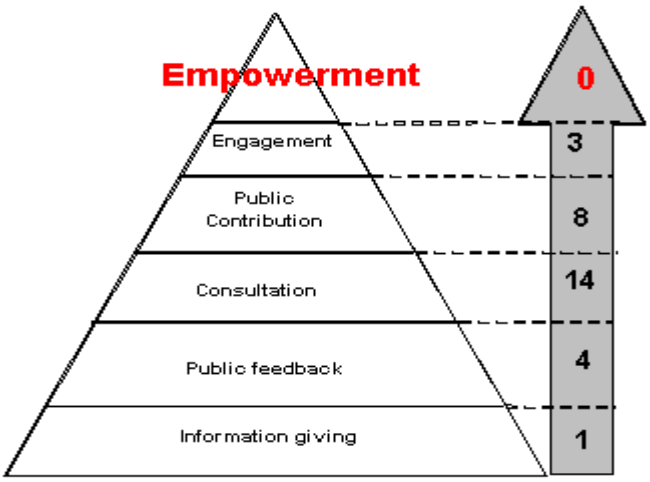
- Principles of effective empowerment include: -
  1) Facilitate process of learning
  2) Actively promote genuine discussions and consultations before decisions are made
  3) Promote engagement in concrete development activities
  4) Community mobilizer to act as a linkage person
  5) Promote role of change agent in the community

3.4 Enabling Factors

1) Incorporating government approaches with broad social and economic strategies aimed at creating greater equity
2) Working with existing community organizations and community forums to promote local engagement
3) Having funding, support mechanisms and development opportunities in place
4) Ensuring equal relationships between communities and professionals

3.5 Level of Empowerment

Diagram 5.4: Level of Empowerment



3.6 Characteristics of an Empowered Community

Table 5.1: Characteristics of an Empowered Community

	Characteristic	Explanation
1.	Confident	• Have necessary skills, knowledge and support to work effectively • Understand principles, processes and time needed for community empowerment
2.	Inclusive	• Awareness of power differences between and within communities • Recognition that discrimination exists, promote equality of opportunity and good relations between groups • Strategies for dealing with competing demands & working constructively with conflict
3.	Organized	• Shared understanding of 'community empowerment' and what it can achieve • Monitor and evaluate community empowerment activity
4.		• Creative ways for delivery of targets to maximize empowerment opportunities
5.	Cooperative	• Broker relationships between elected members and communities? • Support effective community networks and infrastructure, to help community groups work together • Support local and national networking among staff to strengthen their community empowerment skills and knowledge?
6.	Influential	• Clear routes for communities to influence what it does • Give feedback and record evidence of community influence? • Challenge targets or processes which compromise community empowerment

Topic 6: Community Participation, Advocacy and Partnerships

Objectives

At the end of the lesson the leaner will be able to:
1) Discuss the process of participation and advocacy
2) Discuss factors promoting and hindering participation
3) Discuss challenges to community empowerment, mobilization and participation

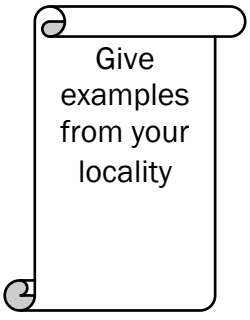
1.0 COMMUNITY PARTICIPATION

1.1 Introduction

- Participation is the heart that pumps the community's life blood (citizens) into the community's business
- It is a vehicle for influencing decisions that affect the lives of citizens and an avenue for transferring power
- Participation is
  - "to have a share in" or "to take part in," thereby emphasizing the rights of individuals and the choices that they make in order to participate (Oxford English Dictionary)
  - a means to educate citizens and to increase their competence (Brager, Specht, and Torczyner, 1987)
  - "collective efforts to increase and exercise control over resources and institutions on the part of groups and movements of those hitherto excluded from control (Westergaard, 1986)
- Community participation is the process
  - in which communities are actively involved in all stages of a project or programme implementation
  - through which all members of a community are involved in and have influence on decisions related to development activities that will affect them
  - that Involves communities in defining their needs and planning how to meet them within the national policy framework, in implementation and evaluation

1.2 Importance of Community Partcipation

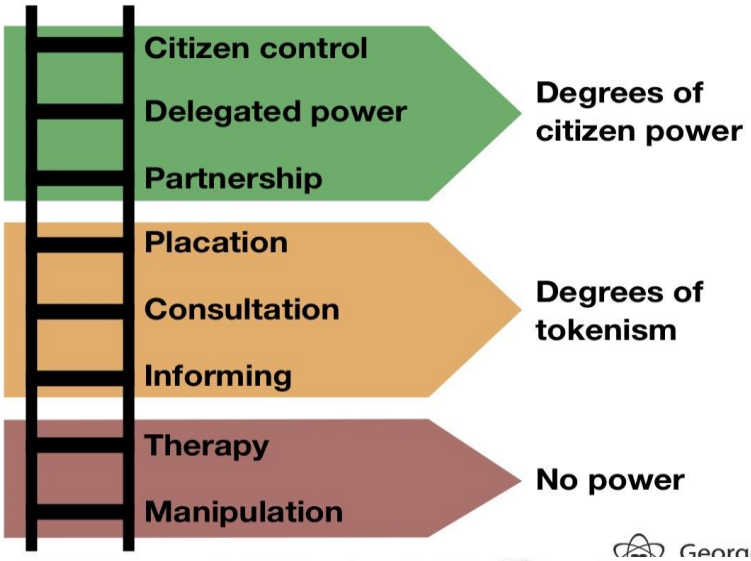
1) Helps community members to identify and prioritize their felt needs
2) Enhances sense of ownership, responsibility and support
3) Empowers the community to manage their own projects
4) Helps to change people's attitude
5) Reduces project costs
6) Promotes utilization of locally available resources
7) Promotes intra and inter sectoral collaboration
8) More culturally appropriate strategies and messages
9) Increases coverage and access to information and services
10) Increases demand
11) Increases advocacy for service and policy change
12) Increases success (results and sustainability) – development
13) Community unity



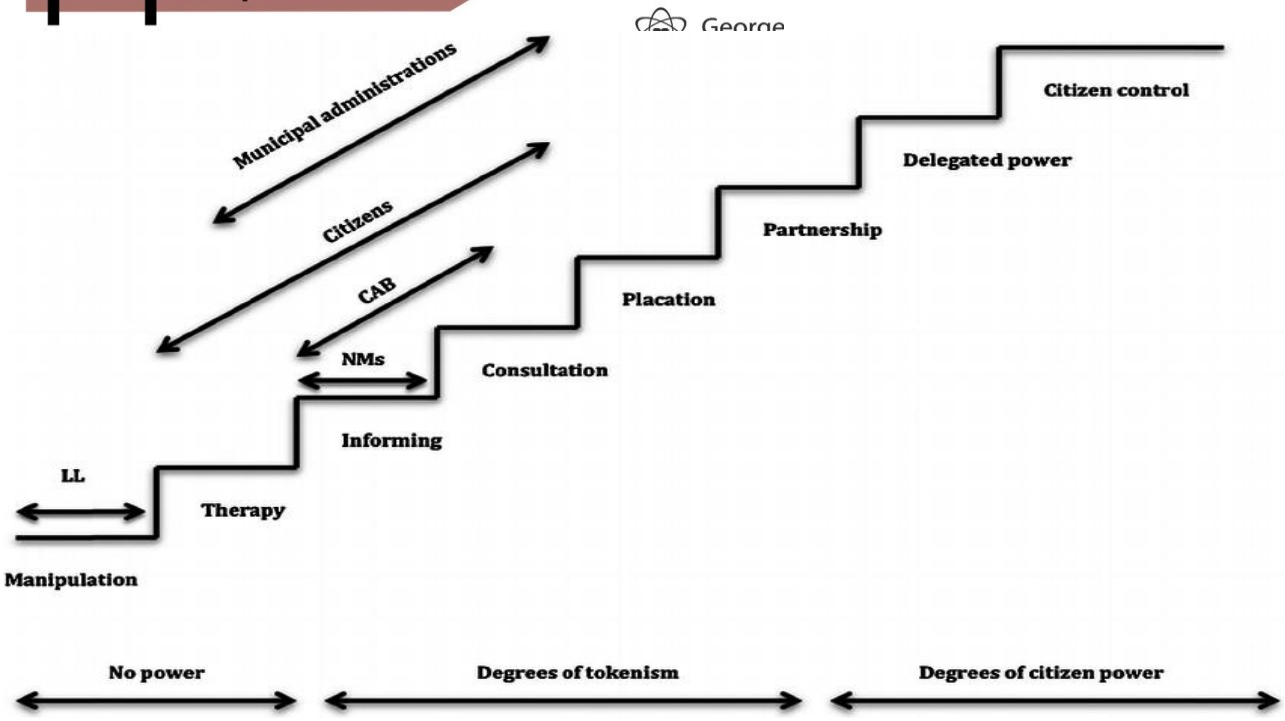
1.3 Ladder of Participation

- Involves eight levels from manipulation (lowest level) to citizen power (highest level)

Arnstein (1969) Ladder of citizen participation



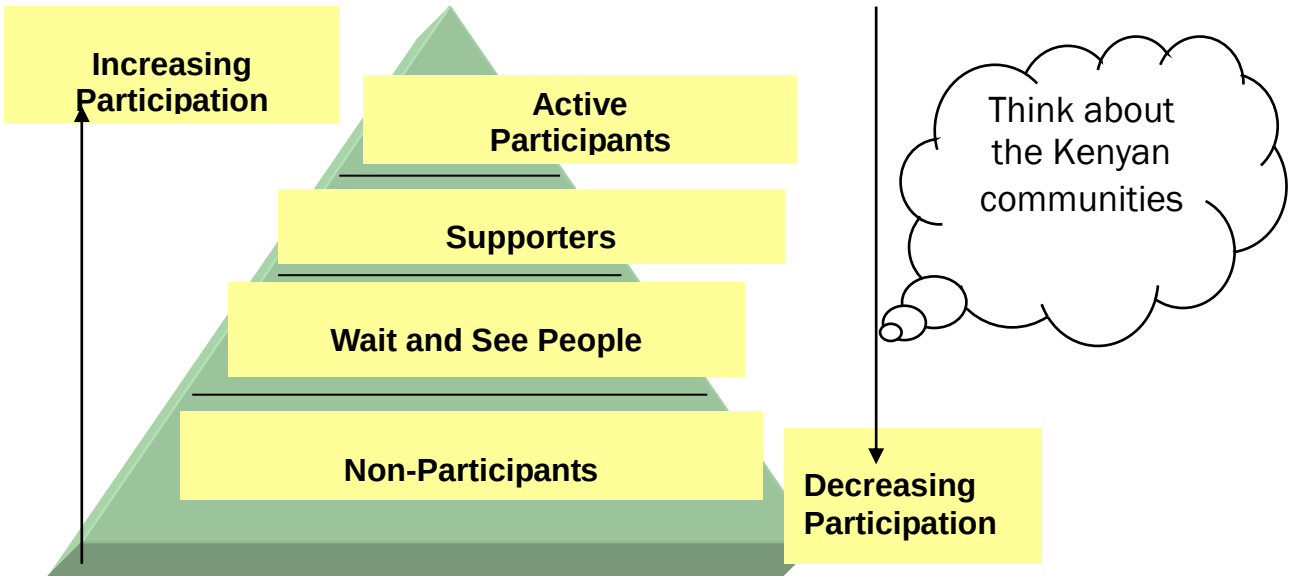
Give one example at each level with regard to community participation in Kenya with regard to health projects and programmes



	Level	Characteristics
1.	Manipulation	• Public manipulated into thinking they are part of decision making • Power holders have created a deceptive form of participation, perhaps around a decision already made • People are "educated" and advised to sign proposals believed to be in their interest
2.	Therapy	• Power holders "cure" the people with the promise to assist them and have them engage in different activities where their opinions may be "cured", and in the end accepted by the citizens
3.	Informing	• Citizens are informed of what is happening in a **one-way information process**, where people receive the information in newspapers, in the media, online or by other means
4.	Consultation	• Citizens' opinions can start to affect the power holder's opinion • Members consulted and assigned • If consultation and information is taken into account as part of the planning process
5.	Placation	• Citizens' opinion will start influencing the power holder's but they are

	Level	Characteristics
		hand-picked to sit on a governing board that makes decisions on the planning process • Likely to work if the committee members are equally split (citizens and power holders), so the citizens cannot be outvoted in the process
6.	Partnership	• Power holders and citizens create a partnership that keeps both citizens and power holders' content
7.	Delegated Power	• Citizens start taking control, and power holders start negotiating with citizens • Majority of the committee members are citizens • Power holders would need to negotiate decisions with the board members
8.	Citizen Control	• Citizens get to influence the decision making directly. • The citizens have the power to decide e.g. voting, referendums

1.4 Levels of Participation and Power



1.5 Models of Participation

	Model	Description	Example
1.	Extractionist model	• Used by government planners • People drawn into participation of implementation of a pre-determined development goals through financial and material resources • People dictated upon	•
2.	Vertical model	• Power brokers develop mutually beneficial relations with elites or government officials	•
3.	Hand out induced model	• Associated with economists and technocrats who consider themselves superior	•
4.	Authentic model	• Empowers the powerless to assume full responsibility of their own destiny	•

1.6 How to Promote Community Participation

1) Conduct dialogue based on evidence
2) Conduct regular meetings to give feedback at all stages of implementation
3) Strengthen existing structures rather than forming new ones
4) Create awareness at all levels of implementation

5) Apply appropriate and effective technology
6) Involve everyone in the participation
7) Bulid capacity of the community

1.7 Challenges To Community Participation

1) Less control
2) Time and cost
3) Differing priorities and interest
4) Stakeholders disagree
5) Community volunteer motivation
6) Community skills and capacity
7) Selection of community participants may be biased
8) Need to plan for sustainability from beginning
9) Adminstrative resistnace to decentralization and distribution of benefits
10) Difficulties in mobilzing previosly un-involved populations

1.8 Factors Hindering Community Participation

- Inadequate awareness creation, poor leadership, dependency syndrome (people expect handouts before participation), political influence, false promises from implementing agencies, lack of prioritization of community needs, gender bias, application of inappropriate technology, poor timing of activities/seasonal priorities, corruption and lack of transparency, use of unskilled agents, lack of decentralization in decision making, poor extension policies and methodology, cultural, attitude, poverty and ignorance

2.0 PARTNERSHIPS

2.1 Introduction

- Definition
  - an arrangement in which two or more individuals or organizations pool resources and skills in accordance with terms of the *partnership* agreement
  - willingness of two or more people/groups to work together to achieve a mutually beneficial outcome(s)
- Partnership working (partnership)
  - is about developing inclusive, mutually beneficial relationships that improve the quality and experience of health care
  - requires equality, willingness and commitment to share knowledge, understanding and resources
  - is intended for joint solving of problems, resource exchange, cooperation, coordination and coalition building
  - can be temporary or permanent
  - brings together institutional capabilities and human resources in the form of skills, experiences and ideas to tackle common problems that are often beyond the capacity of a single organization or group
- Examples –
  i) Government agency like the Ministry of Health and UN organization (WHO, UNICEF), international NGOs (e.g. Care International, World Vision) and local e.g. MYWO7 to enhance child nutrition and immunization
  ii) Ministry of Health/DLTLD, CDC, FBOs and County Governments (TB and malaria programmes) malaria
  iii) Ministry of Health, NASCOP, County Governments, CDC, USAID (HIV/AIDS management)
  iv) KMTC and VVOB – implementation of the skillslab programme
  v) KMTC and USAID/Funzo – curriculum evaluation and review in KMTC

2.2 Types of Partnerships

1) Networks

- Relationships among partners within networks are often less formal or informal
- Main purpose of most networks is to exchange information among members and to share experiences in their local activities

2) Coordination

- Relations among members are more closely linked
- Definition of specific tasks among organizations, which require resources (for representation, management, fulfilment of specific tasks) beyond information sharing

3) Collaboration

- Relations among members are strong with functional more broad ranging areas defined for joint activities
- Attributes of a collaboration include intellectual and cooperative endeavour, knowledge and expertise more important than role or title, joint venture, team working; participation in planning and decision making; non-hierarchical relationship; sharing of expertise, willingness to work together towards an agreed purpose; trust and respect in collaborators; partnership; and inter-dependency; highly connected network; low expectation of reciprocation

2.3 Models of Partnerships

i) Project partnership - a partnership that is time-limited and designed to benefit both the health and social care centres. Example - a partnership between the police and other road safety organizations to lower the speed limit will end when their project is successful
ii) Problem oriented partnerships formed to meet specific problems - a designed partnership meant to meet problems of both health systems; E.g. - NACADA, KPS, County & National Government in substance abuse
iii) Ideological partnerships - Arise from a shared outlook or point of view; Example - in abortion, various organizations, ideologically aligned, form a 'pro-life' and a 'pro-choice' partnership
iv) Ethical partnerships - share a number of features with the above but they also have a sense of 'mission' and have an overtly ethical agenda, that seeks to promote a particular way of life

ADVOCACY

1.0 INTRODUCTION

- Advocacy is a key health promotion activity for overcoming major barriers to public health and occupational health such as poor living and working conditions, rather than individual or behavioural barriers
- Advocacy can be used as part of a community initiative, nested in with other components Health promotion aims at making these conditions favourable through **advocacy for health**". (WHO, 2013) as envisaged in the Ottawa Charter on Health i.e. "political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to good health
- Advocacy does not necessarily involve **confrontation or conflict**
- *Health advocacy* is defined as
  - public support for or recommendation of a particular cause or policy
  - the act of pleading for, supporting, or recommending; active espousal
  - active promotion of a cause or principle
  - "the processes by which the actions of individuals or groups attempt to bring about social and/or organizational change on behalf of a particular health goal, program, interest, or

population" (2000 Joint Committee on Health Education and Promotion Terminology, 2002)

- *Lobbying* is any attempt to influence specific legislation (Vernick, 1999). *Grassroots lobbying* is any attempt to influence the public or segment of the public to take action on specific legislation (Vernick,1999)
- *Electioneering*, is any attempt to influence an election (Vernick, 1999)

2.0 A 10-STEP ADVOCACY FRAMEWORK

1) Take action - overcome obstacles to action
2) Select your issue - identify and draw attention to an issue
3) Understand your political context - identify the key people you need to influence
4) Build your evidence base - do your homework on the issue and map out the potential roles of relevant players
5) Engage others - win the support of key individuals/organisations
6) Elaborate strategic plans - collectively identify goals and objectives and best ways to achieve them
7) Communicate messages and implement plans - deliver your messages and counteract the efforts of opposing interest groups
8) Seize opportunities - time interventions and actions for maximum impact
9) Being accountable - monitor and evaluate process and impact
10) Catalyse health development - build sustainable capacity

3.0 PRINCIPLES FOR EFFECTIVE ADVOCACY

Principle	Description
Consumer centred	The consumer is at the centre of the interaction.
Opportunities	Stakeholders promote and support opportunities for both individual and systemic advocacy
Recognition	Stakeholders recognise that advocacy is legitimate and that it can take many forms.
Relationships	All those involved work together with respect and recognise each other's roles and contribution to the process
Response	Matters raised are acknowledged and responded to.
Resolution	The aim of all parties is to find a solution which is acceptable to the consumer.

4.0 INGREDIENTS MAKE FOR EFFECTIVE ADVOCACY

i) The rightness of the cause
ii) The power of the advocates (i.e., more of them is much better than less)
iii) The thoroughness with which the advocates researched the issues, the opposition, and the climate of opinion about the issue in the community

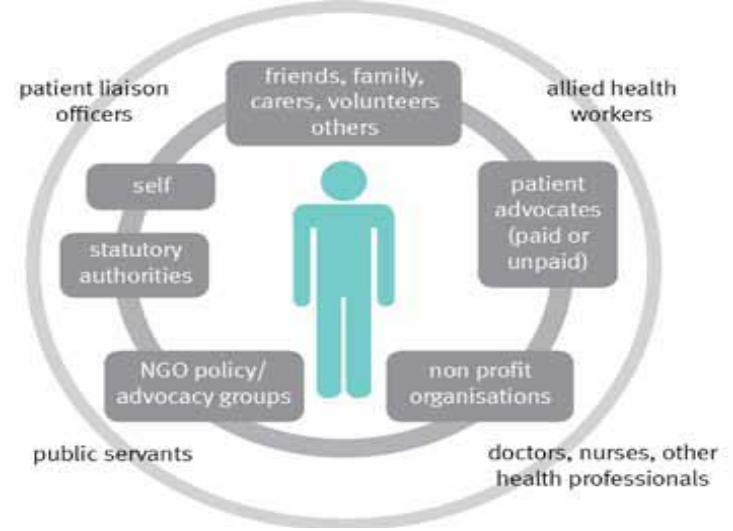
iv) Their skill in using the advocacy tools available (including the media)
v) Selection of effective strategies and tactics

5.0 ADVOCACY TOOLS AND PROCESSES

- These include framing, formative research, working with media (media interviews and advocacy), networking, social marketing, lobbying and internet based advocacy

6.0 ADVOCACY APPROACHES

- The approaches include self-advocacy, citizen advocacy, peer advocacy, parent advocacy and family/group advocacy



1) Self-advocacy
   - An individual or a group of people speak or act on their behalf in pursuit of their own needs and interests

2) Citizen advocacy
   - Seeks to 'promote, protect and defend the rights and interests of people who have intellectual disability

3) Peer advocacy
   - Involves 'one-on-one support by a service user, past or present, to help another to express and fulfil their wishes

4) Parent advocacy –
   - Concerned with 'advocating on issues that affect the person with a disability and their family focusing on the needs of the person with a disability, not the parents or family
   - However, some parent advocacy focuses on the needs of parents first

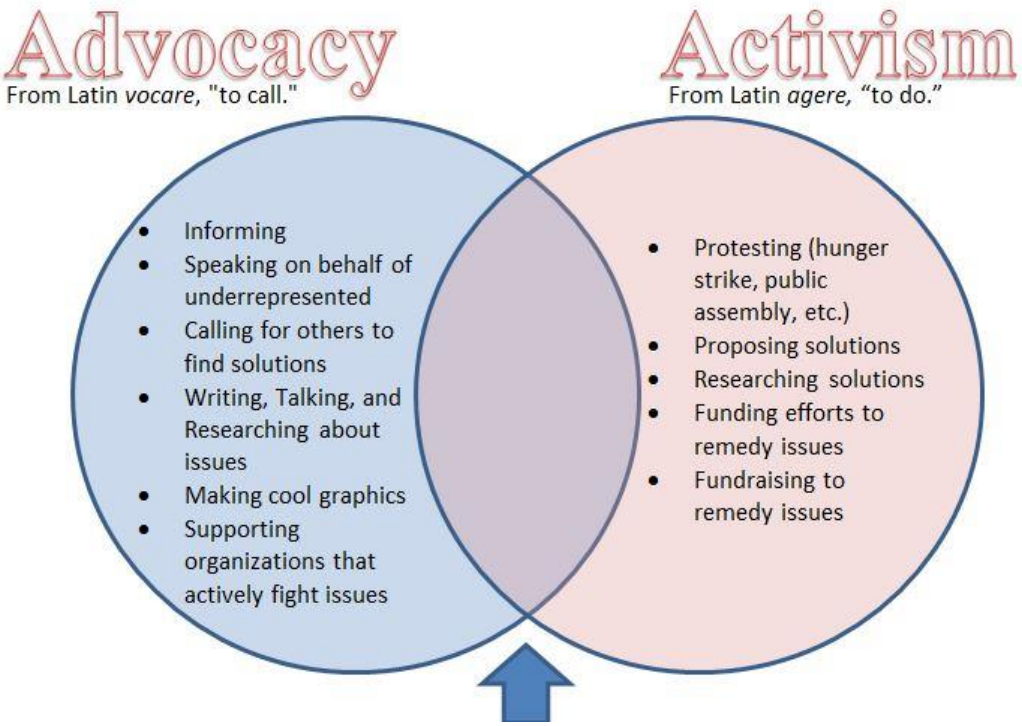
5) Family/group advocacy

7.0 HEALTH ADVOCATES

- Include - Individual consumer, Friends/family/carers/volunteers, Independent patient advocates,
- Non-profit organisations, Non-government policy/advocacy organisations and statutory authorities,
- Health professionals and patient liaison officers, public servants

8.0 BENEFITS OF HEALTH ADVOCACY

1) Positive changes - Legislation, policies, practices, service delivery and developments and community behaviour and attitudes
2) Promotion of wellness and resilience in individuals, families and communities in conjunction with health literacy and patient activation strategies
3) Raised awareness of the significant impact on an individual's health and wellbeing of broader social and environmental factors (such as housing, education, employment, and cultural identity, gender and sexuality identities), thereby enabling health advocacy to facilitate individual and systemic change in these areas
4) Empowering health consumers to become more involved in their healthcare decision-making and broader health policy and initiatives
5) Resolution of consumers' issues as they arise, mitigating escalation and lengthy complaints processes
6) Consumer focused, affordable and responsive health services that are cost-effective



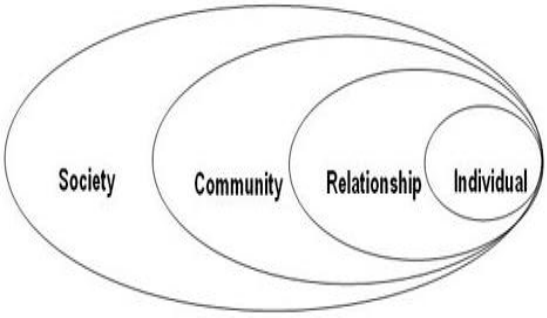
Topic 7: Community Organization & Organizations

Objectives

At the end of the lesson the learner will be able to:-
1) Explain theories of community organization
2) Discuss community organization strategies
3) Identify principal community organizations involves in health care

1.0 DEFINITION

- Social development approach transforms powerless and voiceless people into a dynamic participatory and politically responsive community
- Community organization involves participatory, systematic and sustained process of building people's organization by enhancing the capabilities and resources of the people for resolution of their health issues and concerns
- Community organizing is a process
  - by which people are brought together to act in common self-interest
  - that draws on the power and persuasion of stakeholders to identify & define common problems, mobilize resources and work together to improve health and quality of life
  - by which a community identifies its needs or objectives, orders, finds the resources, takes action and by so doing develops cooperative and collaborative attitudes and practices in the community
  - of bringing about and maintain an effective link between social resources and social needs within a given locality
- Focus is on the needs of the people(e.g. health needs) and means of meeting the needs in a consistent way



2.0 TEN BASIC STEPS IN ORGANIZATION

1) Integration
   - Mix with the local community and build mutual respect, trust and cooperation
   - How?

2) Social investigation or community study
   - Systematically learn and analyse various structures and forces in the community , problems, interests and attitudes to issues and leaders
   - How? – observation, FDG, participatory and dialogue
3) Issue identification and analysis
   - Define, analyse and rank community problems according to importance, urgency, number of people affected, probability of resolving them through community mobilization
   - How - projects and negotiations

4) Core group formation
   - Involve advanced local leaders spotted during integration process
   - Necessary for mobilization and organization building

5) Ground Work and Community Meeting
   - Motivate people on a one-on-one basis or through informal discussions towards collective action
   - May use aid of core group
   - Aims to bring about the emotional, mental and physical energies of the people

6) Role playing
   - Simulation practice for the community members who are tasked to negotiate with persons or authorities or even the adversary

7) Mobilization or Action
   - High point of the organizing process
   - Is the community's expression of power while confronting the powerful

8) Evaluation and/or Reflection
   - An activity conducted after every action or mobilization to extract lesson learned on how to improve future mobilizations
   - Vital part in the training of the core group and the community
   - Self-assessment of the participants

9) Formalization of the community based organization

10) Phase out

3.0 THEORIES OF COMMUNITY ORGANIZATION

3.1 Systems and Ecological Theory

- Focuses on **community maintenance** (establishment and reiteration of deeply held values and social norms)
- For example, a close-knit community might share a common belief in the importance of the family unit or of the need for safe schools
- Business owners who are able to pick up on these systems or "ways of being" within the community will be better informed on marketing their products and services
- Systems theory is closely related to ecological theory, which states that the organization most fit to meet the wants and needs of the community is the one most likely to survive and become profitable e.g. the Asian community in Kenya

3.2 Conflict Theory and Power Dependency

- Today's complex and multicultural communities are often more aligned with the conflict theory
- States that there is an **innate competition** in society between the haves and the have-nots
- Businesses are thus similarly divided into camps, some catering to the needs and wants of more affluent customers - think luxury brands and higher price tags -- whereas other companies are geared toward providing essential services and products to people who are on a budget or who prefer to spend less on their everyday needs
- Power dependency is a sociological term which means that some people, and hence some businesses, will acquire more influence as a result of their economic means or earning potential

3.3 Resource Mobilization Theory

- States that members of a community are able to join together to acquire power and resources
- This approach suggests an idea in line with Marxist theory, which states that alliances of working-class people can form to petition for better rights and working conditions

3.4 Constructivist Theory

- Is the use of informal knowledge to build a business's brand reputation and influence within the community
- As a business owner, this building entails getting involved directly in the inner workings of the community in which your business operates. Sponsor a local sports team, donate some of your profits to a local charity or become the patron for a school event to market your business within the community while at the same time gaining some valuable information on how community members think, feel and respond to the products and services you offer

4.0 GROUP DYNAMICS

4.1 Introduction

- Is the study of human societies in terms of culture, civilization, their functions or how they influence their members, human behaviour and the mental processes with a focus on groups
- Dynamic refers to both the process that occur in groups and the scientific study of the process. briefly, this process include;-
  - i) Group social interactions
  - ii) The impacts of group structures on members behaviour
  - iii) Diversity
  - iv) Usefulness of groups as vehicles for accomplishing group and individual goals
  - v) The way in which groups become cohesive
  - vi) The ability of the group to change over time

4.2 Key Theorists

1) Gustave Le Bon - a French social psychologist whose seminal study, The Crowd: A Study of the Popular Mind (1896) led to the development of group psychology

2) Sigmund Freud - Group Psychology and the Analysis of the Ego, (1922) based on a critique of Le Bon's work, led to further development in theories of group behaviour in the latter half of the twentieth century

3) Kurt Lewin - is the founder of the movement to study groups scientifically and coined the term group dynamics to describe the way groups and individuals act and react to changing circumstances

4) William Schutz - looked at interpersonal relations from the perspective of three dimensions-inclusion, control, and affection

5) Bruce Tuckman (1965) proposed the four-stage model called Tuckman’s stages for a group. Tuckman's model states that the ideal group decision-making process should occur in four stages of forming, storming, norming and performing. Tuckman later added a fifth stage for the dissolution of a group called adjourning (mourning i.e. mourning the adjournment of the group)

6) M. Scott Peck - developed stages for larger-scale groups (i.e., communities) which are similar to Tuckman's stages of group development. Peck describes the stages of a community as pseudo-community, chaos, emptiness and true community

4.3 What is a Group?

- An aggregation of two or more people who to some degree interact with each other (McGrath, 1984)
- Two or more persons who are interacting with each other in a manner that each person influences and is influenced by the other person (Shaw, 1981)

- A social unit which consist of two or more individuals who stay in definite status and role relationship to one another and which possesses a set of values or norms of its own regulating the behaviour of individuals at relating in matters for consequence to the group (Sheriff and Sheriff, 1954)

4.4 Categories of Groups

1) Primary group
   - A group that persists for long enough to develop strong emotional attachment between members
   - Members have their defined functions or roles and a subculture of its own which include and image of the group as an entity and an informal normative system which controls the group actions e.g. an ideal example is the family
   - There is a sense of personal loss when a member is separated from that group

2) Secondary group
   - Group organized mainly to get a job done
   - Group is personal and performance is according to standards of effectiveness, of excellence takes priority of a personal feelings and attachment e.g. the work organization
   - Many groups may not conform to the above two descriptions but may fall in between

4.5 Characteristics of True Groups

1) Interaction
   - Makes members influence one another e.g. offering advice to one another, sharing experiences, asking reactions about their work
   - Is the key ingredient in influencing every members behaviour in the group
   - May be physical, verbal, non-verbal, emotional etc.

2) Structure
   - Refers to a stable pattern of relationship among its members
   - Is defined in terms of *role, status* and *attraction*
     a) Role
        - It is a set of expectations which the group members share concerning the behaviour of a person who occupies a given position in the group
        - Involves – behaviours performed by one member in light of the expectation of group members share about that position e.g. vice chancellor

     b) Status
        - Refers to the individual group members standing and relative to the other members of the group
        - Those in the high status have power to influence others
        - Status and roles are interrelated e.g. the vice chancellor

     c) Attraction
        - Is the extent to which group goals conform to individual members goal
        - The higher the conformity, the greater the group attraction to an individual
        - A group has high attraction to an individual when she/he perceive that it can fulfil an individual's goal
3) Size
   - Groups vary considerably in size
   - The smallest group is the **dyad** (two members), **eriyed** (3 members), small group that consist of 4 - 20 members and **society** has 20 – 40 members
   - The large group is that comprising of more than 40 members

- Size is important because of the direct influence on the other aspects of the group

4) Bonds
   - A group exists for a reason as they are goal oriented and much of the world's work is done by groups rather than individuals
   - It is in groups that we solve problems, create problems, create standards, communicate knowledge, have fun, ensure safety/security etc.; because groups make it easier to attain our goals

5) Cohesiveness
   - Is the strength of relationship linking group members to one another and to the group itself
   - At the individual level, cohesiveness comes from each members attraction to each member
   - Attraction is based on the liking, the respect and the trust that we have for them
   - At the group level, cohesiveness is reflected by the "we feeling" that joins people together to form a single unit
   - Enjoyment and satisfaction are usually much more pronounced in highly cohesive group members and less in non-cohesive groups. In cohesive groups, members tend to participate more fully in group activities and communicate more frequently. They also experience higher self-esteem and less anxiety because the group provides higher source of security and protection. Cohesive groups have a higher capacity to retain their members

6) **Temporal change**
   - Groups undergo developmental changes with time and new experiences in their interactions during the various phases of group development
   - Two theories have been forwarded to explain the changes in groups
     i) **Cyclical theory** - states that certain issues dominate group interactions during the various stages of group development but this issues can recur later in the life of the group
     ii) **Successive theory** - states that group development occurs in a certain order and this theory assumes that group norms are in five stages

4.6 Group Formation

- The FSNPA model takes the team through five stages of team development
- Intimacy of a small group is lost, and the opportunity for misinformation and disruptive rumors grows

Table 7.1: Stages of Group Formation - Bruce Tuckman (1965)

Stage	Name	Characteristics
1.	Forming	• Stage of finding out about the task, rules and methods, acquiring information or resources, and members rely greatly on their leader • Involves - coming together, members discover what behaviours are acceptable to the group, hesitant participation, uncertainty of purpose, complaints about organizational "environment", suspicion, fear and anxiety about new situation • Leadership not accepted and minimum task accomplishment
2.	Storming	• Internal conflict develops; members resist the task at the emotional level • Individuals can become overzealous or hostile s they "jockey for position" • There is in-fighting, defensiveness and competition (inter-group fighting), conflict, tension, jealousy, instability and polarization of team members • Minimum task accomplishment

Stage	Name	Characteristics
3.	Norming	• Conflict is settled, cooperation develops, views are exchanged and new standards (norms) developed • Emotional conflict is reduced, people accept others and the team and roles • There is harmony, minimal conflict, higher confidence, collective sense of identity, greater trust, respect, sharing of ideas/information and constructive comments and support
4.	Performing	• Teamwork is achieved, roles are flexible, solutions found and implemented • Team is functional, cohesive with established its interpersonal relationships and norms thus capable of making decisions, analyzing and solving problems as synergy is realized • Constructive self-change is accepted and on going • Performance/achievement is high, good results are achieved
5.	Adjourning (Mourning)	• Group disperses after achievement of the collective purpose, completion of the task

5.0 TEAM WORK

5.1 Introduction

- Multi-disciplinary teams are a common feature in many communities with a lot of attention put on creation and team building
- This stems from the **principle of synergism** whose idea is that *"the whole team is greater than the sum of its parts"*. Thus people cooperate to achieve organizational goals

5.2 Teamwork Skills

- A wide variety of social skills are desirable for successful teamwork, including listening, discussing, questioning, persuading, respecting, helping, sharing, participating, communicating and time management

5.3 Teams and Groups

- All teams are groups but not every group behaves as a team. A team is a group in which the contributions of individuals are seen as complementary, such that the cornerstone of the team's activities is collaboration (working together)
- Members of a team co-operate and voluntarily co-ordinate their work in order to achieve team objectives
- Team members are highly interdependent and each person feels inwardly responsible for promoting the interests of the team and personally accountable for its actions.
- Within the team there is a high level of cohesion, interaction, mutual support and shared perception of issues
- Team members are willing to interchange roles, share workloads and help each other out

5.4 Team Roles

Role	Characteristics
Coordinator (chair)	• Has clear view of the team objectives • Skilled at inviting the contribution of team members (rather than just pushing his or her own view) • Is self-disciplined and applies this discipline to all, confident and mature • Prepared to take a decision

Role	Characteristics
Shaper	• Full of drive to make things happen and get things going • Quite happy to push their own views forward • Do not mind being challenged and are always ready to challenge others • Looks for the pattern in discussions and tries to pull things together into something feasible, which the team can then get to work on
Planter	• Most likely to come out with original ideas • Challenge the traditional way of thinking about things • So imaginative and creative • Strength is in providing major new insights and ideas for changes in direction and not in contributing to the detail of what needs to be done
Resource investigator	• Has strongest contacts and networks, • Excellent at bringing in information and support from the outside • Very enthusiastic in pursuit of the team's goals but cannot always sustain this enthusiasm
Implementer	• Well organized and effective at turning big ideas into manageable • Both logical and disciplined in their approach. • Hardworking and methodical but may have some difficulty in being flexible
Team worker	• Most aware of the others in the team, their needs and their concerns • Sensitive and supportive of other people's efforts • Promotes harmony and reduces conflict • Particularly important during stressful or difficult periods
Completer (Finisher)	• Perfectionist • Strong sense of the need for accuracy, rarely needing any encouragement from others because • May frustrate their teammates by worrying excessively about minor details and refusing to delegate tasks that they do not trust anyone else to perform
Monitor /evaluator	• Good at seeing all the options • Have a strategic perspective and can judge situations accurately. • Can be overcritical and is not usually good at inspiring and encouraging others
Specialist	• Provides specialist skills and knowledge and has a dedicated and single-minded approach. • Can adopt a very narrow perspective, sometimes fail to see the whole picture

5.5 Characteristics

- The acronym "**RAPIER**" has been used to summarize characteristics of an effective team as shown below

Characteristic	Description
Reason	Purpose, objectives, strategies, rules
Alignment	Individual's and team's objectives and efforts support those of the organization
Process	How team activities and meetings are conducted, leadership, and procedures, decision-making
Interaction	Openness, sharing ideas, building relationship, no hidden agendas, where interaction is high, people are open and team effectiveness increases
Empowerment	Skills, knowledge, understanding, resources and authority
Results	Achieving effective outcome in an effective, productive manner

5.6 Team Building

- Team building or development, is a coverall term given to methods of developing an effective team
- Team building activities are useful for improving team dynamics, building trust, facilitating communication and teamwork
- The methods of doing this vary widely, and include
  i) Sports
  ii) Simple social activities - to encourage team members to spend time together
  iii) Group bonding sessions - fun activities to get to know team members
  iv) Personal development activities - personal change applied on a group level, sometimes physically challenging
  v) Team development activities – individuals approach problem solving
  vi) Psychological analysis of team roles, and training in how to work better together

5.7 Team Building Essentials

- Accomplishment the goals by working effectively than a group of the same individuals working on their own. You have a strong synergy of individual contributions
- Two critical factors in building a high performance team include
  i) Diversity of skills and personalities
     - People use their strengths in full and can compensate for each other's weaknesses and when different personality types balance and complement each other
  ii) Directing team efforts are directed towards the same clear goals, the team goals
     - Relies on good communication and harmony in member relationships

6.0 COMMUNITY ORGANIZATIONS

6.1 Introduction

- An organization is a group of persons who are working together to achieve a common objective and all people are involved in organizations of all kinds everyday of their lives
- Our lives are affected by the products and decisions of organizations
- Organizations are goal oriented and boundary maintain activity systems
- Are non-profit making organizations that operate within a single locality and run on a voluntary basis and are often self-funding
- Can be formal (name, officials, constitution, formal procedures) or informal (mutual agreement with few formal procedures)
  - Formal organizations are patterns of social interactions and shared perspectives that are deliberately formed or established for certain purposes i.e. the organs are formed for achievement of specific objectives
  - Informal groups are formed when people interested in a problem come together and are direct action groups that get directly to the problem at hand

6.2 Features of Organizations

i) Composition - individuals or groups
ii) Orientation towards goals
iii) Differentiated functions
iv) Rational coordination
v) Continuity through time

6.3 Nature of Organizations

- Organizations are purposive systems (have unity of purpose)
- They are boundary maintaining (vision, mission, target groups)
- Are activity systems (embrace technology)

6.4 Importance of Organizations

1) Main methods by which it is possible to get things done and to achieve goals beyond the reach of individuals
2) Primary vehicle/means by which in a systematic way our lives are rationalized, planned and articulated
3) Provide a setting for a wide range of social processes such as socialization, communication, formation of norms, exercise of power and goal setting and attainment

6.5 Elements of Organizations

1.	Social structure	• Are the patterned or regular aspects of the relationships existing among participants in organizations • Normative structure – includes values, norms and role expectations • Behavioural structure – activities, interactions and sentiments that show some form of regular occurrence
2.	Participants	• Individuals who make contributions to the organization (are social actors) • People are instruments of continuity and change or innovativeness
3.	Goals	• Organizational goals are very important • Goals are a central point of reference in organizations • Specific goals guide decisions
4.	Technology	• May be machines and equipment or technical knowledge (inputs and outputs
5.	Environment	• Every organization exists in a specific physical, technological, cultural and social environment to which it must adopt

6.6 Levels of Organizations

- 2 two levels - locally or community based organizations (CBOs) and outside agencies

Community Based Organizations (CBOs)

- These are the formal or informal types of organizations found in communities
- Play an important and relevant role in providing services at the local level.
- They work in a variety of different fields, such as education, health, the rights of the disabled, gender issues
- Life cycle of local organizations
  a) Stimulation period - people with interest are made aware by outside agencies of through local influence of the need to form a group
  b) Rise period
     - Involves frequent meetings to discuss important matters
     - Constitution drawn and officials/committee members chosen
  c) Carrying on period
     - Longest period that the group carries out its activities
     - Group deals with many problems and aims at focusing and re-focusing
  d) Decline period - some groups decline fast while others persist for a long time

Task

- Identify CBOs dealing with health related issues in your community.
- State their activities

- Examples in Kenya include FHOK (Family Health Option Kenya), YIKE (Youth Initiative Kenya) and KCYP (Kibera Community Youth Programme)

Outside Agencies

- Are organizations based outside the community although they have branches or representatives within the community e.g. government agencies, foreign government agencies, UN agencies
- Usually constituted by the law and address community problems such as health, education, social welfare. Examples – government ministries, international NGOs

1) Government Organizations

a) Government Ministries

	Ministry	Role in Health Promotion
1.	Agriculture, Livestock and Fisheries	
2.	Attorney General and Department of Justice	
3.	Commerce and Tourism	
4.	Defence	
5.	Devolution and Planning	
6.	Education	
7.	Energy and Petroleum	
8.	Environment, Water and Natural Resources	
9.	Foreign Affairs	
10.	Health	
11.	Industrialization and Enterprise Development	
12.	Information, Communication & Technology	
13.	Interior & Coordination of National Government	
14.	Labour, Social Security and Services	
15.	Land, Housing and Urban Development	
16.	Mining	
17.	National Treasury	
18.	Sports, Culture and Arts	
19.	Transport and Infrastructure	

b) Government Agencies and Parastatals

	Agency/Parastatal	Parent Ministry	Role in Health Promotion
1.	KHN	Health	
2.	MTRH	Health	
3.	KMTC	Health	
4.	KEMRI	Health	
5.	KARI	Agriculture	
6.	FPKA	Health	
7.	KEMSA	Health	

2) UN Agencies

	UN Agency	HQ	Role in Health Promotion
1.	WHO		
2.	UNICEF		
3.	UNEP		

4.	UNDP		
5.	ILO		
6.	UNHCR		
7.	UNNESCO		
8.	UN-HABITAT		

3) Foreign Government Agencies

	Agency	Parent Country	Role in Health Promotion
1.	USAID		
2.	UKAID		
3.	JICA		
4.	GTZ		
5.	CIDA		
6.	SIDA		
7.	AMREF		

4) Non-Governmental Organizations (NGOs)

Definition

- A non-profit making, voluntary, service-oriented/development oriented organization, either for the benefit of members (a grassroots organization) or of other members of the population (an agency).
- Social development organization assisting in empowerment of people.
- An organization or group of people working independent of any external control with specific objectives and aims to fulfil tasks that are oriented to bring about desirable change in a given community or area or situation.

Characteristics

i) Voluntary - an element of voluntary participation in the organization
ii) Independent - NGOs are independent within the laws of society, and controlled by those who have formed them or by elected or appointed boards
iii) Not-for-profit - are not for private personal profit or gain; engage in revenue-generating activities, but must use the revenue solely in pursuit of the organization's mission
iv) Not self-serving in aims & related values - NGOs aim to improve the circumstances and prospects of people and to act on concerns and issues detrimental to them

Classification

- Classified according to orientation and level of operation

1) NGOs by Orientation

a) Charitable organizations
   - Operate from top-down with minimal participation by beneficiaries
   - Activities directed in meeting the needs of the poor e.g. food, medicines, shelter transport, schools (carry out relief activities during disasters)
   - E.g. World Vision, Red Cross, World Food Programme, Care International

b) Service orientation
   - Involved in activities e.g. provision of health, family planning, education
   - Programs designed by the NGO and people are expected to participate in its implementation and receiving the service
   - E.g. – Kenya Red Cross, AMREF (flying doctors), WFP, MSF, World Vision,

c) Participatory orientation
- Characterized by self-help projects whereby local people are involved especially in implementation of projects
- People contribute cash, tools, materials, labour
- Examples – Habitat International, FARM[3] Africa (Moyale, Marsabit), COW[4], Cooperative societies (SACCOS)

d) Empowering orientation
- Aim is to help the poor to develop clear understanding of the social, political and economic factors affecting their lives
- There is strengthening of the awareness of the people of their own potential power to control their lives
- Examples - ABANTU, AGI (African Gender Initiative), AWC (African Woman and Child Features Service), AMwA (Akina Mama wa Afrika), African Regional Youth Initiative (ARYI), MYWO (Maendeleo Ya Wanawake Organization), ActionAid Kenya

2) Level of Operation

i) Community based organizations (CBOs)
- Arise out of peoples' initiative and some may be supported by national or international agencies
- Examples – see above

ii) Citywide organizations
- May be created for the sole purpose of helping the poor
- Examples – Rotary clubs, Lions clubs, Associations of community organizations, ethnically based groups, educational groups

iii) National NGOs
- Examples – Red Cross, YMCA, YWCA, professional organizations

iv) International NGOs
- Include organizations like Save the Children, CARE, Oxfam, Ford Foundation, Rockfellor Foundation
- Fund local NGOs and institutions, also implement their own projects

6.7 Roles of NGOs in Kenya

1) Development and Operation of Infrastructure
- Example construct housing, provide infrastructure and operate and maintain infrastructure such as wells or public toilets and solid waste collection services
- Example .....

2) Supporting Innovation, Demonstration and Pilot Projects
- Examples .....

3) Facilitating Communication
- NGOs can facilitate communication upward from people to the government and downward from the government to the people
- Communication upward involves informing government about what local people are thinking, doing and feeling while communication downward involves informing local people about what the government is planning and doing

[3] Food Agriculture Resource Management
[4] Children of the World

- NGOs are also in a unique position to share information horizontally, networking between other organizations doing similar work
- Examples .....

4) Technical Assistance and Training
   - Training institutions and NGOs can develop a technical assistance and training capacity and use this to assist both CBOs and governments.
   - Research, Monitoring and Evaluation

5) Advocacy for and with the Poor
   - NGOs become spokespersons or ombudsmen for the poor and attempt to influence government policies and programs on their behalf
   - May be done through a variety of means ranging from demonstration and pilot projects to participation in public forums and the formulation of government policy and plans, to publicizing research results and case studies of the poor.
   - NGOs play roles from advocates for the poor to implementers of government programs; from agitators and critics to partners and advisors; from sponsors of pilot projects to mediators.

6.8 Aims of NGOs

1) Forster peoples' self-confidence
2) Develop human resource including local leadership
3) Develop the quality of life of people
4) Increasing local peoples' income
5) Increasing productivity

Topic 8: Health Promotion

Objectives

At the end of the lesson the learner shall be able to

1) Discuss principles of health promotion
2) Discuss key concepts of health protection and advocacy
3) Explain the approaches and models of health promotion

1.0 INTRODUCTION

- Over the past three decades, the field of health promotion has emerged as a new way of thinking about the root causes of health and wellness. This thinking has sparked the development of new approaches to improving the health of individuals and communities
- Health promotion means changing behaviour at multiples levels

Level	Action
Individual	Knowledge, attitude, personality, beliefs
Interpersonal	Family, friends, peers
Community	Social networks, standards and norms
Institutional	Rules, policies, informal structures
Public Policy	Local polices related to health practices

2.0 DEFINITION

i) Health Promotion is *"the process of enabling people to increase control over, and to improve, their health" (Ottawa Charter for Health Promotion, 1986).* - The most widely accepted definition of health promotion.

ii) *"Health promotion is the science and art of helping people change their lifestyle to move toward a state of optimal health. Optimal health is defined as a balance of physical, emotional, social, spiritual and intellectual health. Lifestyle change can be facilitated through a combination of efforts to enhance awareness, change behaviour and create environments that support good health practices. Of the three, supportive environments will probably have the greatest impact in producing lasting change." (American Journal of Health Promotion, 1989, 3, 3, 5).*

iii) HP is a combination of educational and environmental supports (organizational, political and economic) for actions conducive to health (Green & Kreuter, 1999)

iv) Health Promotion any combination of educational, legal, fiscal, economic, environmental and organizational interventions designed to facilitate the achievement of health and the prevention of diseases (Tones, 1994)

3.0 MAJOR CATEGORIES OF HEALTH PROMOTION

- HP is broadly categorized into 3 major categories (Tannahill, 1985) namely health education, prevention and health protection

3.1 Health Education

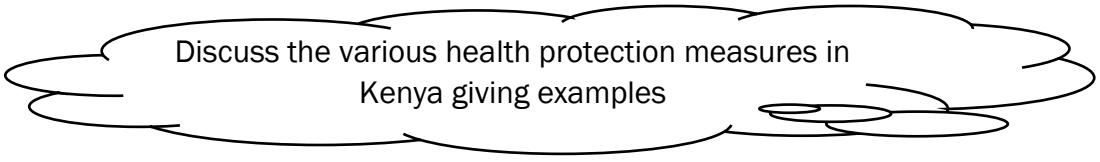
- Is any combination of learning experiences designed to help individuals and communities improve their health by increasing their knowledge or influencing their attitudes (WHO)
- Should also foster the motivation, skills and confidence (self-efficacy) necessary to take action to improve health
- Includes communication of information concerning the underlying social, economic and environmental conditions impacting on health as well as individual risk factors and risk behaviours and use of health care system

3.2 Prevention

- Reduces the risk of occurrence of a disease process, illness, injuries, disability, handicap or some other unwanted events
- There are 4 levels of prevention **(DISCUSS THE 4)**

3.3 Health protection

- Health protection and services include the implementing of laws, rules, or policies approved in a community as a result of health promotion or legislation
- Consists of regulations, policies[5], or voluntary practices that are aimed at improving the living and working environment and prevention of ill health
- Examples - ban on smoking in public places, use of automobile seat belts, mandatory food labelling
- Community health personnel work to identify environmental risks and problems and take the necessary actions to protect the community or population e.g. control of unintentional and intentional injuries; the control of vectors; the assurance that the air, water, and food are safe to consume; the proper disposal of wastes; and the safety of residential, occupational, and other environments
- Protective measures are often the result of educational programs, including self-defense classes; policy development, such as the Safe Drinking Water Act or the Clean Air Act; environmental changes,
- Strategies for prevention include
  i) Environmental or regulatory measures that confer protection on large population groups
  ii) Address issues such as unintentional injuries, occupational safety and health, environmental health, food and drug safety, and oral health
  iii) Interventions to address these issues may include an element of health promotion, but the main approaches involve a community-wide rather than an individual focus



4.0 PRINCIPLES OF HEALTH PROMOTION (WHO)

	Principle	Explanation
1.	Empowerment	HP initiatives should enable individuals and communities to assume more power over the personal, socio-economic and environmental factors that affect their health
2.	Participation	HP initiatives should involve all concerned in all stages of planning, implementation and evaluation
3.	Holistic	Health promotion initiatives should foster physical, mental, social and spiritual health

5

	Principle	Explanation
4.	Inter-sectoral collaboration	HP initiatives should involve the collaboration of agencies from relevant sectors
5.	Equitable	HP initiatives should be guided by a concern for equity and social justice
6.	Sustainable	HP initiatives should bring about changes that individuals and communities can maintain once initial funding has ended
7.	Multi-strategy	HP initiatives should use a variety of strategies and approaches e.g. policy development, organizational change, community development, legislation, advocacy, education and communication

5.0 HEALTH PROMOTION FEATURES

- Health promotion has a number of unique features to ensuring the health and well-being of individuals and communities that distinguish it from other approaches such as population health and disease prevention.

	Feature	Description/explanation
1.	*A Holistic View of Health*	Adopts WHO definition of health HP views health as a positive concept emphasizing social and personal resources as well as physical capabilities (WHO, 1984).
2.	A focus on participatory approaches	HP practitioners address health issues by doing things with people rather than doing things for them. The use of participatory approaches that enable people to take greater control over the conditions affecting their health is perhaps the most important feature of health promotion practice since it embodies key *health promotion values* as; empowerment, social justice and equity inclusion and respect
3.	A focus on the determinants of health	Income and social status, Social support networks, Education Employment and working conditions, Physical environments Social environments, Biology and genetic endowment Healthy child development, Health services
4.	Building on existing strengths and assets	*Health promotion* practice builds on positive factors promoting the health of individuals and communities and not just addressing health problems and deficits. Examples of these strengths and assets include community leaders, existing programs and services, strong social networks, or institutions and events in the community that bring people together
5.	Using multiple, complementary strategies	Health promoters use multiple strategies focused on individuals, families, groups, communities and entire populations (e.g., a region, province or nation) to promote health at the individual and community level. The *Ottawa Charter for Health Promotion* encourages the use of multiple strategies

6.0 THE OTTAWA CHARTER FOR HEALTH PROMOTION

6.1 Background

- The first International Conference on Health Promotion was held in Ottawa, Canada in November, 1986.
- Primarily a response to growing expectations for a new public health movement around the world
- Aim of the conference was to continue to identify action to achieve the objectives of the World Health Organization (WHO) *Health for all by the year 2000* initiative, launched in 1981.
- Was preceded by the Alma Ata Primary Health Care Conference in 1978, and followed by further international health promotion conferences in Adelaide (1988), Sundsvall (1991), Jakarta (1997), Mexico (2000), Bangkok (2005) and Nairobi (2009)

- Each conference continues to strengthen **health promotion principles and practice**, such as healthy public policy, supportive environments, building healthy alliances and bridging the equity gap.

6.2 Basic Strategies for Health Promotion

Advocate

- Good health is a major resource for social, economic and personal development and an important dimension of quality of life
- Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it
- HP action aims at making these conditions favourable through advocacy for health.

Enable

- HP action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential

Mediate

- The prerequisites and prospects for health cannot be ensured by the health sector alone
- HP demands coordinated action by all concerned
- Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health

6.3 Areas for Priority Action

i) Build Healthy Public Policy

- Puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health
- Policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change
- Policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them
- Aim must be to make the healthier choice the easier choice for policy makers as well.

ii) Create Supportive Environments

- Link between people and their environment make the basis of socio-ecological approach to health
- Protect and build environments and conserve natural resources

iii) Strengthen Community Actions

- HP works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health.
- Embraces empowerment, participation, organization and mobilization

iv) Develop Personal Skills

- Health promotion supports personal and social development through providing information, education for health, and enhancing life skills.
- Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

v) Reorient Health Services

- Share the responsibility for HP in health services among individuals, community groups, health professionals, health service institutions and governments
- They must work together towards a health care system which contributes to the pursuit of health.

vi) Moving into the future

- Health is created and lived by people within the settings of their everyday life
- Created by caring for oneself and others by taking decisions and have control of over one's life circumstances
- Make women and men as equal partners in health promotion activities

7.0 THEORIES IN HEALTH PROMOTION

1) Theories explaining health behaviour change in individuals
   a) The Health Belief Model (HBM) - it argues that behaviour can best be understood if beliefs about health are clear and predicts that individuals will act to protect or promote their health if they believe
   b) Theories of Reasoned Action and Planned Behaviour – States that intention to act is the key determinant of behaviour, and that all other factors affecting behaviour are mediated through behavioural intentions which are influenced by attitudes, subjective norms (normative beliefs) and Perceived behavioural control
   c) The Transtheoretical (Stages of Change) Theory - explains the different stages of change which appear to be most common for the majority of behaviour change processes
   d) Social Learning Theory - addresses both the underlying determinants of health behaviour and methods of promoting change. Views change as a product of the interaction between individuals and their environments

2) Theories explaining change in communities
   a) Diffusion of Innovation Theory - explains this process and identifies the most effective ways of encouraging people to adopt innovations
   b) Community Mobilization: Rothman's Framework - the active involvement of community members in identifying their health priorities and developing appropriate actions to deal with these priorities

3) Theories explaining change in organizations
4) Theories explaining the development of healthy public policy

8.0 HEALTH PROMOTION STRATEGIES

i) Health communication
ii) Health education
iii) Self-help/mutual aid
iv) Organizational change
v) Community development and mobilization
vi) Policy development
vii) Advocacy

9.0 APPROACHES TO HEALTH PROMOTION

- There several approaches (**six**) to health promotion

1) The medical approach

- Aims at freeing clients from disease
- Clients remain passive recipients led by experts or professionals
- Crucial value is patient compliance
- Examples - patients' compliance with medical treatments and interventions

2) The behavioural change approach
   - Clients are responsible for their own health
   - Aims at attitude and behaviour change leading ultimately to changes in lifestyle
   - Value of the approach is a healthy lifestyle
   - Example - programmes on healthy eating to prevent heart disease

3) The empowerment approach
   - Work with clients or the community to meet their perceived needs
   - Health workers advocate for clients, allow for discussion, facilitate for them and give them the freedom to choose, and support clients' decisions.
   - Health promoter facilitates client empowerment
   - Example - when dealing with controversial sex issues such as pregnancy termination or premarital sex; the sex educator provides adequate information and facilitates in-depth discussions with the client
   - Provides clients with the freedom to make desired choice based on rational thinking
   - Health professionals then respect their choices

4) The social change approach
   - Addresses inequalities in health based on class, race, disabilities, disease or gender
   - Top-down approach using political action to change the physical and social environment
   - Example - have equal access to information, education, employment, services and facilities, and has the right to be treated fairly

5) Education approach
   - Information on cause and effects of health demoting factors
   - Exploration of values and attitudes and development of skills required for healthy living

6) Settings approach
   - WHO (1998) defines a setting for health as 'the place or social context in which people engage in daily activities in which environmental, organizational and personal factors interact to affect health and wellbeing'.
   - Settings are 'major social structures that provide channels and mechanisms of influence for reaching defined population groups' (Mullen et al., 1995).
   - Facilitates health promotion interventions to focus more on the broader determinants of health rather than simply addressing individual and/or population behavioural risk factors
   - There are 3 key settings - health services, community and education setting
     a) Health Services Setting
        - Ottawa Charter (1986) called for a re-orientation of health services towards health promotion and presented a way to enlarge the scope of health care interventions
        - Involves disease based planning, health care and health inequities, primary care setting, hospital (and other residential care) settings and the health of HSE workforce
     b) Community Setting
        - The Ottawa Charter (WHO, 1986) highlighted the need for active community involvement in matters that affect health, rather than communities merely being passive recipients of professional interventions
        - Involves empowerment of communities and strengthening their capacity to take collaborative action

- The health of people living in disadvantaged communities is determined by structural and environmental conditions such as poverty, poor housing, social discrimination and powerlessness.
- Two distinct community health promotion practices exist
  i) Community-based approaches
     - Individual responsibility for own health
     - Social marketing is the main approach used
     - Professionals are key to solving the problem
  ii) Community development approaches
     - Empowerment of individuals and communities
     - There are strengths and competencies in the community
     - Problem is defined by the community
     - Social justice is the main approach used
     - Professionals are a resource to the community

c) Education Setting
- Education is one of the most important predictors of individual levels of health and reported health behaviour
- Good health is a prerequisite for educational achievement and the school is an ideal setting for young people to learn about the influences on personal and social health
- Health education and health promotion contributes to the preparation of young people for participation in society
- Examples of health improvement opportunities within the EPS model include:-
  i) Teacher training
  ii) Parent initiatives
  iii) Student involvement and participation
     - Opportunities are created for students to become more involved in their school community through participating in the health promoting school process, thereby enhancing self-esteem and self-confidence
     - Support students to take on roles that can enable them to contribute more to their school, their community and to society in general

10.0 HEALTH PROMOTION MODELS

- Different health promotion models are described and most ideas and concepts in these models overlap

HP Models

	Model	Description
i)	Health Persuasion	• Health professionals lead health persuasion activities focused at individuals • Is authoritative and individuals are not given any choices for decisions • Example - a nurse persuading a patient with emphysema to quit smoking for the sake of his health
ii)	Legislative actions	• Interventions initiated by experts or professionals to protect the health and welfare of the community • Example – law on totally ban smoking in restaurants and most indoor public areas
iii)	Personal counselling	• Focuses on the client's specific needs and normally works on one to one basis. • The health worker acts as a facilitator to discuss and negotiate client needs • Decisions are made based on the client's wishes

		• Example, the counsellor works with drug abusers to discuss choices between methadone and conventional drug detoxification programs
iv)	Community development	• Focuses on interventions targeted at the community level • Community identifies their health needs, seeks to empower and makes the best rational choice

COMMUNITY DEVELOPMENT

1.0 WHAT IS DEVELOPMENT?

- Development is a progressive process consisting of a series or parallel successive changes that lead to reasonable satisfaction of a community's material and non-material needs

2.0 COMMUNITY NEEDS

- Unfulfilled needs motivate both in the individual and the community

2.1 Maslow's Theory

- Abraham Maslow (1943) came up with the concept of hierarchy of needs (Maslow's theory)
- Maslow believed that lower level needs must be at least partially satisfied before a higher need is pursued
- The satisfaction of the lower order needs allows the individual to think and to pursue the higher level need
- The last stage where the individual strives for self-actualization represents the individual's need to fulfill his/her own potential and a person that is self-actualized portrays some characteristics

2.2 ERG Theory (E – Existence; R – Relatedness; G – Growth)

- Developed by C. P. Alderfer (1973) through modification of Maslow's hierarchy of needs
- Agreed with the basic idea of groups of needs motivating human behavior but instead of 5 groups of needs he organized then into 3 categories of existence needs, relatedness needs and growth needs

2.3 Aim of Community Development

- Aim of community development profession is the fulfillment of community needs in order to create a self-reliant community i.e. a community that can fulfill majority of its needs without relying on outside help
- Community development needs could be viewed
  i) As either **chronic** or **episodic**.
    - Chronic needs
      - Are always there in the community and members are always aware of them.
      - Motivate behavior towards the achievement of long term goals.
    - Episodic needs
      - Come and go over time e.g. disease outbreak, floods etc.
      - May occur at varying intervals then they fade away until the next time
      - Motivate behavior towards achievement of short and midterm goals e.g. floods

  ii) Development can be **conscious** or **subconscious**.
    - In the course of development communities accumulate experience derived from the initiative of individuals and from these experiences the community gradually formulates a **conscious understanding** of the secrets of success.

- In this sense, the process of development is subconscious i.e. it is carried out before the conscious understanding has been fully acquired. This is enshrined in the social learning theory.

iii) There is **planned** and **natural** development
- Natural development
  - Is the spontaneous almost subconscious progression of communities
  - Usually initiated by individuals or groups of individuals within the community
- Planned development
  - Usually initiated by a person outside the community or the authorities to accelerate social progress
  - Done through special polices, programs or projects
  - Success depends on its ability to provide the necessary conditions and elements required for it to thrive

2.4 Community Development Activities in Kenya

- Included

i) Establishment of social welfare centers or halls in which illiteracy classes and recreational activities were carried out

ii) Establishment of training institutions for training community development workers, 1st in Kabete and 2nd in Maseno

iii) Community betterment schemes were started that first tackled agriculture and health issues. In these schemes work was done on an intensive scale. The first one was started in 1951 in central Nyanza (Siaya) and North Nyanza (Kakamega), and then in 1954 another one was started in Mbooni (Machakos). The activities if these community betterment schemes included: fencing of home steads, digging of pit latrines, improving house facilities, soil conservation, farm planning, building cattle sheds and road making

iv) Women were encouraged to form self-help work groups. Maendeleo ya Wanawake Organization was formed and given the mandate to coordinate activities of women clubs

DISCUSS how community development would influence the health of communities in KENYA