COMMUNITY HEALTH I

DIPLOMA IN CLINICAL MEDICINE & SURGERY

KMTC

1ST YEARS [YEAR 1 SEMESTER 1]

MODULE 11: COMMUNITY HEALTH I

Code: CHE 113; Hours - 30; Credits - 3
Pre-requisite (s): Biology and Chemistry

Module Competence

- This Module is designed to enable the learner identify determinants of disease in the community, plan community health education, design and deliver health promotion messages

Module Outcomes

- By the end of this module, the learner should: -

1. Identify determinants of health status in the community
2. Participate in the process of planning and implementation of Primary Health Care and Community Based Health Care activities.
3. Plan, organize and facilitate health education-related messages
4. Design health promotion materials

Module Units

Module Name	Hours	
	Theory	**Practical**
1. Determinants of health status in the community	**6**	0
2. Health education and health promotion	**10**	0
3. Primary Healthcare and CHBC	**10**	0
4. Health Promotion Materials	**4**	0

Module Content

1. **Determinants of health status:** introduction, community definition, WHO definition, (terms), types of communities, (characteristics of community), functions of community, community feeling, and dimension of community, functions as dimension of community, health and community systems, definition of health, models of health, dimensions of health, concepts of community health, purpose of community health, objectives of community health. (preventive, curative, promotive and rehabilitative health).
2. **Health promotion:** Definition, principles, illness prevention, levels of prevention, health restoration, Ottawa charter.
3. **Health education:** Definition, aims and objectives, health education approaches, steps in carrying out health education program, common topics of health education, methods of health education, planning for heath education and tips for health education.

Module Content - Continued

4. **Primary Health Care (PHC):** definition, characteristic of PHC, principles of PHC, Elements, MDGs – concepts and definitions. SDGs. Vision 2030.
5. **Community Based Health Care (CBHC):** introduction to community based health care and community health strategy.
6. **Health Promotion Materials:** teaching aids, posters, charts, videos, demonstrations, role plays

Teaching Strategies

1. Interactive Lectures
2. small group tutorials
3. Group assignments
4. Participatory learning
5. Group Discussions
6. Assignments

Reference

1. Aggleton, F., Dennison, C & Warwick, I. (2010). Promotion health and Well-being through Schools, (1st Edition). Routledge Publishers. London, Uk
2. Amadan, R. (2010). Planning in Health Promotion Work: An Empowerment Model, London
3. Routledge. Green, J. & Tones, K. (2010). Health Promotion: Planning and strategies, (2nd Ed.).Sage PublicationsLtd. Washington D.C. USA
4. Wood. C.H. (2008). Continuing education for Health workers planning District Programmes. AMREF, Nairobi. Kenya
5. Holimqvist, M. & Maravelias, C. (2010). Managing Health Organizations worksite
6. **E-resources:** case studies, case scenarios, simulations, software

Content Delivery:

Week	Dates		Unit
	From	To	
Week 1:	Introduction		
Week 2:			Definition and approaches to community health
Week 3	Community Health Strategy		Community Health Strategies
Week 4	Health promotion		definitions, principles, Ottawa charter
Week 5:	Health education		Definitions, approaches
Week 6:			Planning for health education, health education topics
Week 7:			Methods of health education
Week 8:			Steps in carrying out health education
Week 9:			**CATS**
Week 10:	PHC		health for all 2000, definitions, characteristics
Week 11			Principles and concepts, elements
Week 12:			Millennium Development Goals, Sustainable Development Goals
Week 13:			CBHC, introduction,
Week 14:			Health promotion materials, health promotion messages
Week 15:			demonstrations
Week 16:			
Week 17:			Study week
Week 18:			End of Semester Examinations

DETERMINANTS OF HEALTH STATUS

Introduction:

Health: (WHO 1948) - A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

Community

- A community is a group of people (a large or small group) living in a certain geographical area and working together for a common goal.
- They share the same resources such as water, climatic and geographic conditions, health services, administration and leadership, as well as disadvantages such as shortages, risks and dangers. Share beliefs and culture
- A group of people with common characteristics or interests living together within a territory or geographical boundary

- community is a collection of people who interact with one another and whose common interest or characteristics gives them a sense of unity and belonging.
- community is a group of people in defined geographical area with common goal and objective and the potential for interacting with one another
- **Disease:** a condition of the living animal or plant body or of one of its parts that impairs normal functioning and is typically manifested by distinguishing signs and symptoms: **(sickness, malady)**
- **Wellness:** is a lifestyle aimed at achieving physical, emotional, intellectual, spiritual and environmental well being.
- **Well-being:** a state of positive health or a person's perception concerning positive health.

- Wellness is the ability to adapt, to relate effectively, and to function at near-maximum capacity and includes:-
- Self-responsibility.
- Nutritional awareness.
- Physical fitness.
- Stress management.
- Environmental sensitivity.
- Productivity.
- Expression of emotion.
- Creativity.
- Personal care.
- Home safety.

Concepts of community

- Those 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. In the past, most individuals could be identified with a community in either a geographical or an organizational sense.

- The characteristics of families living in a community contribute to the overall complexion of that community and in turn the community health care needs.
- The culture contributes to the overall character of a community and in turn its health needs.
- The role of individuals according to their age is often define by culture.in some culture the old are retired from leadership and governing responsibilities whereas in others they are considered.

Community health

- This is the science and art of preventing disease, prolonging life and health efficacy through organized community effort. Or
- It's the science and art of promoting health and preventing diseases through organized community participation.
- Is the art and science of maintaining, protecting and improving the health of all the members of the community through organized and sustained community efforts.
- (WHO) refers to the health status of the community, to the problem, affecting their health & to the totally health care provided to the community

- Community health is concerned with the promotion of health and prevention of diseases through close community participation
- The greatest human possession is health and a healthy community is a productive community
- Currently the natural diseases equals to man made diseases/life style diseases like obesity, hypertension, diabetes, cancer, accidents etc.
- Currently the natural diseases equals to man made diseases/life style diseases like obesity, hypertension, diabetes, cancer, accidents etc.
- In our health facilities, 70% of the cases seen are due to communicable diseases which are preventable at community level.
- As a clinician we need to focus on preserving health, promoting health and preventing illness for all the people in the community so that we can improve their health, prolong their life span and reduce workload/disease burden.

- The term ‘community health’ is also referred to as:
  - ✓ Population medicine
  - ✓ Social medicine
  - ✓ Community medicine
  - ✓ Preventive medicine
- **Community medicine:** The study of health and disease in the population of a defined community or group and the practice of medicine concerned with groups or populations rather than individual patients
- **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. Women over fifty, adolescents, adults twenty-five to forty-four years of age, seniors living in public housing, prisoners, and blue-collar workers are all examples of populations

- **Community Involvement:** The active involvement of people living together in some form of social organization and cohesion in the planning, operation and control of primary health care, using local, national and other resources. In community involvement, individuals and families assume responsibility for their and their communities' health and welfare, and develop the capacity to contribute to their own and their communities' development.
- **Community Health Worker:** A trained health worker who works with other health and development workers as a team. The community health worker provides the first contact between the individual and the health system.

- The types of community health worker vary between countries and communities according to their needs and the resources available to meet them. In many societies, these workers come from and are chosen by the community in which they work. In some countries they work as volunteers; normally those who work part-time or full-time are rewarded, in cash or in kind, by the community and the formal health services.
- **Health promotion:** may be defined as any combination of educational and social efforts designed to help people take greater control of and improve their health. Health protection and health services differ from health promotion in the nature or timing of the actions taken. Health protection and services include the implementing of laws, rules, or policies approved in a community as a result of health promotion or legislation

- **COMMUNITY HEALTH PRACTICE:** It is part of the larger public health effort that is concerned with preserving and promoting the health of specific populations and communities.
- Community health practice incorporates six basic elements:
  - Promotion of health
  - Prevention of health problems
  - Treatment of disorders
  - Rehabilitation
  - Evaluation
  - Research

Environment

- The sum total of all surroundings of a living organism, including natural forces and other living things, which provide conditions for development and growth as well as of danger and damage.
- Also defined as "the sum of all external conditions affecting the life, developments and survival of an organism".
- is all that which is external to the individual human host
- The term environment comes from the French word **"environmer"** which means 'surroundings'.
- Comprises all things that make up your surroundings,
- Everything, which surrounds us whether, living or a non-living is a component of our environment.
- The complex of physical, chemical, and biotic factors (as climate, soil, and living things) that act upon an organism or an ecological community and ultimately determine its form and survival
- The aggregate of social and cultural conditions that influence the life of an individual or community

TYPES OF ENVIRONMENT

- **Biological** - living things e.g. animals and micro organisms.
- **Physical** - physical, geographical & chemical features e.g. land, mountains, climate, chemicals substances.
- **Socio-cultural** - customs, beliefs, religions, leadership and power structure, family and kinship.
- **Economic environment** - local community organisation and development policies.
- **Political environment** - policies, political organization.

WHY STUDY COMMUNITY HEALTH (OBJECTIVES)

- Increase the average span of human life
- Decrease the mortality rate(esp. Infant Mortality Rate & Maternal Mortality Rate)
- Decrease morbidity rate
- Increase the physical, mental and social well-being of individual
- Increasing the pace of adjustment of the individual to his environment
- Providing total health care to enrich quality of life

AIMS OF COMMUNITY HEALTH (PURPOSE)

- Improved sanitation in the environment
- Prioritization of the community's needs
- Control of communicable diseases
- Health education to promote healthy behaviour and practices
- Early diagnosis and prevention of disease
- Disease surveillance
- Case/contact tracing and treatment
- Empowerment of all individuals to realise their rights and responsibilities for the attainment of good health for all

Goals of community health:

- Identify community health problems and needs
- Plan ways of meeting community health needs
- Implement activities geared towards
- meeting the community health needs
- Evaluate the impact of community health services/activities

PRINCIPLES OF COMMUNITY HEALTH:

- Availability of health care for all people at a cost they can afford.
- Promotive and preventive aspects of health should be given priority.
- Integration of curative and preventive services.
- Active participation of individuals and community in planning and provision of care.
- Development of maximum potential for self care
- Inter-sectorial approach
- PHC should be integral part of the national health system.
- Decentralization- activities should be carried out at the most peripheral practice levels of health services.
- Utilization of all levels and types of community manpower.
- Reliance on available community resources

BENEFITS OF GOOD COMMUNITY HEALTH:

- Increased life expectancy (life span) of every individual
- Decreased mortality rates particularly of mothers and children
- Decreased morbidity rates from all causes
- An increase in the total well being (physical, mental and social) of every individual
- An increase in the quality of life for all people
- Overall social and economic development of the population

THE THREE FEATURES OF A COMMUNITY

- A community has three features, location, population and social system.

1. **Location:** every physical community carries out its daily existence in a specific geographical location. The health of the community is affected by this location, including the placement of the service, the geographical features…
2. **Population:** consists of specialized aggregates, but all of the diverse people who live within the boundary of the community.
3. **Social system:** the various parts of communities' social system that interact and include the heath system, family system, economic system and educational system.

COMPONENTS OF A COMMUNITY

- People
- Goals
- Environment
- Boundaries
- Social structures
- Social systems
- **Culture** – all those things which people learn, share and pass on to other generation e.g language, beliefs, superstitions, norms etc.
- **Individual** – each individual is different and unique with a mixture of characteristics, some of which they share with others and some of which are part of a particular culture
- **Family** – smallest recognized group of individuals in a community , one of the oldest institution that a mankind has known

Types of families

- Family is the basic unit of a community
- They include:
  - Nuclear – father, mother and children
  - Extended - – father, mother, children, uncles, aunts, grand ma, grand pa, cousins
  - Single parent- father and children or mother and children
  - Blended- a woman brings her children and a man bring his children together to make a family

Functions of a family

- Bringing about a sense of community togetherness and a balance between individual and shared action by each family member; nurturance and trust, stability and integrity of the group, interdependence and the ability to meet demands on survival and development.
- Socializing it's members into the larger community.
- Teaching respect for individual members and their property
- Teaching tolerance, fairness and a sense of right or wrong among it's members and others.
- Caring for it's members and developing a sense of trust between and among it's members
- Providing an environment for learning and internalizing individual and gender roles and responsibilities

Factors affecting family health

Internal factors:

- Family size
- Structure
- Type of members
- Relationship
- Biological characteristics
- values

External factors

- Family locality
- Terrain
- Climate
- Water supply
- Air
- Biological environment
- Housing and residence

Factors that influence health status of an individual

- **Genetic make up** e.g. some blood group associated to dx
- **Sex** e.g. osteoporosis common to women
- **Race** e.g. Africans have high incidence to sickle cell
- **Age and developmental**-distribution of dx vary with age/milestone
- **Lifestyle** e.g. eating, exercises, stress coping, smoking, alcohol
- Mind body relationship- emotional responses/ defence mechanism
- **Standards of living** – occupation, income, education
- **Nutrition**- healthy eating
- **Physical environment** – housing, sanitation facilities- air, food, water pollutants
- **Family**- primary factor in the learning of wellness behaviour e.g. lifestyle, emotional health, social support
- **Cultural beliefs-** some practices promote health others cause illness

Characteristics of a community

- **Distinctiveness** –each community has defined as geographical boundaries having its beginning and end.
- **Homogeneity**- there is similarity in psychological characteristics of people living in the defined boundaries of the community e.g. language, lifestyle, customs etc.
- **Closeness**- the people in the community have face to face interaction and free communication

- **Sense of belongingness** - the degree and intensity of this feeling may vary among members of the community
- **Sense of togetherness** - there is unity and cohesiveness among the members in the community which is based on their interaction and sense of belongingness to community
- **Self sufficiency** - the community provides all such means and facilities which help in meeting the basic needs of its people i.e. space to live, education, protection and security

FUNCTIONS OF A COMMUNITY

- Socialization, education and welcoming newcomers into the group's culture (acculturation)
- Transmitting and sharing information
- Protection, Producing and distributing services and goods
- Providing companionship and support to individual members and smaller groups
- Providing, Sharing and utilizing space for living, schools, housing, shelter, socialization, recreation, health facilities, fields, roads etc.
- Protecting individual and group rights and welfare
- It provides safety and security by protecting the community members
- Linkages with social system outside the community for meeting needs of its members
- Provides opportunity for employment and substance
- Provides opportunities for interaction amongst members , transmits information, ideas and beliefs and provides support systems

Types of communities

- **Community of action** -focused towards achieving milestones
- **Community of practice** - to achieve something. Focus on new things
- **Community of place** - are brought about by geography. Focus on events
- **Community of interest** - share common interest. Focus on passion of interest.
- **Community of substance** - united by challenge not of their making.

- Geographic communities,
  - Defined by geographic boundaries.
  - e.g. Sub-location, location, town, city
  - Identifiable characteristics would be:
  - Age & sex ratios
  - Families, schools, hospitals are linked in a complex network.
  - Informal power structure
  - Communication system includes newspaper, radio station, chief's baraza etc.
- Formal communities
- Informal communities
- Urban communities
- Rural communities
- Global communities
- Sectoral communities
- Social space communities

CHARACTERISTICS OF A HEALTHY COMMUNITY

- Awareness that ‘we are community’
- Conservation of natural resources
- Recognition of natural resources
- Participation of subgroups in community affairs
- Ability to solve problems
- Communication through open channels
- Resources available to all
- Settling disputes through legitimate mechanisms
- Participation by citizens in decision making
- Wellness of high degree among its members

- Environment- Relatively free from hazards (safe)
- Personal hygiene- high
- Water –adequate wholesome supply.
- Food- adequate and nutritious
- Housing- suitable
- Interpersonal relationships- harmonious
- Health facilities- accessible and available.
- Social facilities- Suitable, accessible and available
- Occupational activities-available and stable.
- Sound communication infrastructure.
- Communal approach to & participation in tackling community problems.

Factors affecting the health of a community:

Four major factors that affect the health of a community

- **Physical factors:** geography, environment, community size, industrial development
- **Social cultural factors:** beliefs, traditions, socio economic status, politics, religion, social norms
- **Community organization-** problem identification, resource mobilization, plan design, implementation strategy and active participation, art of building consensus
- **Individual behaviours-** health seeking behaviour, health practices

Other factors that affect health of a community

- Environmental hygiene
- Housing
- Economic factors
- Water supply
- Food
- Stability of family life
- Literacy
- Community participation
- Weather conditions
- Infrastructure
- Leadership
- Socio-cultural factors

Problems that Affect the Health of the Community

- Unsanitary environment
- Overcrowding
- Poverty
- Unclean and inadequate water supply
- Lack of nutritious food
- Unsafe environment
- Epidemic and endemic disease
- Unstable family life
- Illiteracy and ignorance
- Poor leadership and lack of participation
- Adverse weather conditions
- Poor infrastructure
- Political instability

A successful community health programme achieves:

- Increase the average life span of human life
- Decrease the mortality rate (especially IMR (infant mortality rate) & MMR (maternal mortality rate))
- Decrease morbidity rate from all causes
- Increase the physical, mental and social well-being of individual
- Overall social and economic development of the population
- Equitable distribution of resources
- Increasing the pace of adjustment of the individual to his environment
- Providing total health care to enrich quality of life

Examples of community health activities

- Community health assessment and diagnosis
- Information, education and communication
- Environmental sanitation and supply of adequate clean wholesome water
- Food hygiene and household food security
- Personal hygiene
- Vector and pest control
- Control of communicable diseases

- Provision of prenatal services to pregnant women
- Provision of family planning services
- Provision of child health/welfare services for children under five years old
- Provision of school health services
- Home visiting and home-based nursing care
- Occupational/industrial health
- Care of the disabled, the elderly, the disadvantaged, the chronically ill
- Inter-sectoral collaboration

COMMUNITY SUB SYSTEMS:

A community is made up of various sub systems, all of which have a bearing on how people live and behave. For a community to function smoothly the various sub systems must work in harmony.

- Socio- cultural
- Political
- Education
- Religious
- Economic
- Environmental
- Communication
- Transport
- Health care

SOCIAL-CULTURAL: Made up of all the customs and beliefs, family and kinships, leadership and power structures in society. This sub-system exerts a powerful influence on the lifestyles of the community members, their priorities and their attitudes and values towards health and illness.

- **POLITICAL:** Made up of the government and its development policies as well as political organisations.
- **ECONOMIC:** The communities' ability to provide health and other services to its members i.e. the ability to purchase.
- **EDUCATION:** Education is the main tool of changing behaviour and improving individual and community health. The educational system can be effectively used to pass health related information and messages.
- **RELIGIOUS:** The religious teachings, norms and values may affect health positively or negatively

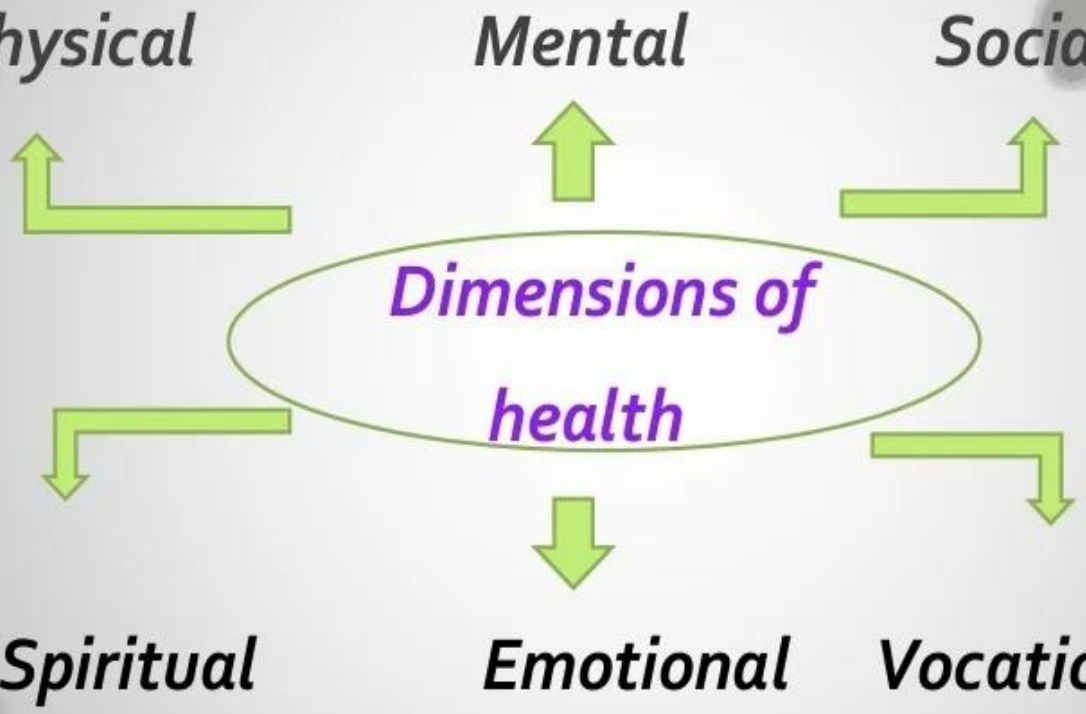
- **COMMUNICATION AND TRANSPORT:** Communication includes all the means of contacting and exchanging information with one another such as roads, bridges, railroad, telephone, television, radio, computers, internet, fax, and postal services.
- **HEALTH CARE:** The health care system exists to provide promotive, preventive, curative and rehabilitative services in hospitals, nursing homes, clinics, health centres, dispensaries, and through special health projects and programs. e.g. Levels of health care in Kenya.

- **ENVIRONMENTAL:** It entails:
  - Clean water supply
  - Proper disposal of waste
  - Adequate housing
  - Pollution
  - Food hygiene
  - Vector control

Dimensions of health

- We define health as a state of complete physical, social and mental wellbeing, and not merely the absence of disease or infirmity. From this definition you can see that health has three dimensions – physical, mental and social – which are interrelated and influence each other greatly.
- As per the definition of WHO there are three dimensions of health:
  - Physical
  - Mental
  - Social
- Dimension of health provide a full picture of health.
- A dimension is a measurement.

DIMENSIONS OF HEALTH



- As the knowledge grows in the minds of people, some other dimension are adding to it which includes spiritual, emotional, vocational and others.
- **Physical dimension:** Implies proper functioning of the body , which health is a biological state in which every cell and organ in function at optimum level, harmoniously.
- **Mental dimension:** Is a state of balance between the individual and the surrounding world, a state of harmony between oneself and others, a coexistence between realities of the self and that of other people and that of the environment.

- **Social dimension:** Implies the persons' ability to interact successfully with people and within the environment of which each person is a part to develops and maintain intimacy with significant others and to develop respect and tolerance for those with different opinions and beliefs.
- **Spiritual dimension:** This implies touch with deeper self and exploring the purpose of life.it is proponent of holistic health in which the person is said to be spiritually healthy , when he/she posses sound mind in a sound body.

- **Emotional dimension:** Relates to feeling in which the person has ability to manage stress and to express emotions appropriately.it involves ability to recognize accept and express feelings to accept one's limitations.
- **Vocational dimension:** A person is said to be healthy if he/she is capable of earning sufficiently to lead the life successfully.
- **Intellectual dimension:** The person has ability to learn and use information effectively for personal, family and career development
- **Environmental dimension:** Is the external factors present around a person and has got influence on health of human being.

Concept of health

- Health is a highly individual perception, meaning and descriptions of health vary considerably.
- Each individual person is different and unique.
- Each has a mixture of some characteristics, some of which they share with others.
- Factors that influence individual's definition of health: developmental status, social and cultural influences, previous experiences, expectations of self, perception of self.

Health care delivery Classification (types of healthcare)

- Health care delivery system" is often used to describe the way in which health care is furnished to the people.
- A health care delivery system is an organization of people, institutions, and resources to deliver health care services to meet the health needs of a target population.
- Within the broader health system, there are various levels or domains of health care practice. They are often described as a pyramidal structure, with three or sometimes four tiers of health care representing increasing degrees of specialisation and technical sophistication, generally with increasing costs of care.
- **Classification** of health care delivery system is by acuity of the client's illnesses and level of specialization of the professionals:-

1. Primary care
2. Secondary care
3. Tertiary care

Primary care

- is the usual entry point for clients of the health care delivery system. It is oriented towards the promotion and maintenance of health, the prevention of disease, the management of common episodic disease and the monitoring of stable or chronic conditions.
- Primary care ordinarily occurs, in ambulatory settings. The client or the family manages treatment with health professionals providing diagnostic expertise and guidance.
- The “first” level of contact between the individual and the health system.
- Essential health care (EHC) is provided.
- A majority of prevailing health problems can be satisfactorily managed.
- The closest to the people.
- Provided by the primary health centers.
- Health is not a gift that could be given to communities by health professionals.
- Communities can achieve better health status through their own efforts and the health worker’s role is to help them identify their problems and to point out methods for dealing with the problems.

Secondary care

- It involves the provision of specialized medical services by physician or a hospital on a referral by the primary care provider.
- A patient has developed a recognizable sign and symptoms that are either definitively diagnosed or require further diagnosis. It is oriented towards clients with more severe acute illnesses or chronic illnesses that are exacerbated. If hospitalization occurs it is usually in a community (district) hospital. Most individuals who enter this level of care are referred by primary care worker, although some are self referred.
- The physicians who provide secondary care are usually specialists and general practitioners.

Tertiary care

- It is a level of care that is specialized and highly technical in diagnosing and treating complicated or unusually health problems.
- Patients requiring this level often present in extensive and complicated pathological conditions. It is the most complex level of care. The illness may be life-threatening, and the care ordinarily takes place in a major hospital affiliated by a medical school. Clients are referred by workers from primary or secondary settings. The health professionals, including physicians and nurses tend to be highly specialized, and they focus on their area of specialization in the delivery of care.

Health care delivery (focuses and involves)

- **Preventive:** is aimed at stopping the disease process before it starts or preventing further deterioration of a condition that already exists.
- **Curative:** is aimed at restoring the client's health.
- **Rehabilitative:** is aimed at lessening the pain and discomfort of illness and helping clients live with disease and disability.
- **Promotive** – aimed at enabling people increase control and to improve their health. Moves beyond a focus on individual behavior towards a focus on individual behavior towards a wide range of social and environmental interventions e.g. mass media campaigns on a disease prevention

Levels of health care (as per Kenya Essential Package for Health) - (KEPH)

- It also defines where health services will be delivered. The preventive and curative services will be provided at six levels of care.

Level 1 - the community level

- This is the foundation of the service delivery priorities. Once the community is allowed to define its own priorities and once services are provided that support such priorities, real ownership and commitment can be expected. Important gains can be reached to reverse the downward trend in health status at the interface between the health services and the community.
- This level comprises all community based demand creation activities, that is, the identification of cases that need to be managed at higher levels of care ,as defined by the health sector.
- Village Health Committees (VHCs) are organized in each community through which households and individuals can participate and contribute to their own health and that of their village.

Level 2-3 (Dispensaries, health centres, maternity and nursing homes)

- These health facilities handle KEPH activities related predominantly to promotive and preventive care, but also various curative services.

Level 4-6 (primary, secondary and tertiary hospitals)-sub county, county & national/ referral hospitals

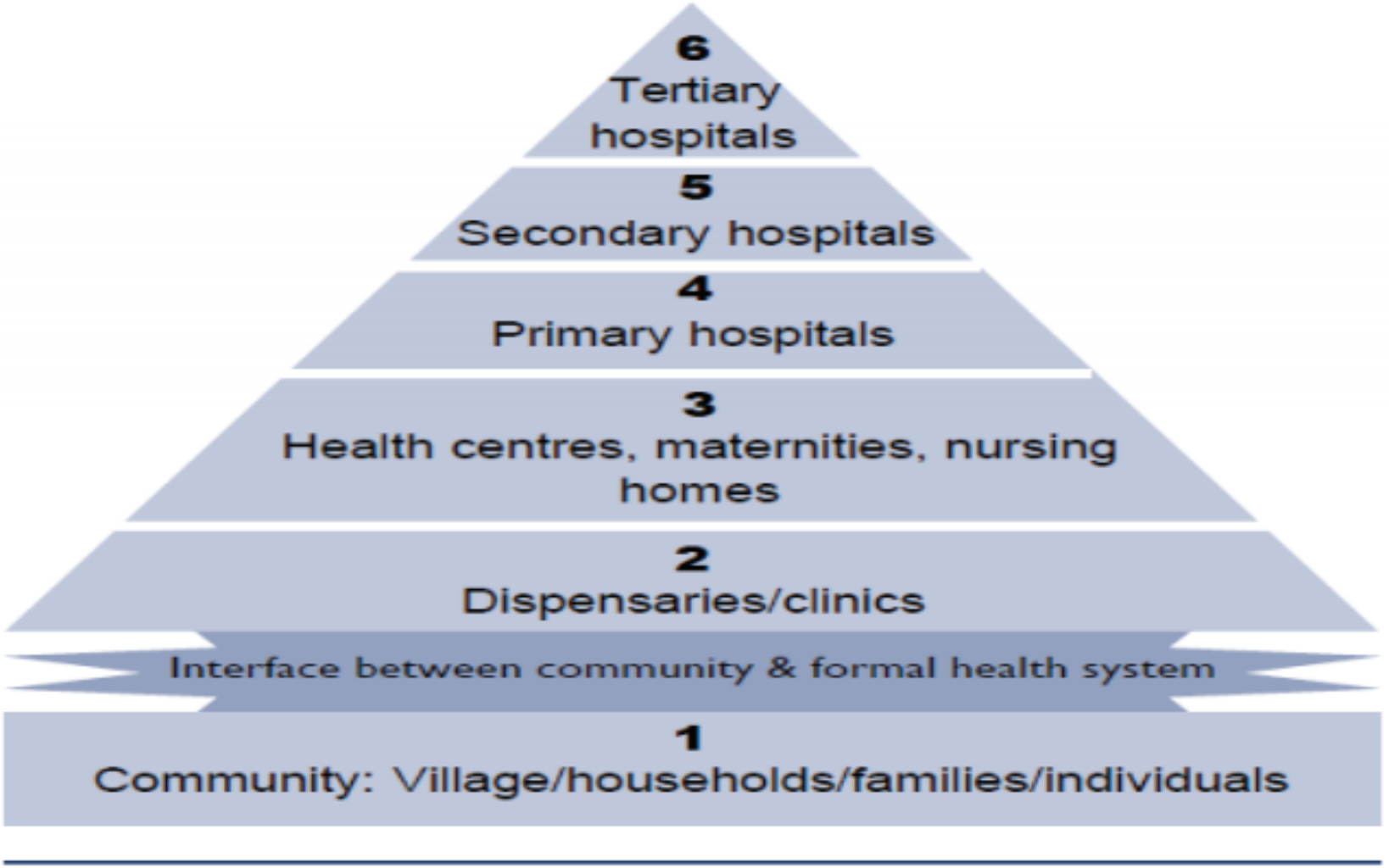
- These facilities are supposed to undertake mainly curative and rehabilitative activities of their service delivery package. They will also address to a limited extent preventive/promotive care.

Summary of Levels of health care in Kenya:

- Level 1: community services
- Level 2: dispensaries and clinics;
- Level 3: health centres and maternity and nursing homes;
- Level 4: sub-county hospitals and medium-sized private hospitals
- Level 5: county referral hospitals and large private hospital
- Level 6 – National Referral Hospitals.

Level of care

Figure 2: KEPH Health Service Levels



Source: KHSSP 2005-2010

The 4-Tier system in organization of health service (Kenya Health Sector Strategic Plan III (2012-2017)

The policy is aligned to constitution of Kenya 2010 and global health commitments. The policy states that under the devolved system, health care facilities are organized into four tiers (levels) as follows;

- **Tier 1:** Community
- **Tier 2:** Primary Care level-Previous KEPH levels 2 and 3
- **Tier 3**: County level – Previous KEPH level 4
- **Tier 4:** National level – Previous KEPH levels 5 and 6

The four levels of MOH

The Ministry of Health operates at four main levels

The four main levels are:

- Level 4: National referral
- Level 3: County hospitals
- Level 2: Primary care facilities
- Level 1: Community care

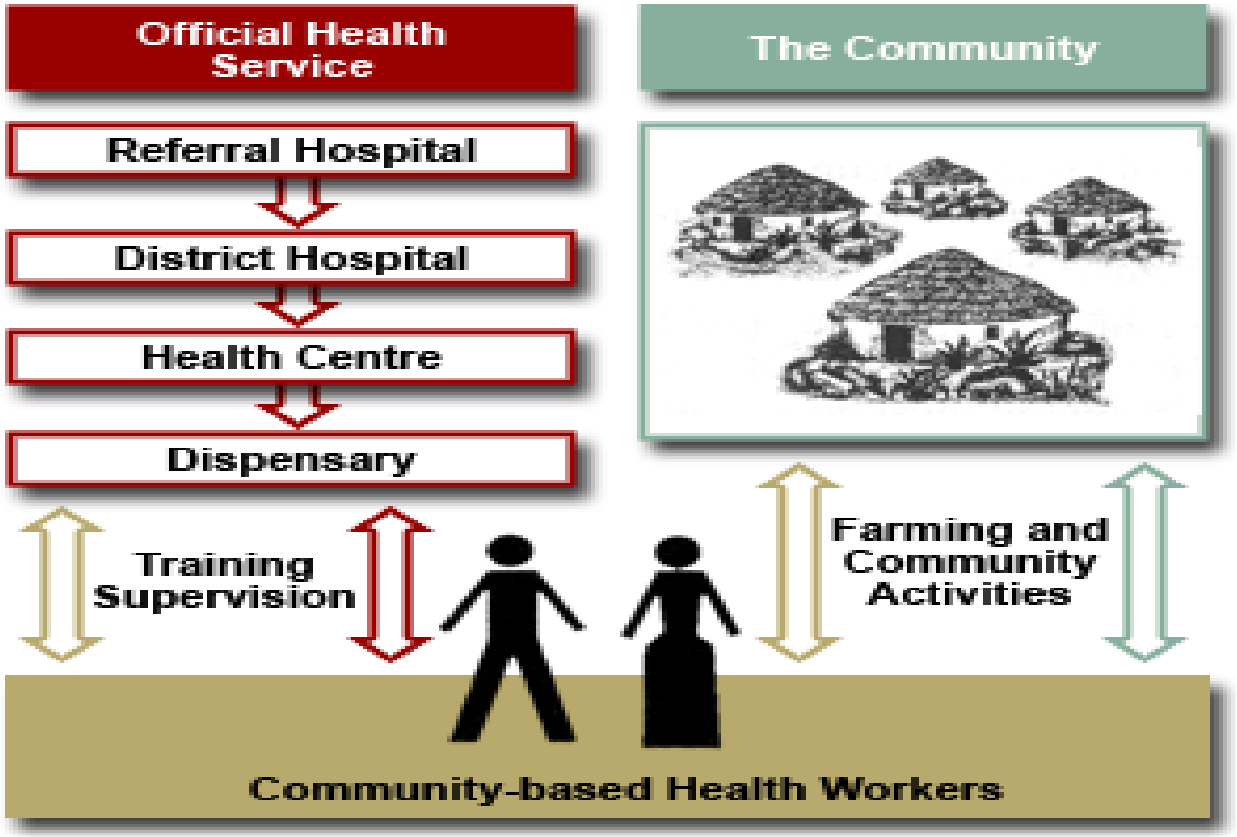
Tiers

Tier 1 Community

Tier 2 Dispensary/HC

Tier 3 County

Tier 4 National



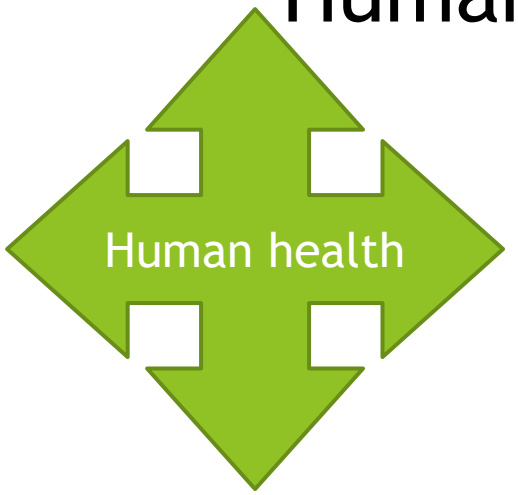
Determinants of disease

- **Disease** is the abnormal state in which all or part of the body is not functioning properly
- A **determinant** is any factor or variable that can affect the frequency with which a disease occurs in a population.
- They are divided into two: Intrinsic and extrinsic
- Intrinsic determinants are physical or physiological characteristics of the host or disease agent (or intermediate host or vector, if present) which are generally determined genetically. Extrinsic determinants are normally associated with some form of environmental influence on the host or disease agent (or intermediate host or vector, if present). They may also include interventions made by man into the disease process by the use of drugs, vaccines, dips, movement controls and quarantines.

Determinants of community health

Human biology

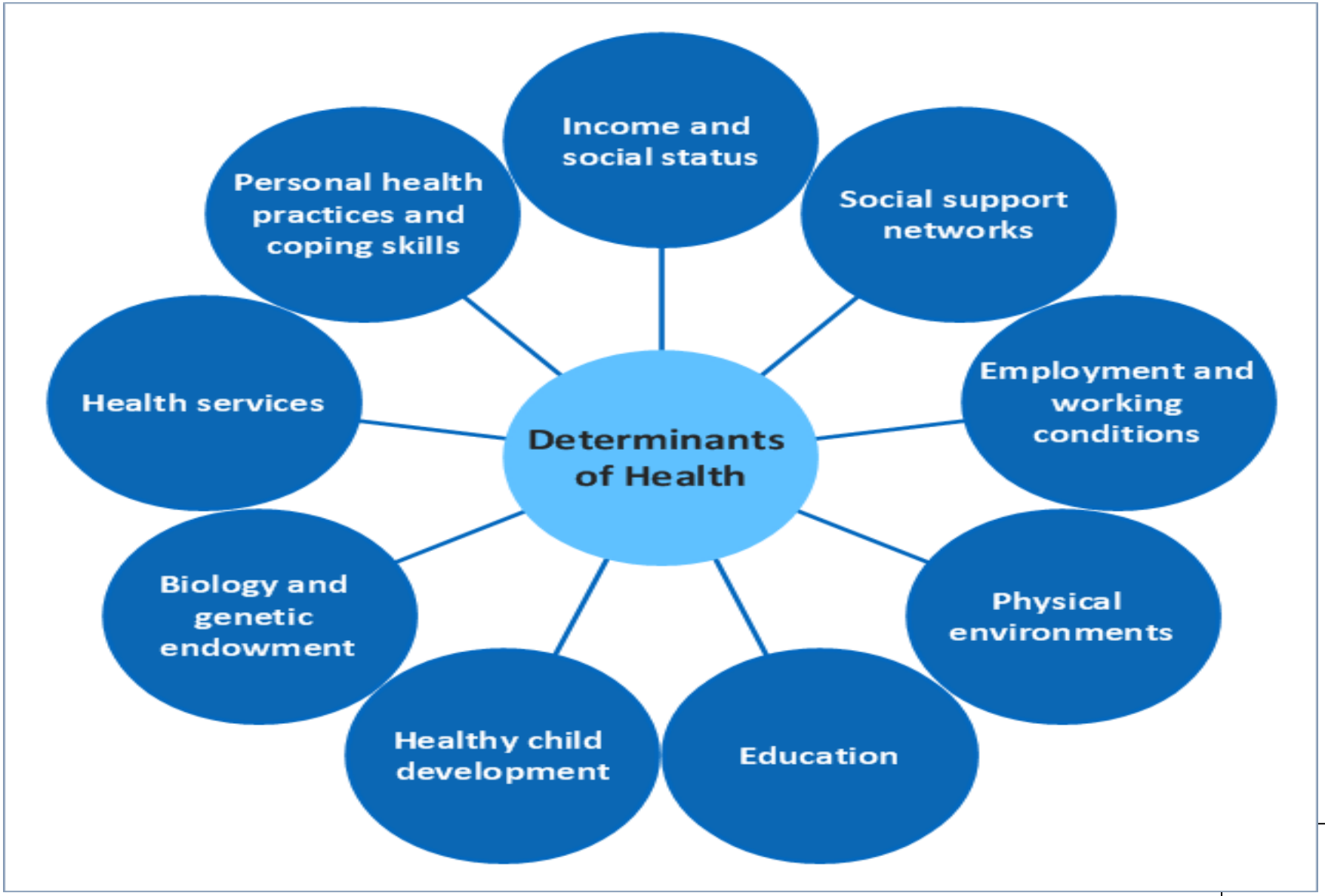
Health care organization



lifestyles

environment

Determinants of health: The range of personal , social, economic and environmental factors that influence health status



Stages of disease development:

- After an infectious agent invades a host (patient), it undergoes a series of phases (stages) that will eventually lead to its multiplication and release from the host.

Stage 1: Incubation period

- This refers to the time elapsed between exposure to a pathogenic organism, and from when symptoms and signs are first apparent. It may be as short as minutes to as long as thirty years in the case of variant Creutzfeldt–Jakob disease. While the term latency period is used as synonymous, a distinction is sometimes made between incubation period, the period between infection and clinical onset of the disease, and latent period, the time from infection to infectiousness. Whichever is shorter depends on the disease.

Stage 2:Prodromal period

- in this phase, the numbers of the infectious agents start increasing and the immune system starts reacting to them. It is characterized by early symptoms that might indicate the start of a disease before specific symptoms occur. Prodromes may be non-specific symptoms or, in a few instances, may clearly indicate a particular disease. For example fever, malaise, headache and lack of appetite frequently occur in the prodrome of many infective disorders. It also refers to the initial in vivo round of viral replication.

Stage 3: period of illness

- This stage is characterized by active replication or multiplication of the pathogen and its numbers peak exponentially, quite often in a very short period of time. Symptoms are very pronounced, both specific to the organ affected as well as in general due to the strong reaction of the immune system . After the pathogen reaches its peak in newly-produced cells or particles (for viruses), the numbers begin to fall sharply. Symptoms are still present but they are not as strong as in the acute illness phase.
- The very peak of an illness' intensity, where you can most easily spread around these microbes, is known as the acme point.

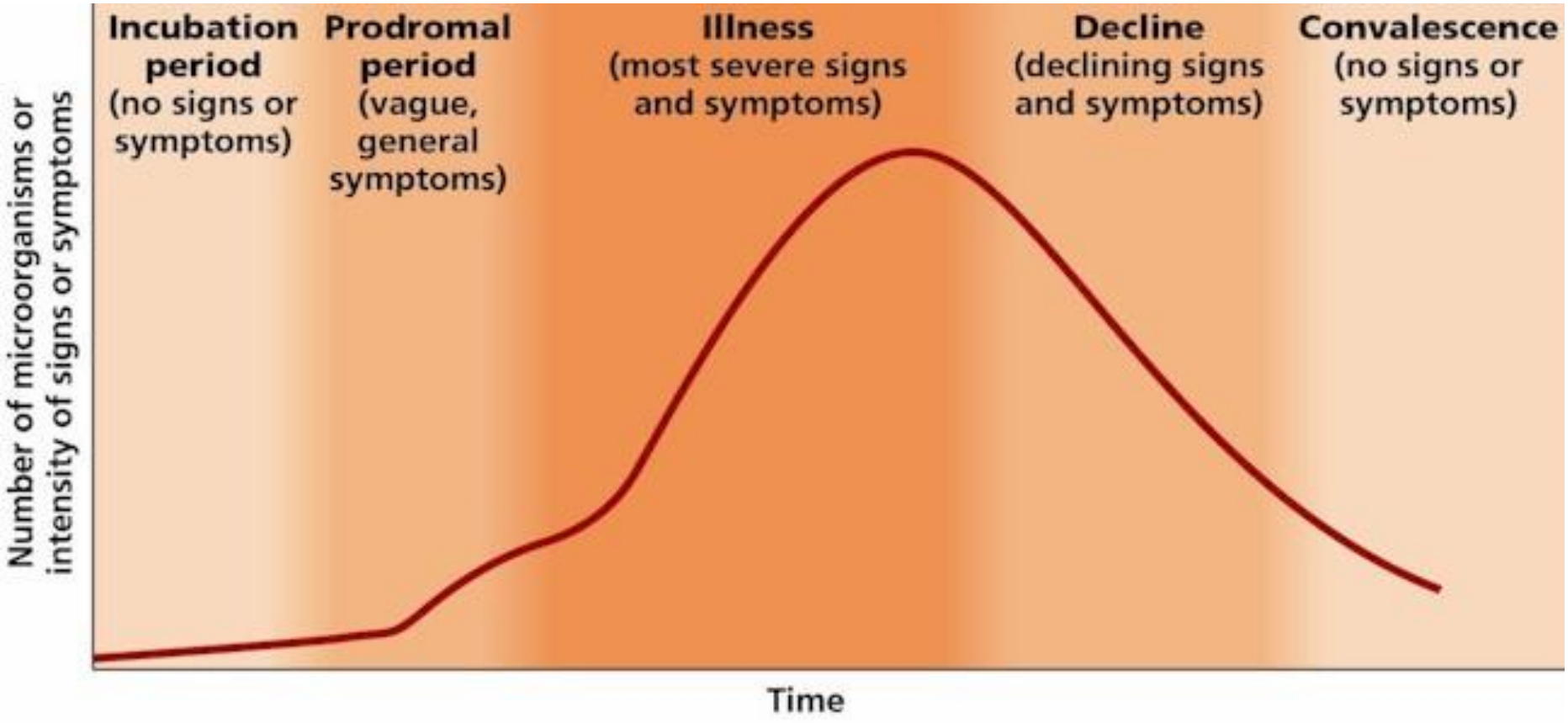
Stage 4 :The period of decline

- Is the stage of disease development where the immune system begins to bring microbial replication under control, which leads to the lessening of clinical signs and symptoms associated with the disease.
- Essentially, you can liken this phase to the train's engineers, our immune system, finally getting the upper hand in fighting off the disease-causing pathogens and fixing our body up enough to get us moving and feeling a bit better.

Stage 5:Period of convalescence

- This is the fifth and final stage of the disease process, one where microbial replication is fully stopped and the person returns to the pre-illness state. In short, this is the stage where the person recovers from their disease.
- However, that definition comes with a catch or two. In some cases, depending on the disease, the person may not proceed to the period of convalescence and may die from their disease or be disabled.

Stages of disease development:



Levels of disease prevention

- **Prevention** includes a wide range of activities — known as "interventions" — aimed at reducing risks or threats to health. You may have heard researchers and health experts talk about three categories of prevention: primary, secondary and tertiary. What do they mean by these terms?
- Prevention is the action aimed at eradicating, eliminating or minimizing the impact of disease and disability
- **Disease prevention** refers to the process and action of negating the occurrence and progression of disease at any stage in its natural history

Levels of Disease Prevention

- Disease prevention may be classified as primordial, primary, secondary or tertiary depending on the time of intervention in relation to the natural history of disease.
- **Primordial prevention:** refers to prevent development of risk factors in a population group which have not yet appeared i.e. health education to discourage people from adopting harmful life style
- **Primary Prevention:** refers to the action of preventing the development and occurrence of disease in persons who are well through specific protective measures such as immunization in the case of immunization preventable diseases, using condoms

in the prevention of sexually transmitted diseases and environmental sanitation in the case of waterborne diseases, or through general health promotion (health communication and education), including provision of conditions that favor healthy living, such as good nutrition, adequate shelter, clean water, adequate appropriate health education and stress free social environment. This is applicable during the period of susceptibility, often by altering susceptibility and reducing exposure factors.

- **Primary Prevention** aims to prevent disease or injury before it ever occurs. This is done by preventing exposures to hazards that cause disease or injury, altering unhealthy or unsafe behaviors that can lead to disease or injury, and increasing resistance to disease or injury should exposure occur.

- Examples include:
- legislation and enforcement to ban or control the use of hazardous products (e.g. asbestos) or to mandate safe and healthy practices (e.g. use of seatbelts and bike helmets)
- education about healthy and safe habits (e.g. eating well, exercising regularly, not smoking)
- immunization against infectious diseases.

Secondary Prevention

- Aims to reduce the impact of a disease or injury that has already occurred. This is done by detecting and treating disease or injury as soon as possible to halt or slow its progress, encouraging personal strategies to prevent re-injury or recurrence, and implementing programs to return people to their original health and function to prevent long-term problems.

- Refers to early detection and identification of disease, usually through screening, and intervening in its early stages, normally resulting in complete cure. In the case of communicable diseases, this entails early detection and prompt treatment, thus reducing the chances of disease spreading to other persons. Examples of application in non-communicable diseases include breast cancer, cervical cancer, etc.
- The control of many chronic diseases such as hypertension and diabetes also falls here. **Screening** and **case finding** are applicable in secondary prevention.

- Examples include:
- regular exams and screening tests to detect disease in its earliest stages (e.g. mammograms to detect breast cancer)
- daily, low-dose aspirins and/or diet and exercise programs to prevent further heart attacks or strokes
- suitably modified work so injured or ill workers can return safely to their jobs.

Tertiary Prevention

- aims to soften the impact of an ongoing illness or injury that has lasting effects. This is done by helping people manage long-term, often-complex health problems and injuries (e.g. chronic diseases, permanent impairments) in order to improve as much as possible their ability to function, their quality of life and their life expectancy.

- Refers to taking action to prevent further deterioration and disability, alleviating suffering and slowing progression, in situations where disease cannot be cured. Often actions include rehabilitation and other forms of terminal care, including both physical and psychosocial interventions

HEALTH PROMOTION

HEALTH PROMOTION

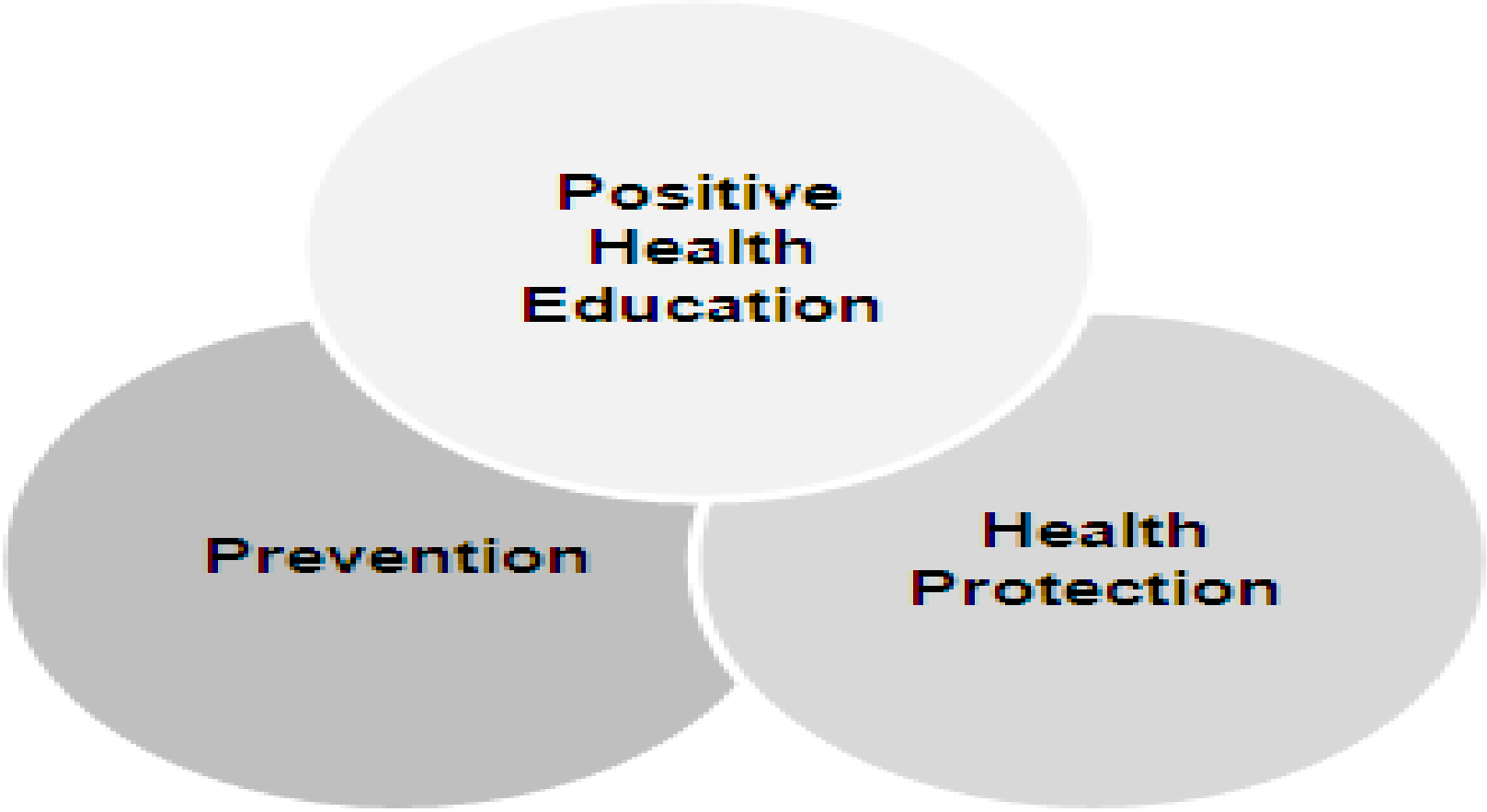
- It is the process of enabling people to increase control over and to improve their health (Ottawa H.P. Charter).
- Integrates all dimensions of health- physical, social, mental and spiritual
- Main aim is to help people to develop personal skills, create supportive environment, strengthening communities and influencing governments to enact health public policies
- Health promotion (HP) refers to 'health enhancing activities' which focus on individuals, groups or the whole population
- HP is involves everyone in different sectors of society or community

- Health promotion is a process of enabling people (individuals and communities) to increase control over the determinants of health, and thereby improving it.
- Consists of general non specific interventions that enhance health and the body ability to resist disease e.g. improving social economic status, adequate clothing, housing, food, emotional and social support(healthier and happy life).
- Health education is a central tool to this process, but not the sum of it
- It was considered by the WHO to be a major strategy of achieving health care for all by the year 2000
- It is concerned with all the factors that influence health
- Health promotion is acknowledged as an inter-sectoral activity and is not considered to be a preserve of the medical services

Definition:

- **The process of enabling people to increase control over the determinants of health and thereby improve their health (WHO, Ottawa Charter)**
- Any combination of educational and social efforts designed to help people take greater control of and improve their health

Major Categories (components) of health promotion:



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).
2. **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, or voluntary practices that are aimed at improving the living and working environment and prevention of ill health.

3. **Prevention** (intervention Programmes)

Level	Examples
Primordial	Policy formulation, regulations
Primary	Reduced risks e.g. healthy life style, immunization
Secondary	Screening, Treatment
Tertiary	Rehabilitation programmes

OTTAWA CHARTER FOR HEALTH PROMOTION:

- It is a name of international agreement signed at the first international conference on health promotion, organized by WHO and held in Ottawa –Canada, 21st November 1986
- It launched a series of actions among international organizations, national governments and local communities to achieve the goal of "Health For All" by the year 2000.
- THE SWIRLING DIAGRAM- illustrates the idea that activities will coalesce and thereby enable people take control over therefore improving their health
- THE OUTER CIRCLE: illustrates the field of health promotion
- SMALL CIRCLE: the role of health professionals

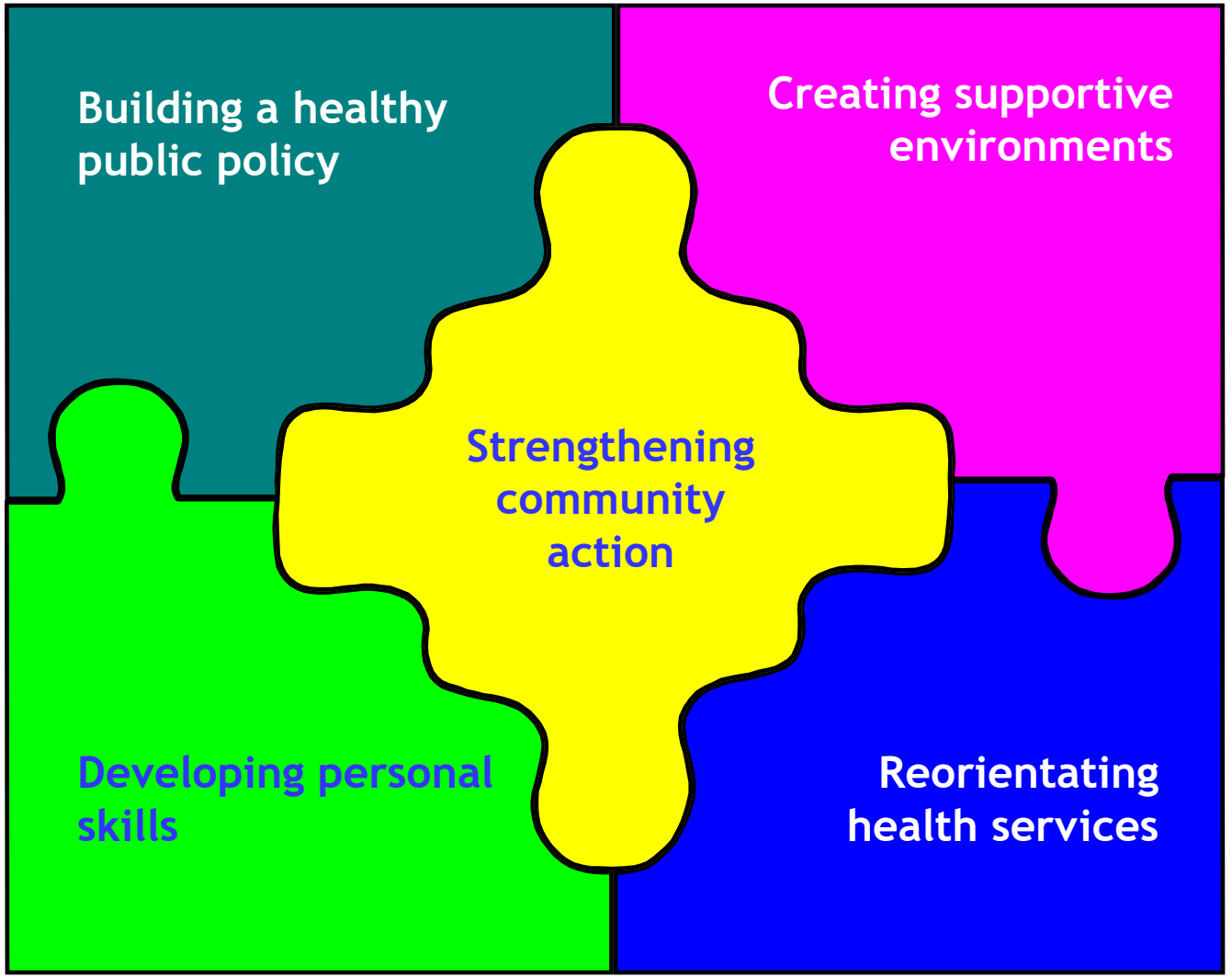
Areas / Strategies For Health Promotion In Ottawa Charter

- A strategy - method or plan chosen to bring about a desired future or a direction and scope of an organization over long term
- HP strategies relate to individual lifestyle (personal choices made in a social context (powerful influence over one's health prospects)
- The strategies set out in the Ottawa charter for health promotion are essential for success:

(Five action (priority) areas / strategies for health promotion in Ottawa charter)

1. Building Healthy public policy - legislation, adopt healthy public policies
2. Creative supportive environments - protection and conservation of natural resources
3. Strengthen community actions - self help and social support
4. Develop personal skills - enable people to learn
5. Reorient health services - Re- orienting health care services towards prevention of illness and promotion of health
6. Moving into the future - guiding principle people to be equal.

IMPORTANT AREAS FOR CONSIDERATION IN HEALTH PROMOTION



Build healthy public policy:

- Promotes healthy policies in all sectors , e.g. healthy workplaces, schools, homes, buildings, villages and communities.
- Health aspect should be thought of and included in the policies of the various sectors.
- Health Policies should also emphasize the prevention and promotion.

Reorienting health services

- Since lifestyle is linked to many of today's health problems, prevention and promotion should decrease the burden on secondary (curative) health care.
- Greater emphasis and resources placed on health promotion and primary health care.
- Less emphasis on purchase of high tech equipment for secondary health care.
- Equity in health care.

Empowering communities to achieve well-being

- Involvement of the community in health decisions, a multisectoral and participatory approach.
- Provide communities with the information and tools to take actions to improve health and well-being.

Creating supportive environments:

- Healthy physical, social and economic environment.
- All development activities should aim for a healthy environment – healthy buildings, roads, workplaces, homes, surroundings and schools.

Developing /increasing personal health skills

- Information and education for personal and family health.
- Take account of values, beliefs and customs of the community.
- Continuous process at all stages of life.
- Guided and supported in developing skills (not imposed on them).
- Build on existing knowledge and attitudes.

Building alliances with special emphasis on the media

- Media key players, influence on health of people.
- Partnership with media ensures their collaboration and that correct information is passed on.
- Free flow of information both ways, on matters vital to health.

Basic principles / strategies of health promotion

According to the Ottawa Charter for Health Promotion, the basic principles / strategies of health promotion are:

- Prerequisites for health
- Enable
- Mediate
- Advocate

There are three main types of strategies used in implementation of health promotion:

1. Enabling (Enable) – Taking action in partnership with individuals or groups to empower them, through mobilization of human and material resources to promote and protect their health.

- Health promotion focuses on achieving equity in health.

- Health promotion 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.
- This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices.
- People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health.
- This must apply equally to women and men.

2. Creating environments that are supportive of health (Mediate) - Mediation which the process through which the different interests of individuals and communities and all sectors are reconciled in ways that promote and protect health

- The prerequisites and prospects for health cannot be ensured by the health sector alone.
- More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by non-governmental and voluntary organizations, by local authorities, by industry and by the media.
- People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.
- Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

3. Advocacy to create the essential conditions for health (advocate) - It implies a combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health programme

- 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.
- Health promotion action aims at making these conditions favourable through advocacy for health.

4. **Prerequisites for health**

- The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity.
- Improvement in health requires a secure foundation in these basic prerequisites.

Health Promotion Important Policy Documents

- Ottawa Charter (1986)
- Health for All 21 and WHO key strategies
- European Health Policy (1999)
- National Health Programme (1995)
- National Environment and Health Action Plan of CR (1998)
- Law No. 258/2000 on Public Health Protection (2000)
- Long-term Programme on Improving Health Status of Inhabitants of CR – Health for All 21 (2002).

WHO - Key strategies of health promotion

- Strategy on environment and children health (2002)
- Global strategy on nutrition, physical activity and health (2003)
- Framework convention on tobacco control (2003)
- European action plan against alcohol (2003)
- Declaration on mental health for Europe (2005)

National Health Programme

- Increase the knowledge of people on healthy life style
- Increase the knowledge of people on possibilities of disease prevention
- Encourage changes of behaviour
- Create coalitions for health promotion in the society

Health Promotion - key developments

- WHO definition of health (1948, 1998)
- Declaration of Alma Ata (1978)
  - blueprint for PHC
  - 'Health For All by the Year 2000'
- Ottawa Charter (1986)
  - Laid down principles of HP still followed today
- Jakarta Declaration on Health Promotion into the 21st Century (1997)
- Bancock Charter (OC revisited in 2005)

AIMS

- To improve the equity in health
- To promote healthy lifestyles
- Enable environments that supports health
- Eliminate disparities

10 Key Action Areas for Health Promotion

(Ottawa Charter and Jakarta Declaration)

- Build healthy public policy
- Create supportive environments
- Strengthen community action
- Develop personal skills
- Reorient health services towards primary health health care
- Promote social responsibility for health
- Increase investment for health development to address social inequalities leading to poor health
- Consolidate and expand partnerships for health
- Strengthen communities and increase community capacity to empower the individual
- Secure an infrastructure for health promotion

FOCUS OF Health Promotion:

- Focus on the whole population.
- Use a number of interventions simultaneously.
- Support people to make a ‘healthy’ choice.
- NOTE: Historically has been skewed towards education, but need all strategies and approaches, not just one

Principles of Health Promotion:

The key principles of health promotion as determined by WHO are as follows:

1. Holistic
2. Participation
3. Inter-sectoral
4. Multi-strategy
5. Empowerment
6. Equitable
7. Sustainable

- Holistic: Health promotion involves the population as a whole in the context of their everyday life, rather than focusing on people at risk from specific diseases.
- Inter-sectoral: Health promotion is directed towards action on the determinants or cause of health. This requires a close co-operation between sectors beyond health care reflecting the diversity of conditions which influence health.
- Participation: Health promotion aims particularly at effective and concrete public participation. This requires the further development of problem-defining and decision-making life skills, both individually and collectively, and the promotion of effective participation mechanisms.

- Multi-strategy: Health promotion combines diverse, but complementary methods or approaches including communication, education, legislation, fiscal measures, organisational change, community change, community development and spontaneous local activities against health hazards.
- Empowerment: Health promotion is primarily a societal and political venture and not medical service, although health professionals have an important role in advocating and enabling health promotion.

Intersectoral approach

- Health Promotion brings together many sectors to work towards the achievement and maintenance of health and wellness.
- The Health sector alone cannot achieve a healthy society.
- All sectors, both government and non-government, need to work together.
- Health Promotion can provide the link between the various sectors.
- Within Health the various disciplines also need to work together towards wellness.

Some non-health sectors with an input into Health Promotion:

- Education/ schools
- Agriculture
- Community Services
- Sport
- Media
- Non-Governmental Organizations (NGO's)
- Community groups
- Youth
- Private sector

Health sectors with an input into Health Promotion

- Environmental Health
- Nutrition
- Community nursing
- Mental Health
- Dental
- Epidemiology
- Hospital (secondary) care
- School of Nursing
- Occupational therapy

Some other sectors which are important

- Legal
- Public Works
- Housing
- Water Authority
- GIU
- Christian Council
- Alternative medicine

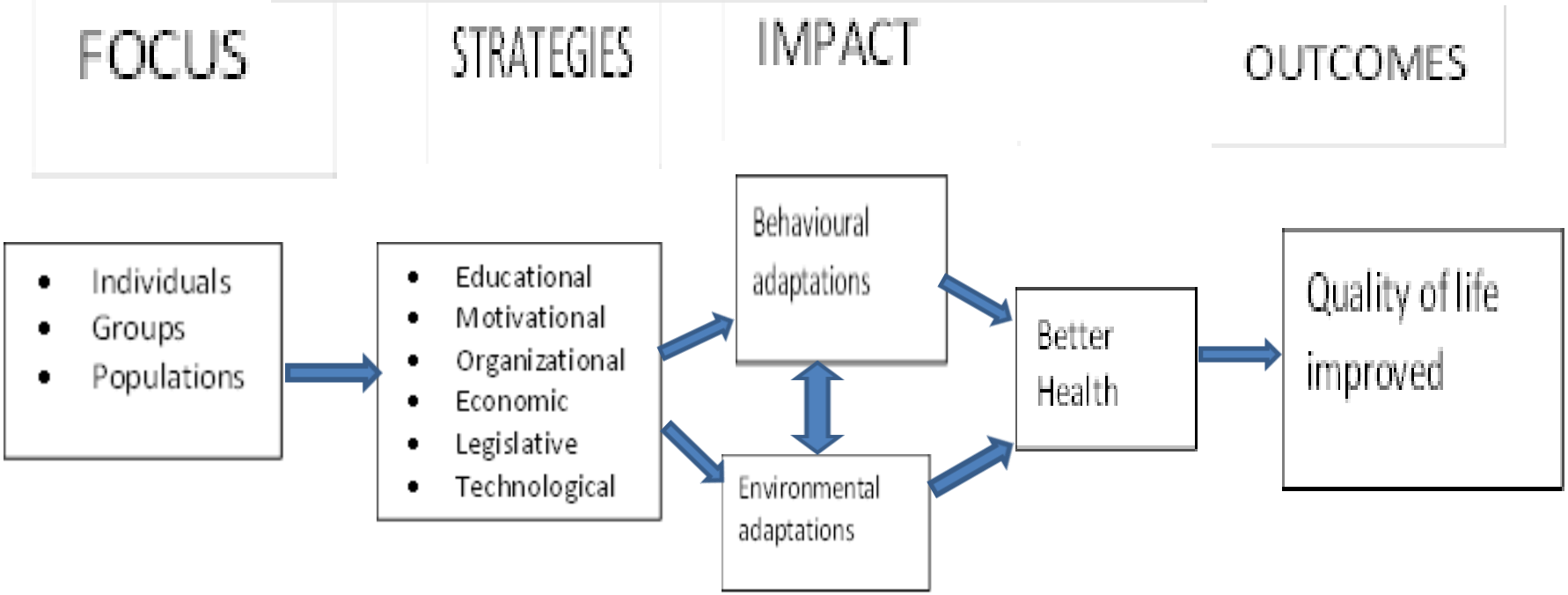
Health Promotion includes:

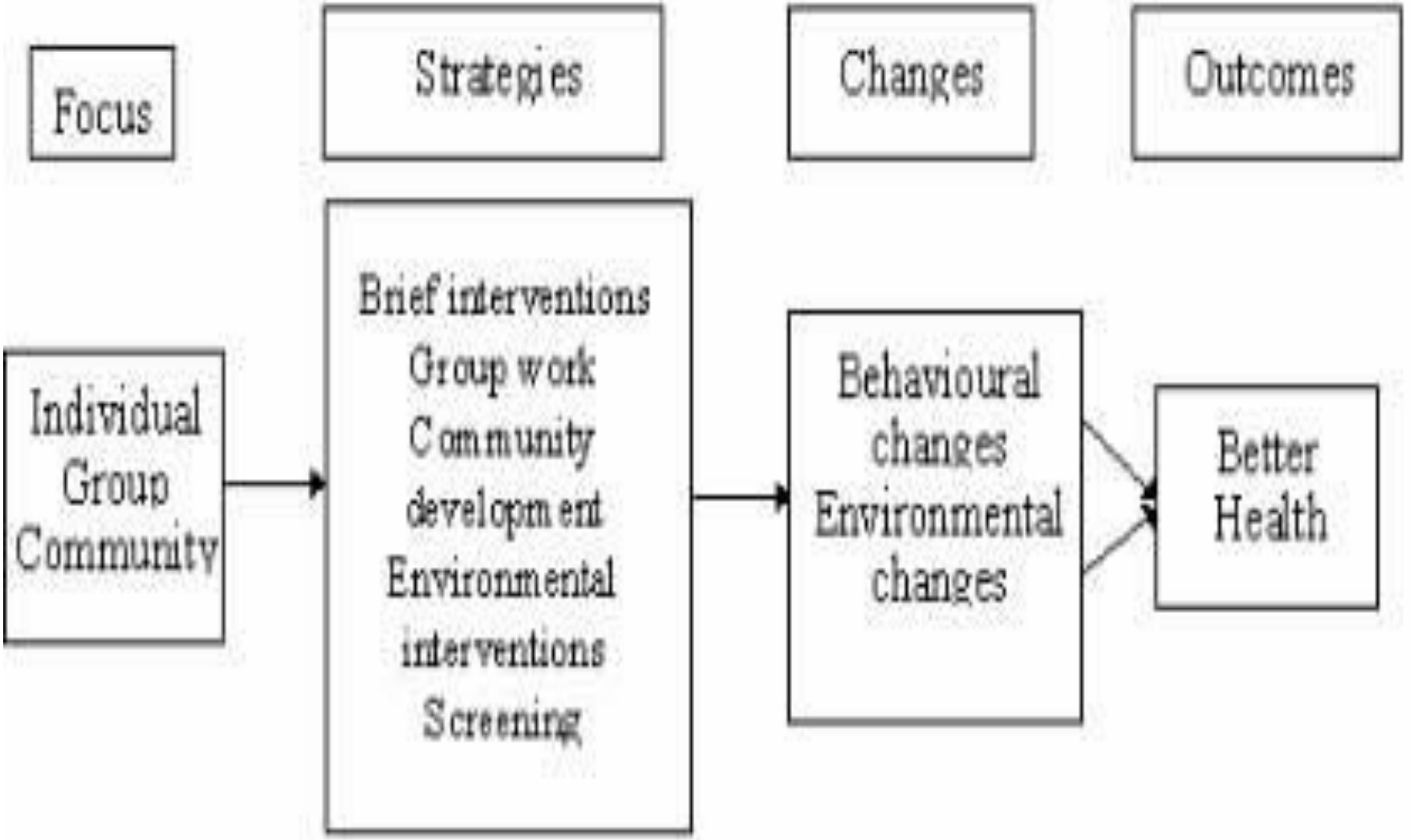
- Promoting healthy lifestyles.
- Getting people involved in their own health care.
- Creating an environment that makes it possible to live a healthy life.
- Recognition of lifestyle diseases as major causes of illness and death.
- Strengthening community participation.

Examples of preventable health problems related to lifestyle:

- Chronic non-communicable diseases such as diabetes and hypertension.
- HIV/AIDS is related to unsafe sexual lifestyle, and causes many deaths

HEALTH PROMOTION PROCESS





Based on Egger et al 19907

HEALTH PROMOTION APPROACHES

Health promotion is an important part of your work as a Health promoter.

Some of the key approaches used in health promotion are as follows;

1. The medical or preventive approach
2. The behavioural change approach
3. The empowerment (client-centered) approach
4. The societal / social change approach
5. Education approach

6. Settings approach

THE MEDICAL APPROACH.

- Aim is freedom from medically-defined disease and disability such as infectious diseases.
- It reduces morbidity and premature mortality.
- Involves medical intervention or risk education to prevent or ameliorate (improve) ill-health.
- Values preventive medical procedures and the medical profession's responsibility to ensure that patients comply with recommended procedures.
- This is done by seeking to increase medical interventions and compliance.
- It ignores social and environmental factors.

Medical Approach

- Aim
  - To reduce morbidity and premature mortality.
  - To ensure freedom from disease and disability.
- Activity
  - Uses medical intervention to prevent ill-health or premature death.
    - Eg. - Immunization, screening, fluoridation.

Based on scientific methods.

Medical Approach

- Expert-led, top down. Emphasizes compliance.
- Does not focus on positive health.
- Ignores social and environmental dimensions.
- Evaluation: Reduction in disease rates & associated mortality.

BEHAVIOURAL CHANGE APPROACH:

Also known as information – giving model. Aims to bring change in individual behavior through changes in individual's knowledge

- Aim is to change people's individual attitudes and behavior so that they adopt a healthy lifestyle
- Examples include teaching people how to stop smoking, encouraging people to take exercise, eat the right food, look after their teeth etc.
- Proponent of this approach will be conceived that a healthy lifestyle is in the interest of their clients and that they are responsible to encourage as many people as possible to adopt a healthy lifestyle

- It brings about changes in an individual's thinking or perception.
- It helps community change the behavior and help them make their own health-related decisions.
- This can be applied using locally available methods and media such as leaflets and posters.
- Considers a wider issues of health education such as individual perceptions of exposure to health risks and risky behavior.
- It also covers the benefits an individual can gain through health practices.
- Methods used is prompting, cueing (provoking), vicarious learning.
- It ignores social and economic factors.
- Proponent of this approach will be convinced that a healthy lifestyle is in the interest of their clients.
- They are responsible to encourage as many people as possible to adopt a healthy lifestyle.
- Examples include teaching people how to stop smoking, encouraging people to take exercise, eat the right food, look after their teeth etc.

Behaviour Change Approach

- Aim
  - To encourage individuals to adopt healthy behaviours.
  - Views health as the responsibility of individuals.
- Methods: Communication
  Education
  Persuasion, motivation
- Expert-led, top down. "Victim-blaming"
- Behaviour is very complex & Multi-factorial.

Behaviour Change Approach

- Evaluation: Behaviour change after the intervention.
  - The behaviour change is only apparent after a long time.
  - Difficult to isolate any behaviour change as attributable to a health promotion intervention.

THE SOCIETAL CHANGE APPROACH:

- Aim is to effect changes on the physical, social and economic environment, in order to make it more conducive to good health
- Focus is on changing society not on changing the behavior of individuals
- Proponent of this approach will value their democratic right to change society and will be committed to putting health on the political agenda
- Methods applied includes lobbing, advocacy, policies, fiscal measures, etc.

Societal/Social Change Approach

- Aim
  - To bring about changes in physical, social, and economic environment which enables people to enjoy better health.
  - Radical health promotion - makes the environment supportive of health.
  - To make the healthy choice the easier choice.
  - The focus is on changing society, not on changing the behaviour of individuals.

Societal/Social Change Approach

- Methods
  - Focus on shaping the health environment
    - lobbying/advocacy
    - development of healthy public policies and legislation
    - fiscal measures
    - creating supportive social and physical environments

THE EDUCATIONAL APPROACH

- Aim is to give information and ensure knowledge and understanding of health issues and to enable well-informed decisions to be made
- Information about health is presented and people are helped to explore their values and attitudes and make their own decisions
- Help in carrying out those decisions and adopting new health practices may also be offered
- Proponent of this approach will value the educational process and respect the right of the individual to choose their own health behaviour
- Responsibility to raise with clients the health issues which they think will be in their client's best interests

- It requires participation of community members at every stage of the program.
- It is a collective action where community participate in assessing the needs of the community.
- It helps in the actions planning, targets and goals to meet those needs.
- Community participation is essential for health educators to understand and deal with many influences over health-related behaviors in community.
- Communities often have detailed knowledge about their culture and surrounding environment, so it is crucial to include them at all stages of community development activities.

Why is the community involved?

- So that it become involved in the implementation of H/E activities successfully.
- To develop self-reliance, empowerment and problem-solving skills of community members.
- It also enables use of locally available resource.
- To creates better relationships with the people in the community you are working in.
- The method is done through small groups or mass media group discussions or role-plays.
- Proponent of this approach will value the educational process and respect the right of the individual to choose their own health behavior.
- Responsibility to raise with clients the health issues which they think will be in their client's best interests.

Educational Approach

- Aim
  - To provide knowledge and information.
  - To develop the necessary skills for informed choice.
  - The outcome is client's voluntary choice.
- Methods
  - Information-giving through interpersonal channels, small groups and mass media, so that the clients can make an informed choice.
  - Group discussion for sharing and exploring health attitudes
  - Role play for decision-making and negotiating skills

Educational Approach

- Weakness
  - Assumes that by increasing knowledge, there will be an attitudinal change, which leads to behavioural change. Ignores the constraints that social, economic and environmental factors place on voluntary change.
- Evaluation
  - Knowledge, attitude and practice.

THE CLIENT- CENTRED APPROACH (EMPOWERMENT)

- Aim is to work with clients in order to help them to identify what they want to know about and take action on and make their own decisions and choices according to their own interest and values
- Health promoter's role is to act as a facilitator in helping people to identify their own concerns and gain the knowledge and skills they require to make things happen
- Self-empowerment of the client is seen as central to this aim
- Clients are valued as equal who have knowledge, skills and abilities to contribute, and who have an absolute right to control their own health destinies
- Empowerment approach - This is the process of by which individuals increase their control over their physical, social and internal environments

- Aim is to work with clients in order to help them to identify what they want to know about and take action on.
- They will make their own decisions and choices according to their own interest and values.
- It involves identifying individual or community health needs and gain the knowledge, skills and attitudes to act upon them through a program of action.
- Self-empowerment is rooted in awareness and understanding that people can act to change their own lives on their own behalf.
- Health promoter's role is to act as a facilitator in helping people to identify their own concerns.
- They gain the knowledge and skills they require to make things happen.
- Clients are valued as equal who have knowledge, skills and abilities to contribute, and who have an absolute right to control their own health destinies.
- This approach provide tools needed for people to make their own choices about their health determinants.
- Such techniques include group work, problem solving, client-centered counselling, social skills training and educational drama.
- Methods applied are Counselling, problem solving, advocacy, public participation.

Empowerment Or Client-centred Approach

- Aim
  - Helps people to identify their own needs and concerns, and gain the necessary skills and confidence to act upon them.

Role of health promoter: facilitator and catalyst.

Empowerment Or Client-centred Approach

- Two types of empowerment:
  1. Self-empowerment
     - based on counselling and aimed at increasing people's control over their own lives.

  2. Community empowerment
     - related to community development to create active, participating communities which are able to change the world about them through a programme of action.

Empowerment Or Client-centred Approach

- Methods
  - Client-centred, including counselling, community development and advocacy.
  - Health advocacy refers to the action of health professionals to influence and shape the decisions and actions of decision- and policy-makers who have some control over the resources which affect or influence health
  - Promoting public involvement and participation in decision-making on health-related issues.
- Evaluation
  - Difficult because empowerment is long term.
  - Results are hard to specify and quantify.

Empowerment Or Client-centred Approach

- Evaluation includes:-
  - Outcome evaluation - the extent to which specific aims have been met.
  - Process evaluation - the degree to which the individual and community have been empowered as a result of the intervention.

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)

1) Health Services Setting
2) Community Setting
   - Community-based approaches
   - Community development approaches - Aims to improve health by addressing socio economic and environmental causes of ill health
3) Education Setting

APPROACHES TO HEALTHY PROMOTION (THE EXAMPLE OF HEALTHY EATING)

APPROACH	AIMS	METHODS	WORKER/CLIENT RELATIONSHIP
Medical	To identify those at risk from disease.	Primary health care consultation, e.g. measurement of body mass index.	Expert led. Passive, conforming client.
Behaviour change	To encourage individuals to take responsibility for their own health and choose healthier lifestyles.	Persuasion through one-to-one advice, information, mass campaigns, e.g. “Look After Your Heart” dietary messages.	Expert led. Dependent client. Victim blaming ideology.

APPROACH	AIMS	METHODS	WORKER/CLIENT RELATIONSHIP
Educational	To increase knowledge and skills about healthy lifestyles.	Information. Exploration of attitudes through small group work. Development of skills, e.g. women's health group.	May be expert led May also involve client in negotiation of issues for discussion.
Empowerment	To work with clients or communities to meet their perceived needs.	Advocacy Negotiation Networking Facilitation e.g. food co-op, fat women's group.	Health promoter is facilitator. Client becomes empowered.
Social change	To address inequities in health based on class, race, gender, geography.	Development of organisational policy, e.g. hospital catering policy. Public health legislation, e.g. food labelling. Lobbying. Fiscal controls, e.g. subsidy to farmers to produce lean meat.	Entails social regulation and is top-down.

Approaches in Health Promotion: the example of healthy eating

Approach	Aims	Methods	Worker/client relationship
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Approaches in Health Promotion: the example of healthy eating

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MODELS OF HEALTH PROMOTION

Model:

In **science**, a **model** is a representation of an idea, an object or even a process or a system that is used to describe and explain phenomena that cannot be experienced directly.

A. *Explain* observations

B. *Predict* future observations

C. Be *realistic*

MODELS OF HEALTH PROMOTION

1. Health Persuasion
2. Legislative actions
3. Personal counselling
4. Community development

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

Legislative Actions:

- Are 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

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

Community Development

- Focuses on interventions targeted at the community level
- Community identifies their health needs, seeks to empower and makes the best rational choice.

MODELS OF HEALTH

Models of health

- Biomedical model of health
- Social model of health
- The Ottawa Charter for Health Promotion

Models of health are conceptual frameworks or ways of thinking about health

Biodemical Model of Health:

- Focuses on the physical or biological aspects of disease and illness. It is a medical model of care practiced by doctors and/or health professional and is associated with the diagnosis, cure and treatment of disease.
- Developed during the age of Enlightenment in the 18th Century, when the traditional natural sciences began to dominate academia and medical practice. The belief that science could cure all illness and disease has remained a core element of modern medicine. This concept of health may be easier to understand as it makes health an attribute you can measure simply by determining if a disease is present or not. However the strong emphasis on the absence of disease as an indicator of good health, and the overdependence on the influence of medical science in health, ignores the power of other important influences.

Biomedical Model of Health

- Has been evolving for many years leading to improvements in medical science, technology, increase in cures and treatments ie: increase in vaccinations /immunizations
- Emphasis on **diagnosis** and **treating** individuals separately from their lifestyle/living conditions – this model of health concentrates on the disease, illness, or disability and attempts to (**cure**) return the physical health of the person to a pre-illness state. The **reasons** for the illness are **not** at the centre of the **biomedical model**.
- Tends to be the first thing people think of when they think of health care
- Receives the majority of government healthcare funding (over 90%)

Biomedical Model of Health

- Dominant for many years and played a large role in prolongin life expectancy
- Bio- living or living organism
- Medical- science of diagnosing-curing disease.
- In the biomedical approach Dr's and hospitals are the real foc of medicine or health. The expectation being that the Dr will able to fix the condition and the patient will take on a passive role.
- The 2 aspects of the biomedical approach are:
  - Diagnosis: identification of the disease or illness through Dr's observations of symptoms or through diagnostic tests e.g. X rays Scans, blood tests
  - Intervention: action taken to improve health e.g. via medical treatment, hospitalisation, prescriptions, surgery etc.

****medical intervention with a fix it approach

Biomedical Model of Health

- The WHO defines Health as "A complete state of physical , social and mental wellbeing, and not merely the absence of disease of infirmity" (WHO 1946)

- *Does the Biomedical model of health address this definition? Explain*

Advantages

- It creates advances in technology and research
  - Without this model of health there would be little known about how to treat and diagnose illnesses
- Many common problems can be effectively treated
  - Diseases that would otherwise develop and cause considerable illness or death can be stopped.
- Extends life expectancy
- Improves quality of life
  - Can be successful in returning someone back to good health

Disadvantages

- Relies on professional health workers and technology and is therefore costly
  - Professionals with specialist knowledge needed are expensive to train
  - Technology, equipment and technological developments expensive
- Doesn't promote good health / narrow view of health
  - Doesn't encourage people to live healthy lives as they are treated to fix problems as they arise. The focus is on the condition and not the determinants that caused it.
- Not every condition can be treated
  - Cancer is an example – advances have been made, but treatment not always successful
- Affordability – not always affordable
  - Not all countries can afford the medical technologies and resources that are part of the biomedical model of health - an important factor contributing to differences experienced in health status

Social Model of Health

- This approach attempts to **address the broader influences on health** (social, cultural, environmental and economic factors) rather than disease and injury.
- It is a **community approach** to prevent diseases and illnesses.
- Focus is on **policies, education and health promotion**. The Social Model of Health goes beyond the focus of lifestyles and behaviour and accepts the need for **social** change to provide prerequisites for health

- ***It was developed in the late 1970's 1980's as some members of the community were not experiencing the same levels as health as others despite the understanding of the impact of lifestyle and behaviours on health.***

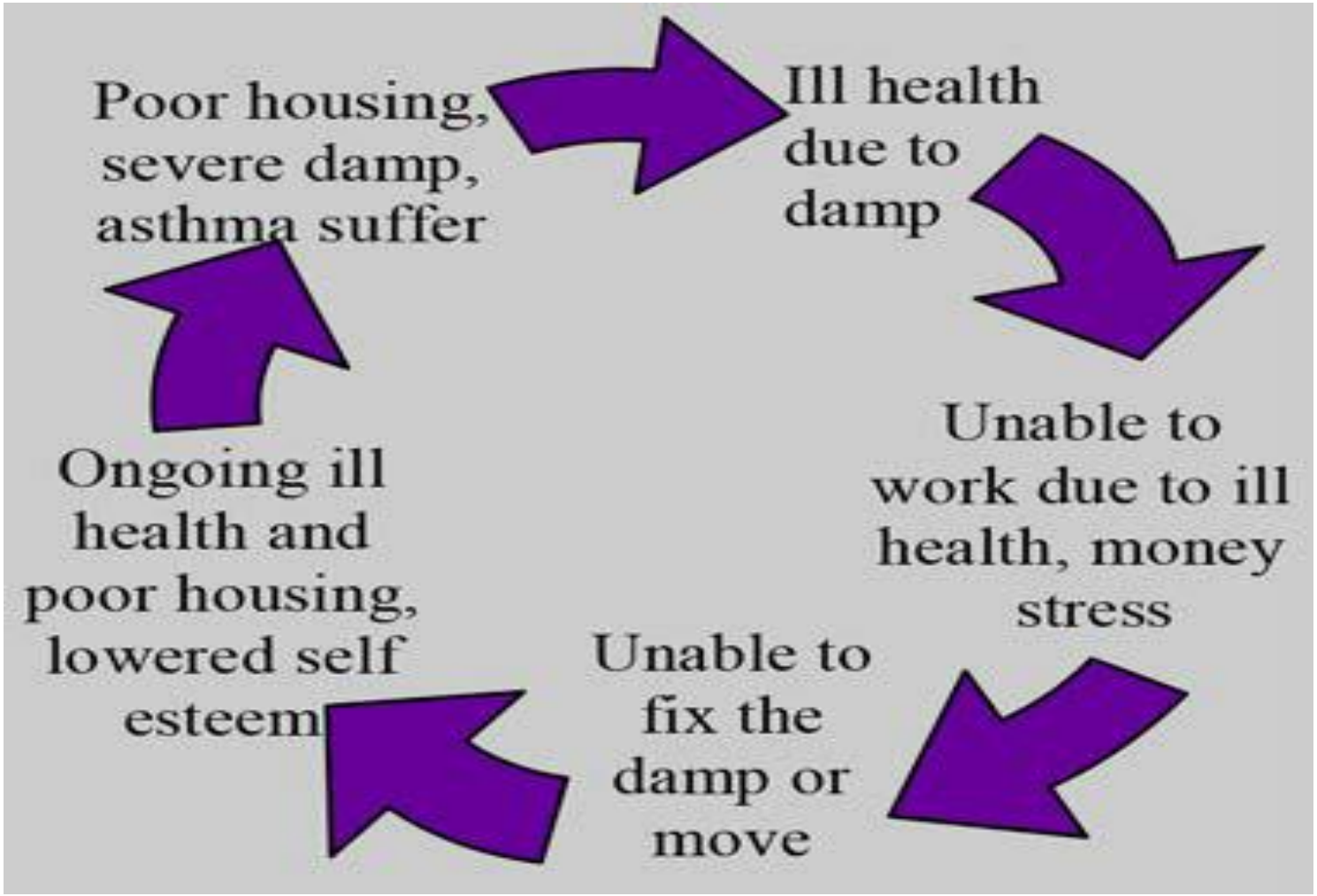
Definition – Social Model of Health

A conceptual framework within which improvements in health and wellbeing are achieved by directing effort towards addressing the social, economic and environmental determinants of health. The model is based on the understanding that in order for health gains to occur, social, economic and environmental determinants must be addressed. *(VCAA HHD Study Design)*

SOCIAL MODEL OF HEALTH:

- This model emerged from the social model of disability, which has been strongly advocated by the disability rights movement.
- It was developed as a reaction to the traditional medical model. The social model of health examines all the factors which contribute to health such as social, cultural, political and the environment. An example is poor housing: It is well documented that both stress and low self esteem can have a negative impact on health. “Low levels of autonomy and low self esteem are likely to relate to worse health.” (Marmot, 2003) CDHN believes that communities know that their health is being affected by a variety of issues. We also believe that communities can and should be actively involved in identifying, planning, designing and implementing solutions to health issues and unjust health inequalities.

Social Model of Health



5 Key Principles (A.R.E.A.S.)

- Addresses the broader determinants of health
- Reduce social inequities
- Empower individuals and communities
- Access to health care
- Inter-Sectorial collaboration

5 Key Principles (A.R.E.A.S.)

Addresses the broader determinants of health (all aspects of health are addressed)

- broader determinants such as gender, ethnicity, socioeconomic state, location and physical environment influence behavioural determinants and have a strong relationship with health and are becoming a focus of health promotion strategies.

Reduce social inequities (addresses equity of the social determinants of health)

- Aims to promote equity for all people and to achieve this the social determinants which lead to inequality such as gender, culture, socioeconomic status, location and the physical environment must be addressed.

Empower individuals and communities (empowers with skills, knowledge & confidence to make positive decisions re: their health)

- Empowering individuals and communities with health knowledge means they have the ability to make positive decisions about their health and participate in healthy behaviours.

Access to health care (accessible and appropriate health information)

- Access to health care is a significant factor contributing to health status. This social model of health acts to enable all people to have access to health care. Social factors that can impact on access to health care include cultural and language barriers, economic and geographical factors and education level.

Inter-Sectorial collaboration (co-ordinated approach health and government departments)

- By involving all organisations and stakeholders (people with a shared interest) who have an influence over the social and environmental determinants of health can all the social determinant be adequately addressed and affect health status positively.

Advantages – Social Model

- Education for people, so don't get the disease
- Govt support/strategies e.g. QUIT, TAC, immunization
- Less costly to prevent the disease before it happens
- Encourages individuals to take responsibility and lead healthier lifestyles => improve quality of life
- Community approach involving all levels of government, non-government organisations
- Increase economic development of the country as the population is in good health and lead productive lives

Disadvantages – Social Model

- Lack of education for the whole population, some people don't get or understand the message
- Population not motivated e.g. suntans, smoking, overweight.
- Not believing it will happen to them
- Changing lifestyles is VERY hard
- Not all diseases can be prevented
- Results of this method of health are not evident until after a long period of time and difficult to measure its effectiveness

Examples of the social model of health:

- Go For Your Life Strategy – made up of different government and non-government stakeholders, targeted approach to education the whole community and encourages all people to adopt healthy dietary practises and exercise.

- Sun Smart Schools Program – aims to reduce the exposure of children to harmful UV rays and educate them about the dangers of sun exposure.

- Be a Man – Talk to your doctor about Prostate Cancer' program – aims to break down cultural beliefs about health held by men and encourage them to visit a doctor to discuss their health.

- Rural Retention Program (RRP) – federal government provide financial incentive for Doctors to work in rural/remote areas

Using the social model of health

Principle of the social model Issue to be Addressed	Addresses the broader determinants of health	Involves intersectorial collaboration	Acts to reduce social inequities	Acts to enable access to health care	Empowers individuals and communities
Mental health issues	Ensure mental health education and advice is available in rural and remote areas.	Get workplaces to play a part. Like the workplace health checks.	Focus on people in indigenous communities or those of low SES.	Provide free access to health care assessments to those in low SES groups, provide information at football matches, pubs etc.	Use men as the promoters of programs targeting men to educate men to identify symptoms of depression Indigenous to develop and promote programs aimed at indigenous.
Case study					
Your Example					

Ottawa Charter for Health Promotion

- Ottawa – Canada hosted the first international conference on health promotion in 1986
- Charter – refers to the document that outlines the functions and principals of health promotion

- In response to the Social model of health the WHO held its first International Conference on health promotion in 1986 in Ottawa, Canada.

- Outcome of this conference was a document that provided organisations and key stakeholders guidelines to help incorporate health promotion into their strategies, policies and campaigns with the aim of taking action to achieve 'health for all by the year 2000 and beyond' through health promotion and reduce inequalities in health.

- **3 Principles** of health promotion
- **8 Prerequisites (conditions or resources)** for gains in health
- **5 Priority** or action areas

Study Design - Definition

An approach to health development by the World Health Organization which attempts to reduce inequalities in health. The Ottawa Charter for Health Promotion was developed from the social model of health and defines health promotion as 'the process of enabling people to increase control over, and to improve, their health' (WHO 1998). The Ottawa Charter identifies three basic strategies for health promotion which are enabling, mediating, and advocacy. *(VCAA HHD Study Design)*

Health promotion

- **Health promotion** is the process of enabling people to increase control over, and to improve, their health.

- Health promotion therefore focuses on prevention rather than cure and uses the causes of disease as the starting point rather than diseases themselves
- Population focused

Three basic Principle of Health Promotion

- **Enable** – Health promotion aims to enable all people to achieve their fullest health by closing the gaps in health inequalities by ensuring equal opportunities and resources for everyone. Reducing differences in health status by ensuring equal opportunities and resources to make healthy choices
- **Mediate** – Professionals, social groups and health personnel have a major responsibility to mediate (negotiate) between differing interests in society to achieve health. Co-ordinated action between all interested parties ie government, NGO's, media, health sectors,
- **Advocate** – supporting and making public health recommendations for health, getting the message out

8 Prerequisites for health

- Peace
- Shelter
- Education
- Safe and adequate food supply
- Adequate income
- A stable ecosystem- a balance between plants and animals in the environment which is important for many health resources such as food, water and air
- Sustainable resources- the need to sustain the many resources needed for health (food, water, income - funding, building supplies, oil) for future generations to benefit
- Social justice and equity- all people being valued and receiving fair treatment so all people share the benefits of society

These 8 conditions or resources are the basic prerequisites that underpin any improvements in health. – Without these improvements in health are limited

5 Priority or Action areas

That should be taken into account when devising health promotion initiatives

1. **Build healthy public policy**
2. **Create Supportive Environments:**
3. **Strengthen Community Action:**
4. **Develop Personal Skills:**
5. **Reorient Health Services:**

(Bad Cats Smell Dead Rats)

Build healthy public policy

- ***Relates directly to the decisions made by the government and organisations in relation to laws, regulations and policies that affect/improve health.***
- Examples, increasing taxes on certain alcoholic drinks which makes participating in unhealthy behaviours more difficult thereby reducing exposure to determinants that can cause ill health.
- Some policies and laws are designed to make the environment healthier for those who chose not to participate in unhealthy behaviours ie banning smoking in public places.
- Some laws are designed to directly influence behaviour ie wearing seat belts, safety restraints for children.
- Some law aim to deglamourise unhealthy behaviours – plain cigarette packaging

Create Supportive Environments

- ***A supportive environment is one that promotes health and assists people in making healthy lifestyle choices. This priority recognises the impact that broader determinants have on health and aim to promote a healthy physical and social environment for the community to allow people to live healthy lives.***
- Examples – Quit line – a support service for people wanting to quit smoking, Providing shaded areas in schools – reduces exposure to UV rays, Sustainable energy production – ensures future generations have access to a healthy environment. Occupational Health and Safety Officers
- Government childcare schemes,
- Walking and bicycle tracks to encourage physical activity

Strengthen Community Action:

- ***Focuses on building links between individuals and the community and the centres around the community working together to achieve a common goal***. Skills need to be developed in the community in order for action to be taken to improve healthy.
- Giving the community a sense of ownership of a health strategy increases the likelihood of its effectiveness.
- Example: Governments immunisation strategy involves the media, doctors, schools, parents Neighbourhood Watch and Safety House Programs, Driver Reviver Stations

Develop Personal Skills

- ***Education is the key aspect of this priority. It refers to gaining knowledge and life skills to make informed decisions that may indirectly effect their health.***
- Personal skills need to be developed to assist people to live healthy lives
- Many parts of society have a role in educating – school, work, families, government, non-government organisations
- Examples: Developing skills to read food labels and select healthy foods, develop financial and budgeting skills, practising safe sex, being sun smart, exercising as part of one's life, healthy eating habits

Reorient Health Services

- ***Refers to reorienting the health system so that it promotes health as opposed to only focussing on diagnosis and treating illness, as is the case with the biomedical model.***
- To reorient health services, the health system must encompass not only doctors and hospitals, but all members of the community including individuals, community groups, health professionals, health service institutions and governments.
- This priority area suggest incorporating health promotion to play a more significant role thereby addressing all the determinants of health, not just disease.
- Example – focusing on healthy eating rather than on surgery to reduce the impact of CVD, doctors prescribing activity before the development of damaging conditions such as type 2 diabetes, self-hep groups, police and emergency services (ie Fire Brigade) working with schools to support road education programs,

- The Ottawa Charter provides governments and health promotion organisations with an effective tool to use when planning effective strategies.
- However it is not necessary to address all five priority areas and some effective programs may only focus on one or two priority areas.
- Focusing on all five areas may spread resources too thinly, meaning the strategy may not achieve its goals.

- *Oxford handout*

Using the Ottawa Charter

Element of the Charter Issue to be Addressed	Build public health policy	Create supportive environments	Strengthen community action	Develop personal skills	Reorient health services
childhood obesity in primary schools	Develop a healthy lunch policy. Tax on junk food	Run a breakfast program and make the canteen a healthy food zone.	Develop a whole school approach to healthy eating and include healthy recipes in the school newsletter	Teach students about healthy eating so they can make healthy choices in food technology and health classes	Invite a local Dr. or dietitian to talk about the dangers of unhealthy eating.
the issue of bullying in schools	Anti-bullying policy in schools	Provide safe places during recess and lunch breaks	Whole school approach to anti-bullying	Parenting courses, self-esteem and 'no blame' classes for students	School nurse / counsellor /youth worker providing health promotion education to students

BIOPSYCHOSOCIAL MODEL: Developed by psychiatrist George Engel in 1977, and recognises that many factors affect health. It pays "explicit attention to humanness" (Engel, 1997). It views health as a scientific construct and a social phenomena. The model looks at the biological factors which affect health, such as age, illness, gender etc. The psychological factors: individual beliefs & perceptions. The social: the community, the presence or absence of relationships "We suffer when our interpersonal bonds are sundered and we feel solace when they are reestablished" (Engel, 1997).

The differences between the Biomedical Model and the Biopsychosocial Model

	Biomedical Model	Biopsychosocial Model
Considering factors	Only takes account of biological factors.	Takes account of biological, psychological and social factors.
Views on what causes illness	All physical factors – pathogens, injury, physiological change.	Multiple factors – physical, social and psychological.
Patient responsibility	No responsibility on the patient, because all factors are out of the patient's control.	There is patient responsibility, because lifestyle has an influence.
Treatment Style	Bodily interventions only.	Whole person themes, mind and body.
Responsible for treatments	Doctor only.	Doctor and patient combined.
Role of psychology	No relationship with physical illness.	Causal influence and consequence of physical illness.

HEALTH PROMOTION INTERVENTIONS

- Interventions are activities used by programme planners to bring about outcomes identified in the programme objectives. These activities are sometimes referred to as treatments
- An intervention may be made up of a single activity but it is more common for planners to use a variety of activities to make up an intervention for a programme

SELECTING APPROPRIATE INTERVENTION ACTIVITIES

- Selection should be based on a sound rationale as opposed to chance and the intervention should be both effective and efficient.
- The following questions will serve as a guide:

1. Do the intervention activities fit the goals and objectives of the programme?
2. At what level(s) of influence will the intervention be focused?
3. Are the activities based on an appropriate theory?
4. Is the intervention an appropriate fit for the target population?
5. Are the necessary resources available to implement the intervention selected?
6. What types of intervention activities are known to be effective in dealing with the programme focus?
7. Would it be better to use an intervention that consists of a single activity or one that is made up of multiple activities?

TYPES OF INTERVENTION ACTIVITIES:

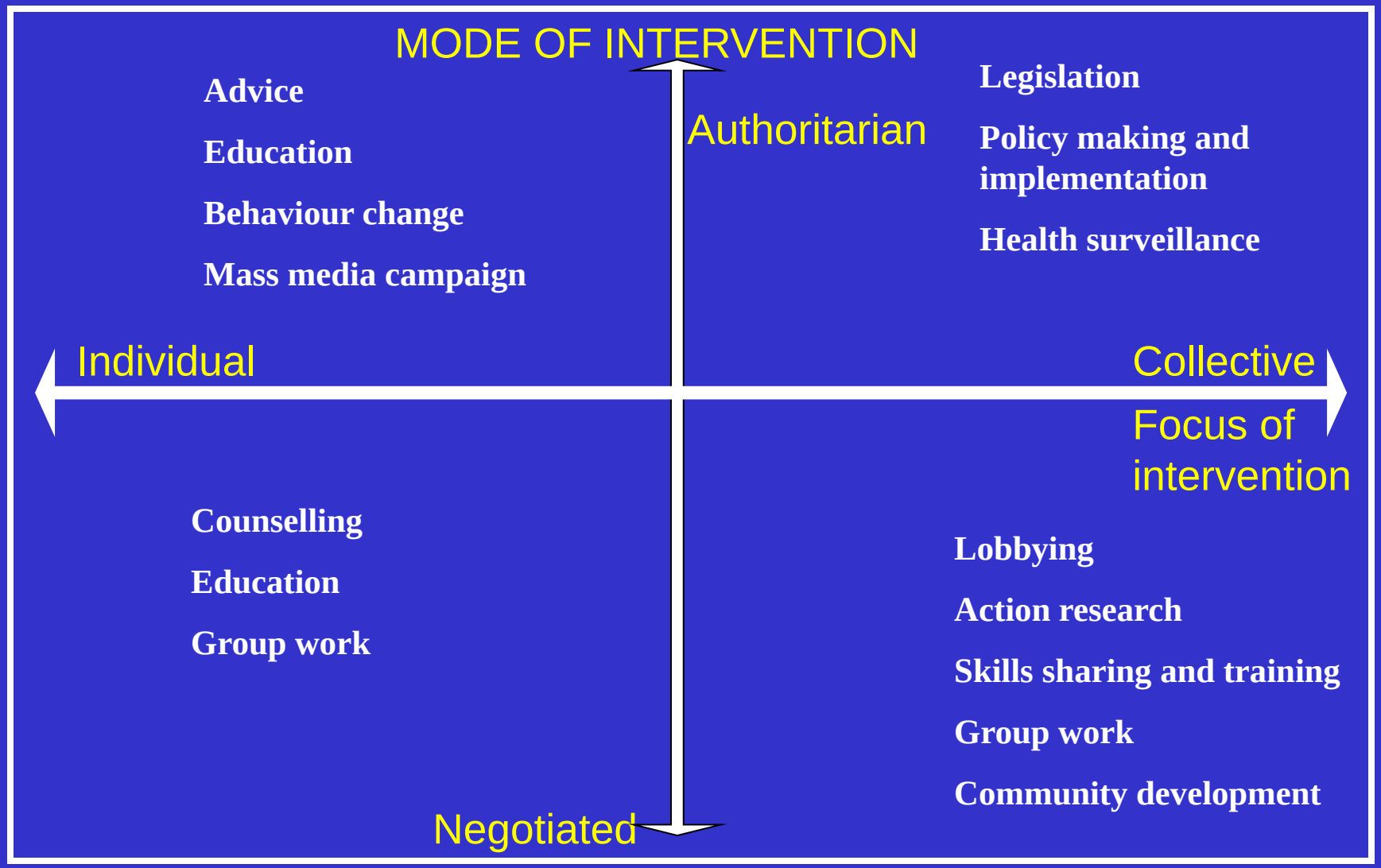
1. Communication activities
2. Educational activities
3. Behaviour modification activities
4. Environmental change activities
5. Regulatory activities
6. Community advocacy activities
7. Organizational culture activities
8. Incentives and disincentives
9. Health status evaluation activities
10. Social activities
11. Technology-delivered activities

METHODS IN HEALTH PROMOTION

AIMS AND METHODS IN HEALTH PROMOTION

AIM	APPROPRIATE METHOD
Health awareness goal Raising awareness, or consciousness, of health issues.	Talks, group work, mass media, displays and exhibitions, campaign.
Improving knowledge Providing information.	One-to-one teaching, displays and exhibitions, written materials, mass media, campaigns, group teaching.
Self-empowering Improving self-awareness, elf-esteem, decision making.	Group work, practising decision-making, values clarification, social skills training, simulation, gaming and role play, assertiveness training, counselling.
Changing attitudes and behaviour Changing the lifestyles of individuals.	Group work, skills training, self-help groups, one-to-one instruction, group or individual therapy, written material, advice.
Societal/environmental change Changing the physical or social environment.	Positive action for under-served groups, lobbying, pressure groups, community-based work, advocacy schemes, environmental measures, planning and policy making, organisational change, enforcement of laws and regulations.

HEALTH PROMOTION METHODS USING BEATTIE'S TYPOLOGY (BEATTIE – 1991)



METHODS AND APPROACHES: INDIVIDUAL

(Individual Approaches to Health Promotion)

- Individual focus – the cradle of health promotion.
- One-to-one basis – individual advice, counselling
- Interactive nature of face-to-face communication allows better possibilities for success than perhaps any other communication medium
- Individual methods of health promotion are usually but not exclusively associated with secondary prevention or tertiary prevention
- As most information concerning health is so technical and complex, a translational process is necessary to transform scientific and medical jargon into information which can be understood and acted on by the general public

- Each time health professionals interact with a client in the course of their work they have an opportunity to find out more about that person and share information.
- Interacting with individuals on a one-to-one basis "allows better possibilities for success than perhaps any other communication medium"
- It is possible to assist individuals to make healthier choices by making the healthier choices the easy choices

LIMITATIONS

- For a large population to labour intensive to reach everyone in this manner
- One-to-one individual methods not as appropriate in the area of primary prevention – cost-ineffectiveness among large target audiences, many of whom may not develop the specific disease
- Difficult to gain access to people and also health information competing with a myriad of other messages (often anti-health forces)

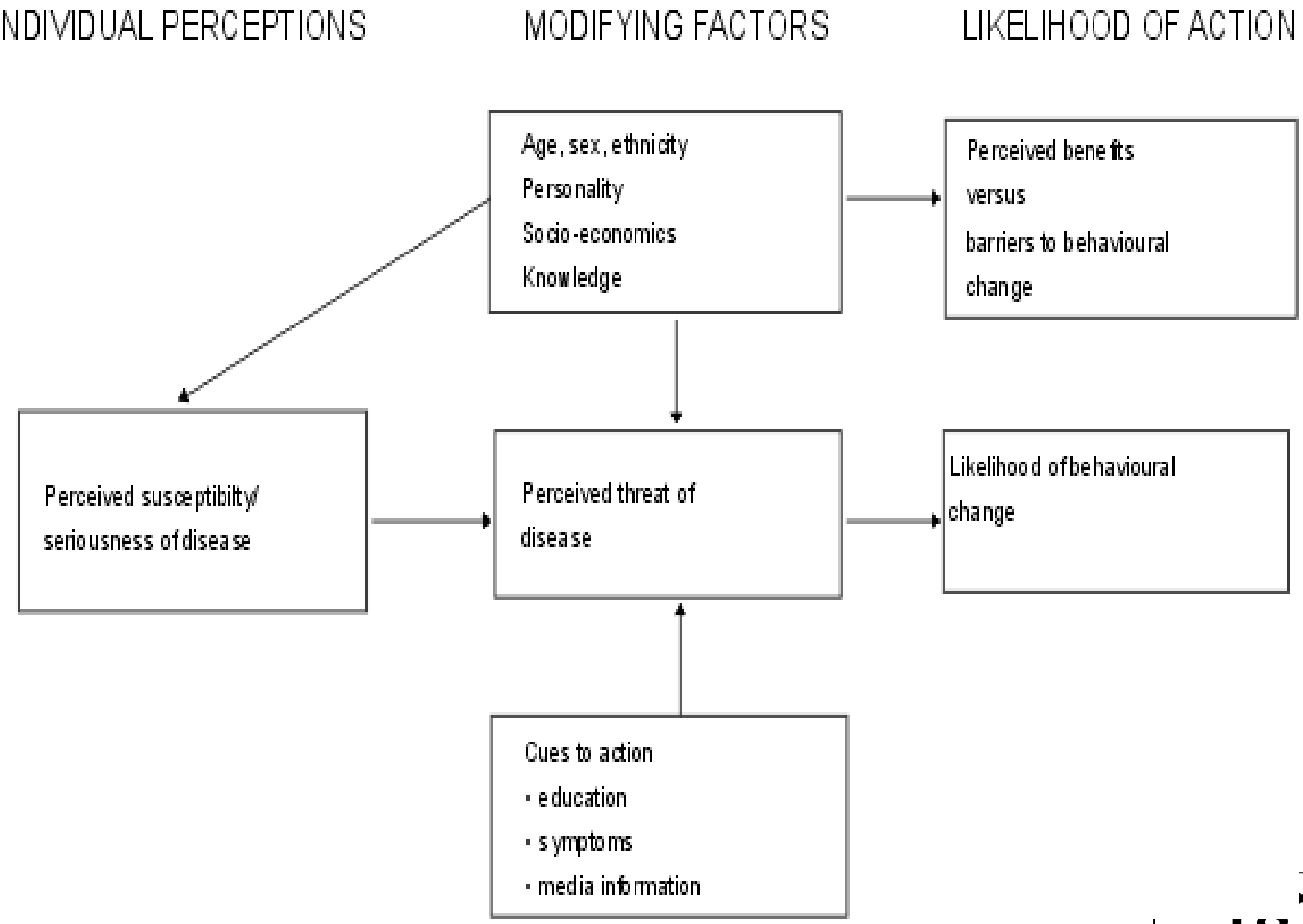
Models of individual health behaviour change:

- Both psychological (internal) and environmental (external) factors motivate people's behaviour which, in turn, may affect health.
- These factors are also influenced by thoughts, feelings and values.
- A variety of models and theories have been developed to explain how these factors interact.
- Two important models for understanding the basis for brief interventions with individuals are the **'Health Belief Model'** and **'The Stages of Behaviour Change Model'.**

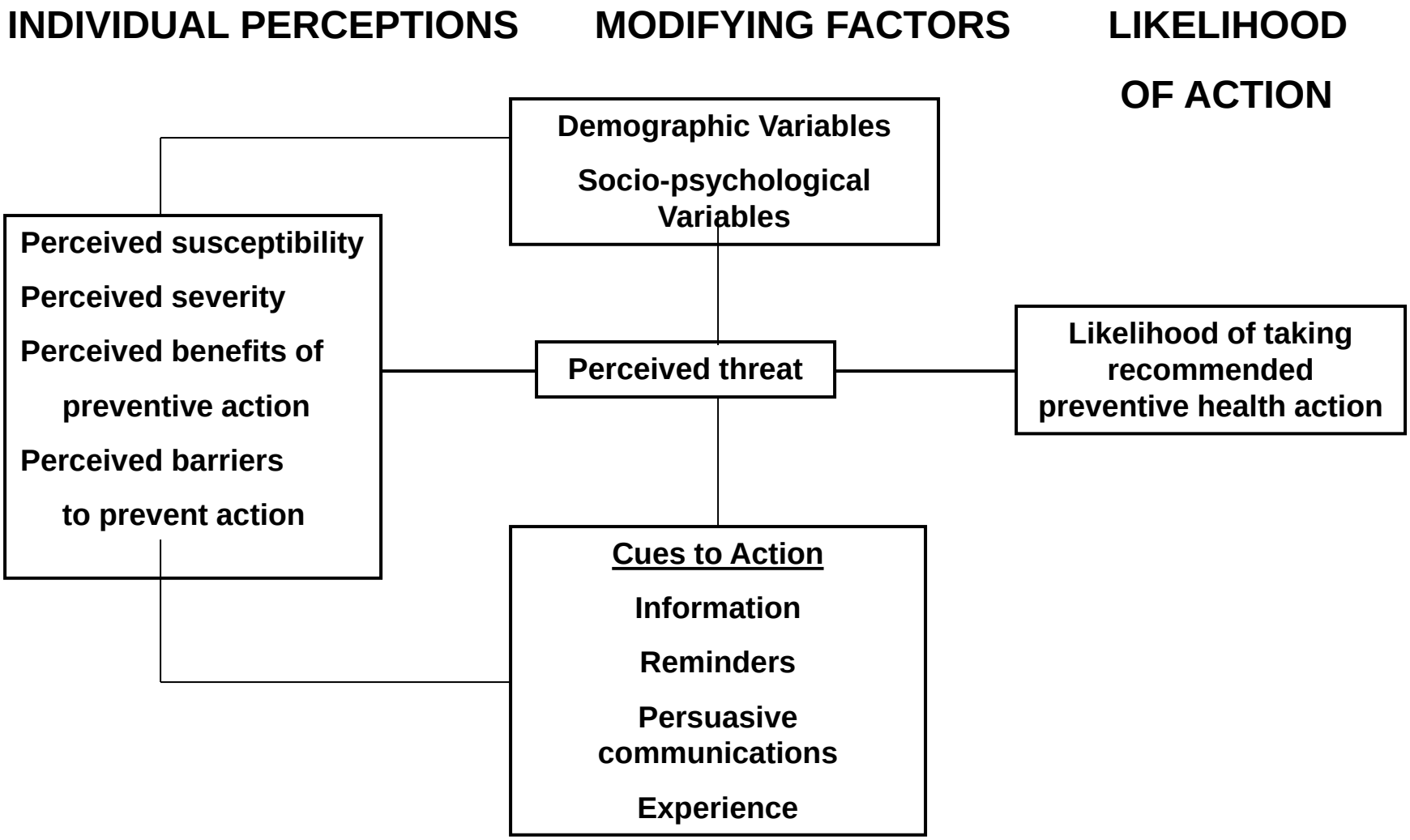
The Health Belief Model:

- This mode is one of the oldest attempts to explain health behavior
- It is based on the premise that for a behavioral change to succeed, individuals must have the incentive to change, feel threatened by their current behavior, and feel that a change will be beneficial and be at acceptable cost.
- They must also feel competent to implement that change.

Health belief model



Health Belief Model



Categories of Belief

- Perceived Seriousness
- Perceived Susceptibility
- Perceived Benefits
- Perceived Barriers

Categories of Belief

Seriousness

- Relative severity of the health problem.
  - E.g. Seriousness of hepatitis encourages individuals to get the hepatitis vaccine.

Susceptibility

- Nature and intensity of perceptions affect willingness to take preventive action.

Categories of Belief

Benefits

- Anticipated value of the recommended course of action.
- Must believe recommended health action will do good if they are to comply.

Barriers

- Perception of negative consequences
- Greatest predictive value of whether behavior will be practiced.

Stages of Change

- Pre-contemplation
- Contemplation
- Préparation
- Action
- Maintenance

Precontemplation

Definition

- Not considering changing their behavior
- Lack of awareness

Intervention Approach

- Novel information
- Persuasive communications
- Experiences

Contemplation

Definition

- Person is beginning to consider behavior change
- Important stage of information acquisition

Intervention Approach

- Motivated by role modeling and persuasive communications
- Receptive to planned or incidental learning experiences.

Preparation

Definition

- Deciding to change by preparing and experimenting.
- Psychological preparation of trying on or visualizing new behaviors and sharing the idea with others. Deciding to change.

Intervention Approach

- How-to information, skill development, attitude change

Action

Definition

- Actually trying the new behavior

Intervention Approach

- Skill
- Reinforcement
- Support
- Self-management
- Attitude and attribution change

Maintenance

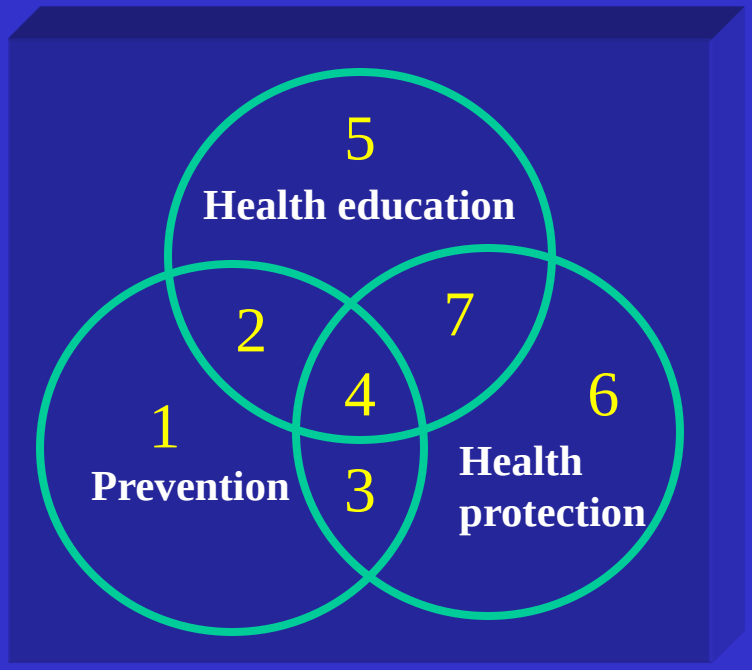
Definition

- Establishment of the new behavior
- Taking on the new attitudinal and environmental supports

Intervention Approach

- Relapse prevention skills
- Self-management
- Social and environmental support

TANNAHILL'S MODEL OF HEALTH PROMOTION (DOWNIE *et al* – 1990)



1. Preventive services, e.g. immunization, cervical screening, hypertension case finding, developmental surveillance, use of nicotine chewing gum to aid smoking cessation.

2. Preventive health education, e.g. smoking cessation advice and information.

3. Preventive health protection, e.g. fluoridation of water.

4. Health education for preventive health protection, e.g. lobbying for seat belt legislation.

5. Positive health education, e.g life skills with young people.

6. Positive health protection, e.g. workplace smoking policy.

7. Health education aimed at positive health protection, e.g. lobbying for a ban on tobacco advertising.

METHODS AND APPROACHES: GROUPS

GROUP APPROACHES

(Working with groups in health promotion)

- Group techniques offer an intermediary between one-to-one approaches and wider community appeals through media and whole community approaches
- Groups can range in size from 2-3 people to several hundreds and can be either homogenous or heterogenous in nature
- Health education methods in such groups can be classified as didactic (i.e. lectures, seminars) or experiential (i.e. skills training, simulation/games etc.)

- Groups can be composed of two or three people or many.
- These include families and groups based on: gender, age, language, a particular disability or condition.
- Clubs or special interests groups, such as sporting clubs or art and craft cooperatives, also provide opportunities for group work.
- Group strategies /methods can take place in a range of settings: including those at which the level of prevention is mainly:

✓ Primary (schools, workplace, organisations): where the focus is on prevention: in schools, in the workplace, out bush, at the women's centre, at the community store

✓ Secondary (medical practice, health centres, out-patient clinics, drug referral centres),

✓ Tertiary (hospitals, rehabilitation centres, nursing homes) - Where strategies may have more of an intervention orientation: in the health centre or old people's home

Group methods have been used by health educators to empower individuals, organisations and communities in key ways.

- These include assisting individuals:

✓ to modify or maintain health-related behaviour

✓ to provide a supportive setting for individuals sharing a common goal or problem

✓ to organise community to improve their capability to identify and solve their own problems (i.e. community organisation)

✓ to organise individuals and groups to undertake macro-level social change (e.g. training community leaders)

Advantages of working in groups on projects

- People are social beings and generally like working with others
- All the resources, abilities and energy of the group are pooled
- There is less chance that mistakes will be made - it is easier to see other people's mistakes than to see our own
- Group discussion stimulates ideas that might not occur to an individual working alone
- Group members support each other and provide security, especially for problem solving

Characteristics of an effective group

- Has a clear understanding of its purposes and goals.
- Is flexible in selecting its procedures as it works towards its goals.
- Has achieved a high degree of communication and understanding among its members…
- Is able to initiate and carry on effective decision making, carefully considering minority viewpoints and securing the commitment of all members to important decisions.
- Achieves an appropriate balance between group productivity and the satisfaction of individual needs.
- Provides for sharing of leadership responsibilities by group members
- Has a high degree of cohesiveness but not to the point of stifling individual freedom.
- Makes intelligent use of the differing abilities of its members. Is not dominated by its leader or by any of its members.
- Can be objective about reviewing its own processes. It can face its problems and adjust to needed modifications in its operations.
- Maintains a balance between emotional and rational behaviour, channelling emotions into a productive group effort.

Tips for working with groups

- Make your role clear to the community and to the group you are working with.
- Build the confidence of the groups within the community.
- Give the group encouragement and support .
- Provide questions which stimulate insight.
- Ensure that the group considers a range of possibilities and not just one when setting up programs.
- Be aware of the limitations of the group.
- Ensure that goals are achievable.
- Always be prepared to learn from the group.

SUMMARY OF GROUP METHODS IN HEALTH PROMOTION

DIDACTIC GROUP METHODS	
LECTURE-DISCUSSION	Best for knowledge transmission, motivation in large groups. Requires dynamic, effective speaker with more knowledge than the audience.
SEMINAR	Smaller numbers (2-20). Leader-group feedback. Leader most knowledgeable in the group. Best for trainer learning.
CONFERENCE	Can combine lecture/seminar techniques. Best for professional development. Several authorities needed.

EXPERIENTIAL GROUP METHODS

SKILLS TRAINING	Requires motivated individuals. Includes explanation, demonstration and practice, e.g. relaxation, childbirth, exercise.
BEHAVIOUR MODIFICATION	Learning and unlearning of specific habits. Stimulus-response learning. Generally behaviour specific, e.g. quit smoking phobia desensitisation.
SENSITIVITIY/ ENCOUNTER	Consciousness raising. Suitable for professional training and some middle-class health goals.
INQUIRY LEARNING	Used mainly in school settings. Requires formulating and problem solving through group co-operation.
PEER GROUP DISCUSSION	Useful where shared experiences, support, awareness are important. Participants homogeneous in at least one factor, e.g. old people, prisoners, teenagers.

SIMULATION	Useful for influencing attitudes in individuals with varying abilities. Generally in school setting, but of relevance to other groups.
ROLEPLAY	Acting of roles by group participants. Can be useful where communication difficulties exist between individuals in a setting, e.g. families, professional practice, etc.
SELF-HELP	Requires motivation and independent attitude. Valuable for ongoing peer support, values clarification, etc. Can be therapy or a forum for social action.

METHODS AND APPROACHES: GENERAL POPULATION

MASS MEDIA: (MASS MEDIA IN HEALTH PROMOTION)

- MASS MEDIA: Any printed or audio-visual material designed to reach a mass audience. This includes newspapers, magazines, radio, television, billboards, exhibition, display, posters and leaflets

Media reaches wide range of people

2 types

1. **Limited reach media** - targets individuals or groups (pamphlets, brochures, booklets etc.)
2. **Mass media** - Reach everyone (TV, radio)

SUMMARY OF MEDIA METHODS

TYPE	CHARACTERISTICS
	Limited reach media
PAMPHLETS	Information transmission. Best where cognition rather than emotion is desired outcome.
INFORMATION SHEET	Quick convenient information. Use as series with storage folder. Not for complex behaviour change.
NEWSLETTERS	Continuity. Personalised. Labour intensive and requires detailed commitment and needs assessment before commencing.
POSTERS	Agenda setting function. Visual message. Creative input required. Possibility of graffiti might be considered.
T-SHIRTS	Emotive. Personal. Useful for cementing attitudes and commitment to program/idea.
STICKERS	Short messages to identify/motivate the user and cement commitment. Cheap, persuasive.
VIDEOS	Instructional. Motivational. Useful for personal viewing with adults as back-up to other programmes.

SUMMARY OF MEDIA METHODS

TYPE	CHARACTERISTICS
	Mass reach media
TELEVISION	Awareness, arousal, modelling and image creation role. May be increasingly useful in information and skills training as awareness and interest in health services.
RADIO	Informative, interactive (talkback). Cost effective and useful in creating awareness, providing information.
NEWSPAPERS	Long and short copy information. Material dependent on type of paper and day of week.
MAGAZINES	Wide readership and influence. Useful as in supportive role and to inform and provide social proof.

Terms in mass media:

- Message: A cultural communication encoded in signs and symbols.
- Marketing: The sum total of all activities (the marketing mix) designed to persuade people to adopt certain behaviours
- Advertising: One component of marketing mix.
- Audience segmentation: The division of a mixed population into more homogenous groups or market segments. Market segments are defined by certain shared characteristics which affect attitudes, beliefs and knowledge. Targeting specific market segments allows for more specific messages which will have a greater effect.

The mass media can:

- Raise consciousness about health issues
- Help place health on the public agenda
- Convey simple information
- Change behaviour if other enabling factors are present

The mass media cannot:

- Convey complex information
- Teach skills
- Shift people's attitudes or beliefs. If messages are presented which challenge basic beliefs, it is more likely that the message will be ignored, dismissed or interpreted to mean something else
- Change behaviour in the absence of other enabling factors

FACTORS IMPORTANT TO MEDIA EFFECTIVENESS

- CREDIBILITY: The source must be trusted and reliable
- CONTEXT: The message should be relevant to the receiver
- CONTENT: The message must be meaningful
- CLARITY: The receiver must be able to understand the message
- CONTINUITY: The message should be consistent without being boring
- CHANNELS: The message must used the established channel of the receiver use the media
- CAPABILITY: The receiver must be capable of acting on the message meaningful
- COLLABORATION: Media professionals should be involved to determine how best to use the media

WHEN TO USE THE MEDIA IN HEALTH PROMOTION

- When a wide exposure is desired
- When public discussion is likely to facilitate the educational process
- When awareness is the main goal
- When media is on-side
- When accompanying on the ground back-up can be provided
- When long-term follow-up is possible
- When a generous budget exists
- When counter-argument is likely to be productive
- When the behaviour goal is simple
- When a hidden agenda is public relations

SOCIAL MARKETING:

- Social marketing is the application of marketing concepts and techniques to the marketing of various socially beneficial ideas and causes instead or products and services in the commercial sense. (FOX & KOTLER, 1980)

THE MARKETING MIX: THE FOUR P'S

- PRODUCT: the physical product and its symbolic meaning
- PRICE: the value of the product
- PLACE: where the product is available
- PROMOTION: advertising, sales promotion, personal selling and publicity

8 IMPORTANT STEPS IN SOCIAL MARKETING PROGRAMMES

1. Establishing management and operating procedures
2. Selecting the products to be marketed
3. Identifying the consumer population
4. Deciding on brand names and packaging
5. Setting an appropriate price
6. Recruiting sales outlets
7. Arranging and maintaining a distribution system
8. Carrying out promotion

SOCIAL MARKETING: STRENGTHS

1. A valuable change tool
2. Useful in persuasion
3. Useful in creating awareness and interest
4. Helpful by reinforcing through repetition of message
5. Usually offer long term benefits of the behaviours promoted
6. Useful in increasing programme effectiveness if used in combination with other strategies
7. Has mass media appeal
8. Cost-efficient

SOCIAL MARKETING: WEAKNESSES & LIMITATION

1. Heavy reliance on mass media (effects of selective processes)
2. Makes the audience passive
3. Tends to be manipulative
4. May create negative public sentiments for real consumer products
5. Creates resistance if opposed to strongly reinforced and deeply entrenched ideas/habits
6. Focus on the "individual" rather than the "community" at large for the proposed change
7. Only appropriate in certain circumstances
8. Ideas from "outside" - not the audience's own

COMMUNITY DEVELOPMENT APPROACH:

- Means working to stimulate and encourage communities to express their needs and to support them in their collective action
- It is not about dealing with people's problems on a one-to-one basis
- It aims to develop the potential of a community
- A community development approach to health involves working with groups of people to identify their own health concerns and to take appropriate action
- Community development health workers are essentially facilitators locally based whose role is to help people in the community to acquire the skills, knowledge and confidence to act on health issues

ADVANTAGES AND DISADVANTAGES OF THE COMMUNITY DEVELOPMENT APPROACH

ADVANTAGES	*DISADVANTAGES*
Starts with people's concerns, so it is more likely to gain support.	Time consuming.
Focuses on root causes of ill health, not symptoms.	Results are often not tangible or quantifiable.
Creates awareness of the social causes of ill health.	Evaluation is difficult.
The process of involvement is enabling and leads to greater confidence.	Without evaluation, gaining funding is difficult.
The process includes acquiring skills which are transferable, for example, communication skills, lobbying skills.	The health promoter may find his or her role contradictory. O whom are they ultimately accountable – employer or community?
If health promoter and people meet as equal, it extends principle of democratic accountability.	Work is usually with small groups of people.

COMMUNITY PARTICIPATION IN PLANNING HEALTH WORK

NO PARTICIPATION	The community is told nothing, and is not involved in any way.
VERY LOW PARTICIPATION	The community is informed. The legacy makes a plan and announces it. The community is convened or notified in other ways in order to be informed; compliance is expected.
LOW PARTICIPATION	The community is offered ‘token’ consultation. The agency tries to promote a plan and seeks support or at least sufficient sanction so that the plan can go ahead. It is unwilling to modify the plan unless absolutely necessary.
MODERATE PARTICIPATION	The community advises through a consultation process. The agency presents a plan and invites questions, comments and recommendations. It is prepared to modify the plan.

Cont…

HIGH PARTICIPATION	The community plan jointly. Representatives of the agency and the community sit down together from the beginning to devise a plan.
VERY HIGH PARTICIPATION	The community has delegated authority. The agency identifies and presents an issue to the community, defines the limits and asks the community to make a series of decisions which can be embodied in a plan which it will accept.
HIGHEST PARTICIPATION	The community has control. The agency asks the community to identify the issue and make all the key decisions about goals and plans. It is willing to help the community at each step to accomplish its goals even to the extent of delegating administrative control of the work.

WAYS OF DEVELOPING COMMUNITY PARTICIPATION

- Be open about policies and plans
- Plan for the community's expressed needs
- Decentralise planning
- Develop joint forums and networks
- Provide support, advice and training for community groups
- Provide information
- Provide help with funding and resources

NB:

SELECTING THE RIGHT METHODS FOR EFFECTIVE HEALTH PROMOTION

FACTORS TO CONSIDER IN CHOOSING METHODS

- Which methods are the most appropriate and effective for your aims and objectives?
- Which methods will be acceptable to the consumer?
- Which methods will be easiest?
- Which methods will be cheapest?
- Which methods are the most acceptable to the people involved?
- Which methods do you find comfortable to use?

CHOOSING METHODS FOR HEALTH PROMOTION:

- The choice will be decided in part by external considerations, such as the amount of funding or the particular expertise of the health promoter
- The type of methods chosen should also reflect the objectives set. Certain methods go for certain objectives but would be inappropriate for other objectives
- Participative small group work is effective at changing attitudes but a more formal teaching session would be more effective if specific knowledge is to be imparted
- Community development is effective at increasing community involvement and participation bit would not be appropriate if local government policy change is the objective

- The mass media is effective in raising people's awareness of health issues but ineffective in persuading people to change their behaviour
- Deciding which methods would be the logical choice given the objectives is critical.
- A compromise may need to be considered owing to constraints of time, resources or skills
- This compromise should not concern the amount of input, or the use of complementary methods
- It should not mean that we end up using inappropriate methods which are unlikely to achieve the objectives

PRECEDE-PROCEED MODEL OF HEALTH PROMOTION PLANNING AND EVALUATION

- This model was developed by Green and Kreuter 1991
- They explained that the model is best used if the change agents begin with the final consequences (quality of life) then work backwards to the original causes
- This involves nine phases as follows:

Phase 1: Social Diagnosis:

- The process begins with the assessment of a community needs and their aspirations
- This can be enhanced by involving the community to identify what health related outcome they would want to achieve
- These outcomes take the form of social indicators and includes variables such as level of personal achievements, crime, crowding, discrimination and unemployment

Phase 2: Epidemiological diagnosis:

- Specific health goals that may contribute to social goals or problems noted in phase 1 are identified and ranked
- These includes assessing indicators such as morbidity, mortality, disability, and fertility while noting their prevalence, intensity and their incidence

Phase 3: Behavioural And Environmental Diagnosis

- Behaviours and environmental factors that contribute to the health problems are identified and ranked
- Behaviours such as compliance, consumption patterns , coping, preventive actions and self care re noted
- Economic, physical, service and social services are also ranked in terms of Access, affordability and equity

Phase 4: Educational and organisational diagnosis

- Prioritize predisposing factors, reinforcing and enabling factors which are likely to bring about behavioural and environmental changes
- Predisposing factors are those that hinder or facilitate or hinder motivation for change e.g. attitude, knowledge
- Reinforcing factors are those that are likely to reinforce any behavioural change e.g. behaviours and attitudes
- Enabling factors are the skills, resources or barriers that can help or hinder the desired change as well as environmental changes

Phase 5: Administrative and policy diagnosis

- Assess organisation and administrative capabilities and resources
- It also entails the selecting the right level and combination of methods and strategies and the launching of the community organisational or developmental process

Phase 6: Implementation

- This phase is the culmination of all other previous phases
- It should be as comprehensive as possible
- It should be acceptable in the community through social marketing meaning that it must be developed to meet the needs and interests of the populations

Phase 7,8,9; process, impact & outcome evaluation:

- It is a continuous and integral part of the entire diagnostic process
- Criteria for evaluation are derived from the educational objectives
- The extent to which education objectives are met represent process evaluation
- Objects of process evaluation includes measure of quality of life, health status indicators , behavioural and environmental factors, etc.
- The overall outcome evaluation represent impact evaluation

Developing health promotion programmes

Health promotion program should include:-

- Rationale
- Population group
- Programme description
- Linkages
- Review and evaluation
- Resources

Measuring changes in behavior evaluation

Quantitative and qualitative methods of evaluation are used

This Aims to change peoples attitudes and behavior

- **Short term -** develop indicators to look at the process programme
- **Long term -** develop indicators to for the outcome / impact of the programme
- **Documenting** the results of health promotion

Means to health promotion

1. Individual
2. Groups- schools, workplaces
3. Environmental – Modification of the environment, Development and enforcement of policy, technical interventions, intersectoral approach, advocacy and lobbying

Screening

- Is the process of checking or assessing individuals, families or communities who feel healthy, to identify if they have certain health problems or risks of developing health problems

Approaches to screening

1. History taking on various health risks, behaviors or exposures
2. Examining a person, family or entire community
3. Laboratory tests such as blood tests

Types of screening

- **Mass screening -** Screening whole populations
- **Targeted screening -** Individuals with high likelihood of suffering from a certain health problem
- **Opportunistic screening -** Taking an advantage when interacting with a patient
- NB/ After screening appropriate intervention should be undertaken; refer, treatment, counselling

Importance of screening in health promotion

1. Helps to detect health problems for prompt interventions
2. Identify individuals at risk and offer health education
3. Helps reach the unreached populations
4. Raise community awareness about health issues affecting them
5. Helps in planning of various community health interventions

COMMUNITY SKILLS:

ELEMENTS:

- Good governance
- Health literacy
- Health cities

GOOD GOVERNANCE

- Strengthening governance and policies to make healthy choices. Accessible and affordable to all and to create sustainable system that make whole of a society

HEALTHY CITIES

- Creating greener cities that enable people to live, work and play in harmony and good health

HEALTH LITERACY

- Increasing knowledge and social skills to help people to make the healthiest choices

HEALTH EDUCATION

Health Education

- Process which affects changes in the health practices of people and in the knowledge and attitude related to such changes.

OR

- Teaching process providing basic knowledge and practice of health, so as to be interpreted into proper health behavior.

- Process which affects changes in the health practices of people and in the knowledge and attitude related to such changes, so as to be interpreted into proper health behavior.

Terms:

- **Behaviour** - The way in which one acts or conducts oneself, especially toward others.
- **Attitude** - a settled way of thinking or feeling about someone or something, typically one that is reflected in a person's behaviour.
- Manner, disposition, feeling or position toward a person or thing
- **Learning** - the acquisition of knowledge or skills through experience, study, or by being taught and becoming changed.
- **Motivation** – Willingness of action especially in behavior or an incentive or reason for doing something.
- **Perception** – Conscious understanding of something or identification and interpretation of sensory information.

Terms:

- **Knowledge** – an intellectual acquaintances with facts, truth, or principles gained by sight, experience, or report.
- **Skills:** The ability to do something well, arising from talent, training or practice.
- Belief: Acceptance of or confidence in an alleged fact or body of facts as true or right without positive knowledge or proof; a perceived truth
- **Values:** Ideas, ideals, customs that arouse an emotional response for or against them.

Health education

Health education has been used interchangeably with

- Behaviour change communication
- Information, Education & Communication (IEC)

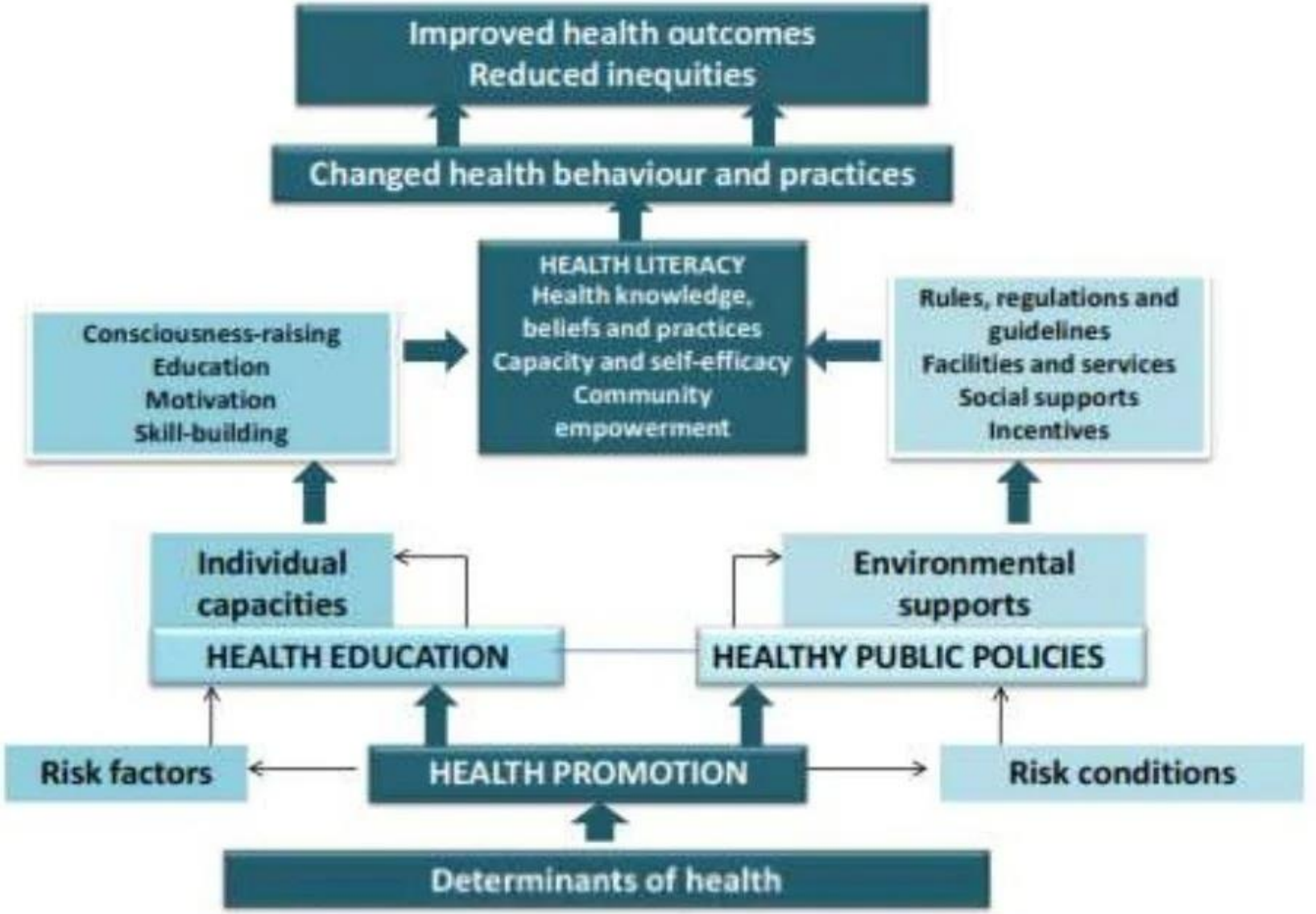
Behaviour Change Communication

- Is a process of working with individuals, families and communities through different communication channels
- to promote positive health behaviours
- and support an environment that enables the community to maintain positive behaviours taken on.

Information Education and Communication

- Is a process of working with individuals, communities and societies to develop communication strategies to promote positive behaviours that are appropriate to their settings.

Relationship between major health concepts



Aims of Health education

1. Health promotion and disease prevention
2. Early diagnosis and management.
3. Utilization of available health services.

Specific objectives of health education

1. To make health an asset valued by the community.
2. To increase knowledge of the factors that affect health.
3. To encourage behavior which promotes and maintains health.
4. To enlist support for public health measures, and when necessary, to press for appropriate governmental action.
5. To encourage appropriate use of health services especially preventive services.
6. To inform the public about medical advances, their uses and their limitations

Adoption of new ideas or practice:

Five steps

1. Awareness (know)
2. Interests (details)
3. Appraisal / Evaluation (Advantages Verses Disadvantages)
4. Trial (practices)
5. Adoption / Rejection (habit)

Stages for health education

1. Sensitization
2. Publicity
3. Education
4. Attitude change
5. Motivation and Action
6. Community Transformation (social change)

Contents of health education:

1. Personal hygiene
2. Proper health habits
3. Nutrition education
4. Personal preventive measures
5. Safety rules
6. Proper use of health services
7. Mental health
8. Sex education
9. Special education (occupation, mothers …..etc)

Principles of Health education:

1. Interest.
2. Participation.
3. Proceed from known to unknown.
4. Comprehension (thorough).
5. Reinforcement by repetition (Tell them, tell them……..).
6. Motivation
7. Learning by doing
8. People (be knowledgeable), facts (be reliable) and media (be acceptable).
9. Good human relations
10. Leaders

Objectives of Health education:

- W.H.O (1954) stated the objectives of health education as follows:

1. To make health an asset valued by the individual, family and community.
2. Help individual, family and community become competent in identifying their health problem and take responsibility in solving them.
3. Help them find ways and take appropriate action to prevent illness.
4. Promote the development and proper use of available service.

Changing Concept of Health Education

Pouring on concept:

- For many years health education was seen only acquiring information or knowledge.
- It was seen as sort of pouring information process.
- Information was disseminated without a purpose
- There was a little planning and evaluation.
- Health Education was making all people exposed to health information.
- This concept / dimension of Health Education was seen to be not working.

Getting result dimension / concept

- After shorter while it was realized Health Education was more than acquiring information.
- A new dimension was added to Health Education.
- It focused on **getting the results.**
- Health Workers were out to get the results regardless of what will happen.
- It was done by coercing, threatening , forcing and taking people to court if they failed to carry out the assigned activities.
- The dimensions had still some shortfalls.

COMMUNITY INVOLVEMENT IN HEALTH EDUCATION:

- The concept in use today
- Health Workers have realized that community should be involved in Health Education.
- Community should be involved from planning to implementation.
- Community participation and involvement is the only way to succeed in Health Education

PREPARATION FOR HEALTH EDUCATION

A. PLANNING HEALTH EDUCATION:

- Adequate preparation is very important before one sets out to give Health Education.
- Do not assume people you're going to give Health Education know nothing about your topic
- Establish their level of understanding.
- Health Education should be aimed at encouraging people develop confidence & skills on how to help themselves

Seven basic skills used for Health Education

1. Collection of information

- Collect information from the community to identify the problem.

Kind of information to collect;-

- How many have health problems.
- Possible cause for the problem.
- Reason for such act.

Importance

- Helps one to have health education to give to a particular community.
- Know the size of the problem and its seriousness.
- Helps one to identify the strategy to apply

2. Understanding the problem

By involving the community try to know the following;-

- Why there are problems?
- How the problem can be addressed?

3. Decide on the priority need

- It will help to know the area to talk on Health Education.

4. Resource identification.

- Resources within community.
- People in the community able to donate funds.
- Available materials.
- Skills in the community.
- Resources outside the community
- Agencies & ministries which can fund.
- People with skills & Materials.

5.Timetable preparation

- Plans tasks, who to do and when.

6.Selection of the appropriate methods.

- Which methods are applicable in solving the problems.

7. Evaluation

- After giving Health Education one should assess if b there any change.
- Can be done through data collection and comparing the actual and the expected.

PREPARATION FOR HEALTH EDUCATION – Continued

B: ORGANIZING.

- When organizing H/E, get what one needs for H/E.
- People needed and materials.

C: IMPLEMENTATION.

- This is the stage where you do the actual H/E activity.

Communication

- **Communication** - The process of creating a meaning or commonness between two or more people.
- **Communicator:** the person or the team give the message (Educator).
- Message: the contents (materials) of health education
- Channel: method of carrying the message
- Audience: the receivers (users or targets) of the message

Good communication technique

- Source credibility.
- Clear message.
- Good channel: individual, group & mass education.
- Receiver: ready, interested, not occupied.
- Feed back.
- Observe non-verbal cues.
- Active listing.
- Establishing good relationship.

Educator

- Personnel of health services.
- Medical students, nursing & social work.
- School personnel.
- Community leaders & influential.

Requirements:

- Personality: popular, influential and interested in work.
- Efficiency trained and prepared for the job.
- Must show good examples

Message

- What information to be communicated.
- Simple, at the level of understanding.
- Culturally accepted.
- Interested.
- Meet a felt need.
- Avoid technical jargon.
- Use audiovisual aids.

Practice:

1- Individual

Face to face

Education through spoken word.

A- Occasions of health appraisal.

B- Home visits Nurses

Health visitors

Social workers

2- Group

a) Lessons and lectures in schools.
b) lectures in work places e.g. factories.
c) Demonstration and training

3- Mass media.

a) Broadcasting: radio & TV.
b) Written word: newspapers, posters, booklets.
c) Others e.g., theaters.

Communication Barriers

1. Social and cultural gap between the sender and the receiver
2. Limited receptiveness of receiver
3. Negative attitude of the sender
4. Limited understanding and memory
5. Insufficient emphasis by the sender (health professional)
6. Contradictory messages
7. Health education without identifying the “needs "of the community

Major Variables in Behavior Change

- Thoughts and ideas inside a person's mind have significant influence on an individual's health behaviors. These variables interact with social and environmental factors and it is the synergy among all these influences that operate on behavior.
- **Knowledge:** An intellectual acquaintance with facts, truth, or principles gained by sight, experience, or report.
- **Skills:** The ability to do something well, arising from talent, training, or practice.
- **Belief:** Acceptance of or confidence in an alleged fact or body of facts as true or right without positive knowledge or proof; a perceived truth.
- **Attitude:** Manner, disposition, feeling, or position toward a person or thing.
- **Values:** Ideas, ideals, customs that arouse an emotional response for or against them.

METHODS & APPROACH TO HEALTH EDUCATION

Health education levels

Health Education can be carried out in three levels; -

1. Individual level
2. Group level
3. Community level / General /Mass

These levels are / makes the TARGETS OF HEALTH EDUCATION

Targets of health education

- As a Health Educators you use H/E activities to promote healthy behaviour and practices in the community you work in.
- H/E activities are expected to reduce health risk factors to maintain health of the community.
- Every stage of life, each individual or social group in the community are appropriate targets of health education programmes.
- Knowing target group enable to adapt a Health Education methods and activities to fit that particular group

NB: Levels of health education summary

- The health of **individuals,** and here is to educate the individual about the things that charge, such as nutrition, nature and causes of the disease and its prevention, personal hygiene and environmental sanitation ... etc.
- Healthy family, a lot of health behavior instills in the soul through the family so the education at this level demand because of its positive impact on the future of family members and then society as a whole.
- Health **groups**: Group include individuals with similar characteristics and exposed to or infected with some common health problems based on sex, age, that includes different groups of society, such as children group of smokers and others
- **Community**-based health education is done through the media so that up to a large number of citizens of different segments and levels.

INDIVIDUAL Health education (individual approach)

- All Health Educators use H/E to communicate with individuals within their community.
- Individuals include all health service users such as women receiving antenatal care, school children, adolescents and young children. Educators deliver health education messages at both household and at a community level.
- Such individuals may include TB patients in the community who are receiving anti-TB drugs.
- H/E for these individuals include giving advice to cover their mouth while coughing, adhere to the full course of their treatment as well as a variety of other educational issues that will help them get better themselves and protect the rest of the community from infection.

- Doctors and nurses, who are in direct contact with patients and their relatives, have opportunities for much individual health education. The topic selected should be relevant to the situation. For instance, a mother who has come for delivery should be told about child birth-not about malaria eradication.
- The biggest advantage of individual health teaching is that we can discuss, argue and persuade the individual to change his behaviour. The disadvantage is that the numbers we reach are small.

Individual Approach

Advantage	Disadvantage
■ Credible	■ Expensive
■ Permit 2 way discussion	■ Time Consuming
■ Can be motivational, influential and supportive	■ Limited Audience
■ Most effective for teaching, caring and helping	

GROUP health education (group approach)

- Are gatherings of two or more people with common interest and are good target for H/E sessions.
- To understand the concept of group H/E, imagine that there is a gathering of an HIV/AIDS peer educator group at the local secondary school.
- You may be invited by the school administrator to deliver health messages on HIV/AIDS to help train groups such as these.
- The groups are many – mothers, school children, patients, industrial workers – to whom we can direct health teaching. The choice of subject in group health teaching is very important; it must relate directly to the interest of the group. For instance, mothers may be taught about baby care; school children about oral hygiene; a group of TB patients about tuberculosis, and industrial workers about accidents.

Methods of health education for groups (Group Health Education)

These have been classified as below:

One – way or didactic methods:

- Lecture
- Films
- Charts
- Flannel graph
- Exhibits
- Flashcards

Two-way or Socratic Methods:

- Group discussion
- Panel Discussion
- Symposium
- Workshop
- Role playing
- Demonstration

Group Approach

Advantage	Disadvantage
Familiar, trusted and influential	May not provide individual personal attention
Provide Motivation / support more than media alone	Needs approval from organization
Can be inexpensive	Can be costly and time consuming
Offer shared experiences	
Reach large intended audience in one place	

COMMUNITY / Mass / General (Education of the general public (Mass Approach))

- H/E is also implemented at community level.
- A community can be described as a collection of people who have a feeling of belonging and share a common culture, beliefs, values and norms.
- In this context a community will also have a common interest regarding the possible health problems within your area.
- community members gain their personal and social identity through shared culture, beliefs, values and norms.
- All health education work relies on good relationships with people in your community.
- Community members exhibit some awareness of their identity as a group, their common needs and will have a commitment to meeting these needs.
- A community could be a town or a large area that is sparsely populated, it might also be the people involved with the school where you are working or a work site.

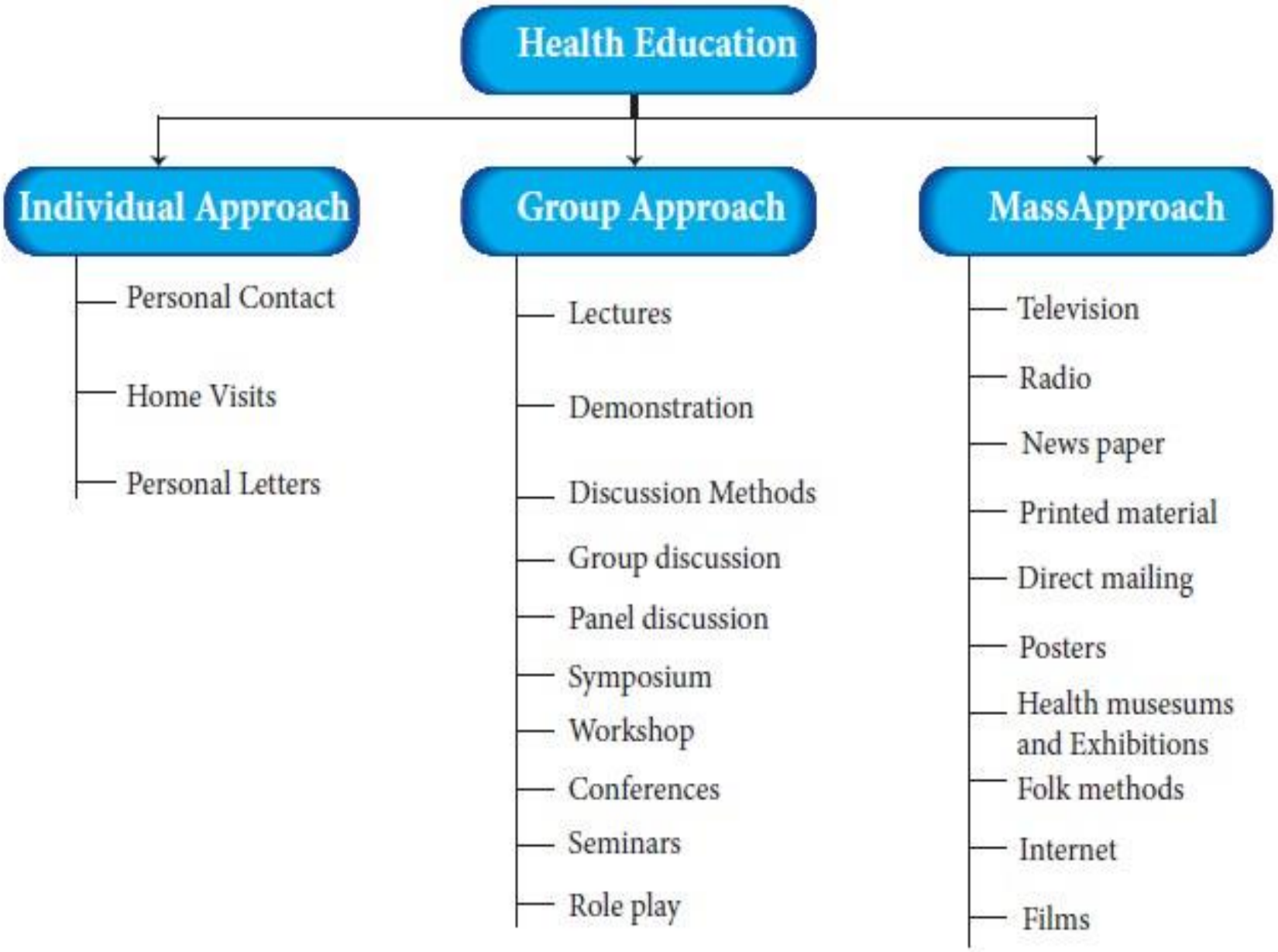
- For the education of the general public, we employ “mass media of communication’ – Posters, health magazines, films, radio, television, health exhibitions and health museums. Mass media are generally less effective in changing human behaviour than individual or group methods. But however, they are very useful in reaching large numbers of people with whom otherwise there could be no contact. For effective health education mass media should be used in combination with other methods.

Mass Approach

Mass Media	Advantage	Disadvantage
News Paper	■ Reach broad intended audience rapidly ■ Can convey health news/ break thoughts more thoroughly than T.V ■ Intended audience has the chance to clip reread, en template and pass along materials	■ Larger circulating papers may take only paid advertisement ■ Exposure is limited only to one way ■ Article placement requires contacts and may be time consuming
Internet	■ Reach large number of people rapidly ■ Updated and disseminated information ■ Control information provided ■ Tailor information specifically for intended audience can be interactive ■ Demonstration can be by individual and graphs ■ Can use banner advertisement to direct intended audience	■ Can be expensive ■ Many people do not have access to internet ■ Intended audience must be proactive ■ May require monitoring ■ May require maintenance over time

Mass Media	Advantage	Disadvantage
Radio	■ Range of intended audiences with known listening preference ■ Opportunity for direct intended audience involvement ■ Distribution is Expensive	■ Reaches Smaller intended audiences than T.V ■ Public service ads run infrequently and at low listening times ■ Many stations have limited formats that may not be conducive to health messages ■ Difficult for intended audiences to retain or pass on material
TV	■ Reaches potentially the largest & widest range ■ Combination of Audio visual is effective in emotional appeals and demonstration of behaviours ■ Can reach low – income audience ■ Specific programmes can reach specific intended audience ■ Opportunity for direct intended and audience involvement	■ Advertisement is expensive to produce ■ Running infrequently and in low viewing times ■ Message can be observed by commercial culture ■ Some stations reach small intended audience ■ Promotion can result in huge demand ■ Difficult to retain or pass on materials

Methods & Approaches of Health Education



APPROACH IN HEALTH EDUCATION

1. Regulatory Approach(Managed Prevention)
2. Service Approach
3. Educational Approach
4. Primary health care Approach

Legal or Regulatory Approach

- Any governmental intervention, direct or indirect, designed to alter human behaviour.
- Eg: Child marriage act in India, Seat belts rule in cars etc.
- Advantages: Simple , Quick
- Particularly , be useful in times of emergency or in limited situations such as control of an epidemic disease or management of fairs and festivals

Legal or Regulatory Approach

Limitations :

- In area of personal choice (alcohol , exercise etc.) no govt. can take away their right of freedom
- Difficult to enforce laws without a vast administrative infrastructure and considerable expenditure.

Service Approach

- Intends to provide all the health facilities needed by the people at their door steps on the assumption that people would use them to improve their own health.
- Limitation :not based on the felt-needs of people

For example, when water seal latrines were provided, free of cost, in some villages in India under the Community Development Programme, people did not use them. This serves to illustrate that we may provide free service to the people, but there is no guarantee that the service will be used by them.

Educational Approach

- Most effective
- Gives autonomy towards their own lives
- Components :

  1. motivation
  2. communication
  3. decision making

- results slow , but permanent and enduring.
- Sufficient time for an individual to bring about changes and learning new facts as well as unlearning wrong information as well.

Primary health care approach

- Radically new approach starting from the people with their full participation and active involvement in the planning and delivery of health services based on principals of art health care via community involvement and inter-sectoral coordination
- Individuals helped to become self-reliant in matters of health

Primary health care approach

- It can be done if the people receive the necessary guidance from health care providers in identifying their health problems and finding workable solutions.
- This approach is a fundamental shift from the earlier approaches.

APPROACH IN HEALTH EDUCATION

- Since individuals vary so much in their socio-economic conditions, traditions, attitudes, beliefs and level of knowledge
- A single approach may not be suitable.
- Combination of approaches must be evolved depending upon local circumstances

HEALTH PROMOTION MATERIALS

Methods of health promotion

1. Audio visual aids.
2. Role play.
3. Songs.
4. Poems.
5. Community barazas.
6. Schools.
7. Women and men groups.
8. Youth group etc.

HEALTH PROMOTION AIDS.

Various teaching aids are used by health promoter to public about health issues.

Importance of health promotion aids.

- Faster to understand.
- Stimulate learning.
- Bring out conducive environment.
- Bring out clarity of the concept.
- Provide a welcome break for learners who have been sitting for a while and listening to an instructor lecture in front.
- Pique (irritates) learners' interest and demonstrate how things work.

THE PROMOTION AIDS.

1). Audio-visual aids.

- These are aids which require the involvement of learners' listening and visual senses. Examples, of such types of aids include viz. graphic aids, display boards, and print material, television, films, videos, etc.
- Right expressions and audio effects in the visual aids help people to understand the real situation.
- Audio-visual aids allow one to teach behavior and concepts without much strain.
- People are able to relate to the format and pictures.
- Visual aids can also be used to talk about many things e.g hand washing, breast cancer examination etc.
- Charts can be used for teaching.
- Emotions can be well taught with the help of flip charts and computer based games and this can be like happy or sad expression.
- People are able to relate to the expressions almost immediately but repeating the session reinforces the same in their minds.

Visual-aids only.

- These are good for the deaf people.

1). Audio-visual aids.

Audio-aids.

- Help in developing the listening skill of a learner.
- They are those aids which can be only listened to. e.g. such types of aids include, radio, gramophone, tape recorder, audio-tapes, walk man, headphones etc.
- They are very useful for the blind people.

Tape recorder.

- Consists mainly of three parts-the microphone, the amplifier and the receiver.
- The talks/speech can be recorded and reproduced in the teaching through this teaching aid.
- Important merit of this aid is that the speech of a person can be recorded at any time and it can be used for a number of times at will, again and again.

Radio.

- General discussion or information on social issues, health and diseases, culture and life, about the events happening around the world etc, are broadcasted.
- As a follow-up activity, this program also supplement the presentation of a H/E whenever they are deemed fit for the discourse.

Cassettes:

- Cassettes can be used for recitations of health messages e.g. poems plays and stories, etc.

2). Role play / Drama.

- In role play, some of the participants take the roles of other people and act accordingly.
- Role play is usually a spontaneous or unrehearsed acting out of real-life situations where others watch and learn by seeing and discussing how people might behave in certain situations.
- Learning takes place through active experience, it is not passive.
- It uses situations that the members of the group are likely to find themselves in during their lives.
- You use role playing because it shows real situations.
- It is a very direct way of learning, participants are given a role or character and have to think and speak immediately without detailed planning, because there is usually no script.
- In a role playing situation people volunteer to play the parts in a natural way, while other people watch carefully and may offer suggestions to the players.
- Some of the people watching may decide to join in with the play.

Purpose of role play.

- The purpose of a role play is that it is acting out real-life situations in order that people can better understand their problems and the behavior associated with the problem.
- Role play is usually undertaken in small groups of 4 to 6 people.
- Remember role play is a very powerful thing.

NB:-

a) Role play works best when people know each other.
b) Don't ask people to take a role that might embarrass them.
c) Role play involves some risk of misunderstanding, because people may interpret things differently.
d) When doing role plays members of the group should be careful and stick to the play rules and regulations.

Drama:

- Drama is a very valuable method that you can use to discuss subjects where personal and social relationships are involved.
- Basic ideas, feelings, beliefs and values about health can be communicated to people of different ages, education and experience.
- It is a suitable health promotion method for people who cannot read, because they often experience things visually.
- However, the preparation and practice for a drama may cost time and money.

General principles in drama are:

- Keep the script simple and clear.
- Identify an appropriate site.
- Say a few words at the beginning of the play to introduce the subject and give the reasons for the drama.
- Encourage questions and discussions at the end.

3). Songs.

- A song is a work of music that is typically intended to be sung by the human voice with distinct and fixed pitches and patterns using sound and silence and a variety of forms that often include the repetition of sections.
- Songs in a simple style that are learned informally are often referred to as folk songs.
- A song may be for a solo singer, a lead singer supported by background singers, a duet, trio, or larger ensemble involving more voices singing in harmony.
- Songs may be written for one or more singers to sing without instrumental accompaniment or they may be written for performance with instrumental accompaniment.
- A song should be clear, loud enough and convey the intended message to the target population.

4). Poems.

- A poem is an art form in which human language is used for its aesthetic qualities in addition to, or instead of its notional and semantic content.
- It consists largely of oral or literary works in which language is used in a manner that is felt by its user and audience to differ from ordinary prose.
- There are certain ingredients that are important when composing a poem;

a) Message.
b) Form/Structure.
c) Point of View.
d) Voice/Tone.
e) Rhythm.
f) Grammar.

5). Community Barraza:

- Barraza is a Swahili word that describes the semi-formal and mostly regular public open air meetings convened by a local Chief/Leader for purposes of addressing local issues and facilitating the percolation of state agenda and policy down to the grass-roots.
- Apart from conflicts, barrazas are also called to address matters of public interest such as drug and substance abuse, illicit brews, HIV/AIDS awareness campaigns, missing children, lost animals, recruitments etc.
- Barrazas are very much a crucial component in the local resident's life.
- They are a crucial component in problem solving and dispute resolution because of various reasons i.e:

a) Inaccessibility aid - The common man is unable to get legal aid in conflict resolution and also health related matters like during disease outbreaks. This is possible in a barraza.
b) Simplicity - Barazas are very much informal settings where parties sit around and everyone is addressed as an “equal”.
c) Speedy - Based on the nature of the issues resolved in Barazas and the entire setting, the process is usually pretty quick and speedy. Simply agree on a convenient date and time, see the chief/leader, and that’s it.
d) Queue. There’s literally no queue and the informal setting means information is passed easily and quickly.
e) Message: Message should be simple and clear.
f) Questions: Allow the target group to ask questions at the end of the talk for clarification.

6) Schools:

- School health focuses on ensuring health promotion, conservation, protection and correction of abnormalities of the school population.
- A school health approach is advocated in the provision of health services as school children are easy to reach (captive audience).
- The message is also likely to have a multiplier-effect among the community members, through school children.

Objectives of School Health

- Promoting and maintaining the health of the school children.
- Promoting positive health behaviour among staff and students.
- Bringing up citizens who understand basic good health habits.
- Ensuring general community health by using the child as a channel for health messages to the family.
- Improving the physical and social environment of the school.
- Providing aspects of prevention of disease; Primary prevention, for example eating diets rich in vitamins A and C, iron and protein; Secondary prevention, that is, early diagnosis and treatment; Tertiary prevention which includes rehabilitation.

Needs of school children which requires health promotion interventions.

- A Stable Home: The home should provide basic needs especially shelter and security.
- Proper Nutrition: The child needs to grow well physically and mentally. It is therefore important for the child to take adequate nutrition at least three times a day.
- Freedom from Fatigue: The child needs to have enough rest at home from school activities.
- Clothing: This is normally provided as school uniform, which should be clean and tidy.
- Good Sight, Hearing and Speech: Defects of sight, hearing and speech interfere with the learning process of a child.
- Freedom from Infection: All school children should be immunised against childhood diseases.
- Pure and Safe Water: This should be provided in the school and at home to prevent water related diseases.
- Clean Buildings: The home and school environment should be kept clean.

7). Group discussion.

- The groups may be of men, women, youth or mix-up groups.
- Group discussion involves the free flow of communication between a facilitator and two or more participants.
- Often a discussion of this type is used after a slide show or following a more formal presentation.
- This type of teaching method is characterized by participants having an equal chance to talk freely and exchange ideas with each other.
- Group discussions do not always go smoothly and sometimes a few people dominate the discussion and do not allow others to join in.
- Your job as the facilitator is to establish ground rules and use strategies to prevent this from happening.

OTHER METHODS OF HEALTH PROMOTION IN THE COMMUNITY.

1) HEALTH TALKS.

- Talking is often the most natural way of communicating with people to share health knowledge and facts.
- In the part of your job that involves health education, there will always be many opportunities to talk with people.
- Group size is also important.
- The number of people who you are able to engage in a health talk depends on the group size.
- However, you will find talks are most effective if conducted with small gatherings (5–10 people), because the larger the group the less chance that each person has to participate.

Preparing a health talk.

When you are preparing a talk there are many things to consider:

- **Know the group.** Find out its needs and interests and discover which groups are active in your locality.
- **Select an appropriate topic.** The topic should be about a single issue or a simple topic. Always ensure that you have correct and up-to-date information and look for sources of recent information.
- **List the points you will talk about:** Prepare only a few main points and make sure that you are clear about them.
- **Write down what you will say:** If you do not like writing, you must think carefully what to include in your talk. Think of examples, proverbs and local stories to emphasize your points and which include positive health messages.
- **Prepare visual aids:** Visual aids are a good way to capture people's attention and make messages easier to understand. Well-chosen posters and photos that carry important health messages will help people to learn.
- **Practice your talk beforehand:** This should include rehearsing the telling of stories and the showing of posters and pictures.
- **Determine the amount of time you need:** The complete talk including showing all your visual aids should take not more than about 20 minutes. Allow another 15 minutes or more for questions and discussions. If the talk is too long people may lose interest.

LECTURE.

- You may have the opportunity to give a lecture, perhaps in your local school or in another formal setting.
- A lecture is usually a spoken, simple, quick and traditional way of presenting your subject matter, but there are strengths and limitations to this approach.
- The strengths include the efficient introduction of factual material in a direct and logical manner.
- However, this method is generally ineffective where the audience is passive and learning is difficult to gauge.

DEMONSTRATION.

- In your work as a health promoter, you will often find yourself giving a demonstration.
- This form of health education is based on learning through observation.
- There is a difference between knowing how to do something and actually being able to do it.
- The aim of a demonstration is to help learners become able to do the skills themselves, not just know how to do them.
- -Some health related things that would be best taught through demonstration include;

✓ The whole process of measuring blood pressure.
✓ How to use a mosquito net.
✓ Putting/Inserting a condom.
✓ Giving a child medicine.
✓ Proper breast feeding, etc.

MASS MEDIA.

Any printed or audio-visual material designed to reach a mass audience. This includes;

- Newspapers; Magazines; Radio; Television; Billboards; Exhibition; Display; Posters; Leaflets

Mass media is effective if:

1. It is part of an integrated campaign including other elements such as one-to-one advice.
2. The information is new and presented in an emotional context.
3. The information is seen as being relevant for "people".

PRIMARY HEALTH CARE (PHC)

Primary Health Care:

- This is an essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participations and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

NB:

- **Essential health care:** Group of functions essential for the health of the people given at lower level of health service. e.g. Medical care, MCH/FP, school health, environmental health, control of communicable diseases, health education, referral, etc.

- **Scientifically sound:** Scientifically explainable and acceptable.
- **Socially acceptable methods and technology:** Intervention should consider the local value, culture and belief.
- **Universally accessible:** Because of the inequitable distribution of the available resources, the services are not reachable by all who need them. Only a few can afford or within the reach to use them, while the majority are excluded from the service. Therefore, PHC being health care as close as possible to where people live and work, guarantee universal accessibility.
- Community based programs: These are public Health interventions that are designed, implemented and evaluated with the participation of the community representatives and with the guidance of professional experts.

Historical development of PHC

Early Approaches.

- In the 1950's, there were vertical health service strategies that included mass campaigns, specialized control programs for communicable diseases such as Tuberculosis, Malaria, sexually transmitted diseases (STDs), etc., but the strategy was very expensive and so unsuccessful.
- The concept of basic health service came into being in the mid 1960s. This gives more attention to rural areas through the construction of health centers and health stations providing both curative and preventive services.
- Early 1970: Integration of specialized disease control programs with basic health services came to appear. However, even this approach was disease oriented, based on high cost health institutions and requires advanced technology.

Summary on effect of health services and programs during 1950-1970s.

- Despite health being a fundamental human right the health status of hundreds of millions people in the world was unacceptable.
- In spite of the tremendous efforts in medicine and technology, the health status of people in disadvantaged areas of most countries remained low.
- The organized limited health institutions failed to meet the demands of those most in need who are usually too poor or geographically or socially remote to benefit from such facilities (Accessibility).
- The health services often created were in isolations, neglecting other sector (Agriculture, Education, Water Supply etc.), which are relevant to the improvement and development of health.

- Health institutions stressed curative services with insufficient priority to preventive, promotive and rehabilitative care.
- The community has already been given the opportunity to play an active role in deciding the types of activities they want and have not participated in the actual services they receive.
- All the above facts summed up and led WHO and UNICEF to evaluate and reexamine the existing policies in 1978, Alma-Ata, and the concept of PHC.

Elements of primary health care from the Alma-Ata declaration (1978).

- Education concerning prevailing health problems and the methods of preventing and controlling them.
- Promotion of food supply and proper nutrition.
- An adequate supply of safe water and basic sanitation.
- Maternal and child health care, including family planning.
- Immunization against the major infectious diseases.
- Prevention and control of locally endemic diseases.
- Appropriate treatment of common diseases and injuries.
- Provision of essential drugs.

Additional elements incorporated after Alma-Ata.

- Dental Health.
- Mental Health.
- Use of traditional medicine.
- Occupational health.
- HIV/AIDS.
- Community –based Rehabilitation.

PHC PRINCIPLES.

Emphasized principles in PHC are:

1. Inter-sectoral collaboration.
2. Community participation.
3. Use of appropriate technology.
4. Equity.
5. Focus on prevention and promotion of health.
6. Decentralization.

1. Inter-sectoral collaboration:

- Means a joint concern and responsibility of sectors responsible for development in identifying problems, programs and undertaking tasks that have important bearing on human well-being.

- Inter-sectoral collaboration is very important, as the intrinsic relationship of health to other sectors is evident. That is low level of education, poor access to transport, limited access to safe water supply can affect health status.
- Similarly, development in these sectors cannot process smoothly without health development.

Benefit of Inter-sectoral collaboration.

- It enhances communication and good relationship among the sectors.
- It avoids resource wastage by minimizing duplications of projects and programs.
- Encourages a forum for exchanging and sharing ideas, skills, resources and technologies.
- It leads to a successful project implementation.
- Avoids confusion of the community.
- As a long term outcome it promotes integrated and fast development of a country.

2. Community participation:

- Community is a group of people living together in the same geographical area, sharing common interests.
- Community participation/involvement implies sensitizing the people to their health problems, increasing their receptivity and ability to prevent disease, death and disability.
- This helps them to respond to development programmers and encourages local initiatives.
- Community participation/involvement in programs is a spectrum that ranges from receiving the benefits to actually planning and evaluating them.

Types of community participation/involvement.

- **Marginal:** Participation of people in the health programs in a limited and transitory way.
- **Substantial:** The community plays active role in determining priorities and helping in carrying out health related activities, such as, health education, provision of drinking water and maintenance of good personal and food hygiene.
- **Structural:** Participation of the community in health care becomes an integral part of the program and a major basis for health activities.

Interpretations on community involvement.

- At a WHO sponsored meeting on community participation in health, held at Brioni, Yugoslavia, in 1985, two broad and distinct interpretations on community involvement were identified.

Those were:

i. Creating awareness and understanding, regarding the causes of poor health, thus making it a basis for their involvement in health related activities.
ii. Ensuring easy access to information and knowledge about health service programs and projects.

Therefore, in this approach, people have the right and duty to actively involve themselves in:

- Solving their own health problems.
- Assessing their health needs.
- Taking responsibility for mobilizing local resources.
- Supporting new approaches and solutions to their problems.
- Creating and maintaining local organizations.
- Administration and financing of the health services.

Advantages of a community participation approach.

- It is a cost-effective way of extending a health care system to the geographical and social periphery of a country.
- Communities that begin to understand their health status objectively rather than fatalistically may be moved to take a series of preventive measures.
- Communities that invest labor, time, money and materials in health-promoting activities are more committed to the use and maintenance of the things they produce, such as water supplies.
- Health education is most effective as part and parcel of village activities.
- Community health workers, if well chosen, have the people's confidence because they know the most effective techniques for achieving commitment from their neighbors and they are not likely to exploit them.

Factors that hinder involvement of the community in health:

- Rigid professional behavior of health service providers, which need to be tempered to allow greater community involvement.
- The professional staff generally takes decisions in health services and there is no tradition of allowing people to be involved in decision making.
- Wrong assumption by health staff that community does not know what is good for them and that only health staff can determine their needs.
- Lack of flexibility in health service and general unwillingness to change.

Mechanisms for supporting community Involvement.

- **Political commitment:** National health policy should clearly design the need and support of community involvement in health care, and lay down working arrangement. The government should assure full political support.
- **Reorientation of bureaucracy:** Bureaucracy has the power to make all decisions. Their role should be changed and they should learn to seek community involvement in health, so that people can determine their own priorities and decide on the process to achieve their goals.
- **Support to the community in managing health project:** Management support and guidance should be given to the community to help the people in overseeing primary health care activities in their area.
- **Inputs:** There should be critical minimum inputs for basic health services and coverage to ensure co-operation of the community. People can be involved in health activities only if these are available to their satisfaction.
- **Partnership:** Genuine partnership between health professionals and people is necessary for success.
- **Leadership:** Individual and collective leadership at the community level should be promoted.
- **Active community involvement:** Community involvement in decision making should be at a realistic level so that it is sustainable and durable.
- **Decentralization:** There should be decentralization of administrative and decision making functions. This should be accompanied by shift of resources to the locality.
- **Safeguards:** Sufficient safeguards should be built in to prevent local political and elite from exploiting the resource for their own end benefits.

3. Use of appropriate technology.

- It takes account of both the health care and the socio-economic context of the country.
- This must include consideration of cost (efficiency and attractiveness) in dealing with the health problem.
- It should also take consideration of the acceptability of the health care approach to both target community and health service technology and it does not necessarily mean low cost.

Criteria for technology appropriateness.

To be appropriate, a technology must be;

- Effective i.e. should meet its objectives.
- Culturally acceptable and valuable.
- Affordable.
- Locally sustainable: We should be not over dependent on important skills and supplies for its continuous function, maintenance and repair.
- Environmentally accountable: The technology should be environmentally harmless or at least minimally harmful.
- Measurable: - The impact and performance of technology should be measurable.

4. Equity.

- This is to close the gaps between the “haves and have nots” which will help to achieve more equitable distribution of health resources.
- If all cannot be served, those most in need should have priority.
- While planning for equity in PHC, one requires the identification of groups, which are currently disadvantaged in terms of health services access and utilization of service.
- Generally, it implies that the rural and peri-urban poor population should also have a reasonable access to health service.

5. Focus on prevention.

- In addition to the fact that prevention is better, cheaper and easier than cure, the main health problems plaguing developing countries are preventive in nature. Community should engage more on preventive services.

6. Decentralization.

- It is sharing and transferring power and decision away from the center to the periphery.
- It brings decision closer to the communities served and the field level providers of services.
- It leads to greater efficiency in service provision

PHC STRATEGY

The following are the strategies for PHC;

- Changes in the Health care system.
- Total coverage with essential health care.
- Integrated system.
- Involvement of communities.
- Use and control of resources.
- Redistribution of existing resources.
- Re-orientation of Health manpower to PHC.
- Legislative changes - Health policy should address the need of the strategy of PHC.
- Design, planning and management of Health system.

Pillars of PHC.

1) Health care system.
2) Priority.
3) Sustainability.
4) Appropriate technology.
5) Science.
6) Culture.
7) Equity.
8) Participation.
9) Intersectoral collaboration.

THE BAMAKO INITIATIVE

BACKGROUND

- In 1987 Sub-Saharan Africa was in a deep political and economic crisis. In several Countries child mortality rates exceeded 200 per 1,000 live births. The debt service obligations were crashing stagnant economies. National budgets for health, education and other social services were declining, despite a rapidly increasing population.
- The Government financial allocation to public health, in the best cases, was barely enough to pay the salary of the staff. As a result the availability of public health services was deteriorating fast.
- During this period, the philosophy of Primary Health Care (PHC) was the main strategy to improve health service delivery. However, African countries were bogged down by the lack of resources and of practical implementation strategies.
- In many African Ministries of Health, PHC became one of the several, externally financed, vertical programs.
- At that time, the World Bank was tentatively moving into the health sector with little experience, a strong ideological framework based on privatization, cost recovery and big loans.

- This led to the introduction of Structural Adjustment Programs (SAPs) by the World Bank and the International Monetary Fund (IMF). The ideology of SAPs was to assist the third world countries in using donor money prudently. The health sector was much affected.
- The Bamako Initiative (BI) was a pragmatic strategy to implement primary health care (PHC) in the era of economic structural adjustment.
- UNICEF, then under the leadership of Mr. James P. Grant, had embarked in a strong advocacy effort (Adjustment with a Human Face) to call the world's attention to the need of rescheduling the debt and of guaranteeing that under the adjustment program imposed by the International Monetary Fund (IMF) and the World Bank (WB) social safety nets were solidly in place.
- Mr. Grant had launched the Child Survival Revolution, which was accused by the WHO of lacking the comprehensiveness of Primary Health Care and thus missing the sustainability component.
- The surprise launch of the Bamako Initiative during the September 1987 WHO Regional Meeting of the African Ministers of Health was his response to the critics of the Growth Monitoring, Oral Rehydration, Immunization, Family Planning, Female Education approach and his attempt to focus the world attention to the African situation.

- The Bamako Initiative (BI) was a pragmatic strategy to implement primary health care (PHC) in the era of economic structural adjustment.
- Championed by UNICEF's charismatic leader, James Grant, it sought to fill the gap created by WHO's open-ended approach to health for all and a hard economic reforms pursued by the World Bank and IMF.
- Economic reforms virtually destroyed social services and safety nets. The idea of BI was to select a few critical elements of PHC for child survival, which would be funded partly through community contributions.
- These contributions were expected to be in addition to donor and Government expenditure.
- Grant's proposal was based on the awareness that many health facilities lacked the medicines and the cash in hand to function. As a result, the health workers were merely prescribing drugs to be bought from private outlets, very often unlicensed an unsupervised.
- Many patients were not even bothering to turn up, when sick, to the inefficient public clinics. They were just buying drugs in pharmacies and markets or visiting private clinics, where they were available and affordable.
- So in Grant's mind several questions were urgently in need of practical answers.

- E.g. How could we increase and sustain the progresses in immunization?
- How could we ensure that diarrhea, respiratory infections and, maybe, malaria, could get properly addressed in an efficient way?
- How could we guarantee that drugs were always available in public facilities to attract a large number of clients to the curative and preventive services required to drastically reduce child mortality?
- The core of the challenge was to promote additional donor investment, stop and reverse the decline of Government expenditure and attract back into the public health system the money spent by people to purchase drugs in the private and informal sector.
- The communities were not expected to contribute more resources out of their pocket, but on the contrary to receive better quality services, curative as well as preventive, from a fraction of what they were already spending in the informal system.
- The cost reduction was to be achieved by improvement of the infrastructure, supply of drugs and consumables, training of the staff (all financed by donors) and by introducing a mechanism of oversight, run by community representatives.
- The expected advantages of this reform process were the availability of a limited, but lifesaving package of health services, both preventive and curative and a community of users responsible for running their basic health units, while primed for health action at community level.

INTRODUCTION OF USER FEES FOR HEALTH

- One principal vehicle for implementation of user fees is the Bamako Initiative (BI), adopted by African health ministers in 1987, and aimed primarily at increasing availability of resources for essential drugs.
- The Initiative was promoted by the UNICEF and the WHO, and stressed the need for community and individual self-reliance and participation in planning, organization, operation and control of primary healthcare, making fullest use of local, national and other available resources.
- The BI proposed decentralizing health decision making to the district level; establishing a realistic national drug policy; and providing basic essential drugs.
- It advocated a combination of financing by users, communities, districts and the central government, depending on the specific circumstances in each country.
- It stipulated that fees collected from patients should not replace existing health budgets. The community would control locally generated funds with consideration for protecting the poorest.

- The BI recognized that fees could be a barrier to treatment for low-income districts or households, and included ways of dealing with this. Charges were supposed to be set at a level which is modest in relation to household income, but which still generates enough income to allow for a proportion of patients not to pay anything.
- Community health committees or the government could subsidize those on low incomes.
- Preventive care, such as vaccinations, could be given free or heavily subsidized.
- Charges for less essential but very popular treatments, such as injections, were allowed to be higher than for vital treatments. It was also expected that low-income areas would receive larger government subsidies.
- The emphasis of the resolution adopted by African health ministers was on community participation in the financing of health services, through "drug revolving funds" (in which an initial supply of drugs is provided to a community, and proceeds from the sale of these drugs are used to buy further supplies).
- Although countries followed different paths in implementing the Bamako Initiative, in practice they had a common core objective: providing a basic package of integrated services through revitalized health centers that employ user fees and community co-management of funds

- A number of common support structures were organized around this core agenda, including the supply of essential drugs, training and supervision, and monitoring.
- The pace of expansion of BI varied depending on the availability of internal and external resources, local capacity, the need to work at the speed of community needs and pressure from governments and donors.
- Most of the sub-Saharan countries that adopted the BI employed some form of phased scaling up, and several countries – most notably Benin, Mali and Rwanda – achieved significant results.
- In essence, implementing the BI was a political process that involved changing the prevailing patterns of authority and power.
- Community participation in the management and control of resources at the health-facility level was the main mechanism for ensuring accountability of public health services to users.
- Health committees representing communities were able to hold monitoring sessions during which coverage targets, inputs and expenditures were set, reviewed, analyzed and compared.
- It is estimated that the initiative improved the access, availability, affordability and use of health services in large parts of Africa, raised and sustained immunization coverage, and increased the use of services among children and women in the poorest fifth of the populace.

LIMITATIONS OF BAMAKO INITIATIVE

- The application of user fees to poor households and the principles of cost recovery drew strong criticism, and though many African countries adopted the approach, only in a handful were initiatives scaled up.
- Even in those countries where BI has been deemed a success, poor people viewed price as a barrier in the early 2000s, and a large share did not use essential health services despite exemptions and subsidies.
- Public accountability is now well recognized as a non-optional component in the production of public goods and can be achieved in several ways depending on the cultural and political context. The group of people with a vested interest in public health, i.e. local community, creates a system of checks and balances. The users and providers are both accountable. If the users are powerless, the system works for the provider's exclusive interest.

- The user power is not free to have and it needs to be maintained. A substantive amount of control by the users of the resources needed for the functioning of the health unit is a prerequisite for accountability.
- If money is essential, information is equally important. In the BI, health committees representing communities were able to hold monitoring sessions in which coverage targets, inputs and expenditures were set, reviewed, analyzed and compared. The health staff acted as technical resources, not as masters of the facilities.
- To gain the popular support needed to win over the resistance of staff to changes of their power, it is important to start by producing rapid improvements at the service delivery end. In the BI experience, the bulk of resources were invested in the basic health units to improve availability, quality and affordability of services to gain a rapid support of the people in the early phase of the process.
- The challenge to provide quality services for the poor is compounded today by the AIDS pandemic. Health statistics in Africa are worse today than they were in 1987.
- Africans are today more aware that it is up to them to hold their leaders accountable. The experience gained in implementing the BI could provide them with few practical hints of how to assert their rights to essential social services.

ALMA ATA DECLARATION

- International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.
- It expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world.
- It was the first international declaration underlining the importance of primary health care.
- The primary health care approach has since then been accepted by member countries of the World Health Organization (WHO) as the key to achieving the goal of "Health for All".

The declaration

1. The Conference strongly reaffirms that health, is a fundamental human right.
2. The existing gross inequality in the health status of the people, is politically, socially, and economically unacceptable and is, therefore, of common concern to all countries.
3. Economic and social development, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries.
4. The people have a right and duty to participate individually and collectively in the planning and implementation of their health care.
5. Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community should be the attainment by all peoples by the year 2000.

6. Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.
7. An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts.
8. All governments should formulate national policies, strategies and plans of action to launch and sustain PHC as part of a comprehensive national health system and in coordination with other sectors.
9. All countries should cooperate in a spirit of partnership and service to ensure PHC for all people since the attainment of health by people in any one country directly concerns and benefits every other country.

The Basic Requirements for Sound PHC (the 8 A's and the 3 C's)

1. Availability.
2. Adequacy.
3. Accessibility.
4. Acceptability.
5. Affordability.
6. Appropriateness.
7. Accessibility.
8. Accountability.
9. Completeness.
10. Comprehensiveness.
11. Continuity.

Appropriateness.

- Whether the service is needed at all in relation to essential human needs, priorities and policies.
- The service has to be properly selected and carried out by trained personnel in the proper way.

Adequacy.

- The service is proportionate to requirement.
- Should have sufficient volume of care to meet the need and demand of a community.

Affordability.

- The cost should be within the means and resources of the individual and the country.

Accessibility.

- Reachable, convenient services.
- Geographic, economic, cultural accessibility.

Acceptability.

- Acceptability of care depends on a variety of factors, including satisfactory communication between health care providers and the patients, whether the patients trust this care, and whether the patients believe in the confidentiality and privacy of information shared with the providers.

Availability.

- Availability of medical care means that care can be obtained whenever people need it.

Accessibility.

- Accessibility means that medical care can be readily evaluated.

Accountability.

- Accountability implies the feasibility of regular review of financial records by certified public accountants.

Completeness.

- Completeness of care requires adequate attention to all aspects of a medical problem, including prevention, early detection, diagnosis, treatment, follow up measures, and rehabilitation.

Comprehensiveness.

- Comprehensiveness of care means that care is provided for all types of health problems.

Continuity.

- Continuity of care requires that the management of a patient's care over time be coordinated among providers.

To Summarize.

Primary health care is an approach that:

1. Focuses on the person not the disease, considers all determinants of health.
2. Integrates care when there is more than one problem.
3. Uses resources to narrow differences.
4. Forms the basis for other levels of health systems.
5. Addresses most important problems in the community by providing preventive, curative, and rehabilitative services.
6. Organizes deployment of resources aiming at promoting and maintaining health.

PHC LEVELS OF CARE.

1) Primary health care.
2) Secondary health care.
3) Tertiary health care.

Primary health care level

- The “first” level of contact between the individual and the health system.
- Essential health care (EHC) is provided.
- A majority of prevailing health problems can be satisfactorily managed.
- The closest to the people.
- Provided by the primary health centers.
- Health is not a gift that could be given to communities by health professionals.
- Communities can achieve better health status through their own efforts and the health worker’s role is to help them identify their problems and to point out methods for dealing with the problems.

Secondary health care level.

- More complex problems are dealt with.
- Comprises curative services.
- Provided by the district hospitals.
- The 1st referral level.

Tertiary health care level.

- Offers super-specialist care.
- Provided by regional/central level institution.
- Provide training programs.

Individual and collective responsibility for Health.

- 1st Aspect is a political issue: - Decentralization of decision-making.
- 2nd Aspect is realization: - Personal responsibility for their own and their family's health.
- NB: It is important to have informed and motivated public on the practice at both aspects.

COMMUNITY BASED HEALTH CARE (CBHC)

HOME AND COMMUNITY BASED CARE (HCBC):

- HCBC is Care of persons with chronic or terminal illnesses extended from health facility to the patients' home through family participation and community involvement within available resources and in collaboration with health care workers.

Why HCBC?

- Most patients with chronic and terminal illnesses are discharged before full recovery and therefore the need for continuity of care.
- Health institutions have many limitations such as shortage of health workers and bed capacity.
- Most care providers at home lack basic knowledge on self-protection when caring for patients especially those with HIV and other infectious infections.
- HCBC helps reduce the stigma attached to some chronic diseases.
- There is need to offer continuity of care to prolong lives and reduce suffering of patients with chronic/terminal illness.

Objectives of HCBC.

1. To facilitate the continuity of the client's care from the health facility to the home and community.
2. To promote family and community awareness of disease prevention and care related to chronic illnesses.
3. To empower the clients, the family and the community with the knowledge needed to ensure long-term care and support.
4. To raise the acceptability of terminally ill patients by the family/community, hence reducing the stigma.
5. To streamline the patient/client referral from the institutions into the community and from the community to appropriate health and social facilities.
6. To facilitate quality community care.
7. To mobilize the resources necessary for sustainability of the service.

PRINCIPLES OF HOME AND COMMUNITY BASED CARE

1. Ensure **appropriate, cost-effective** access to quality health care and support to enable persons living with chronic illnesses to retain their self-sufficiency and maintain quality of life.
2. Encouraging the **active participation** and involvement of the patient and their family.
3. Fostering the active participation and involvement of those **most able to** provide support to the community at all levels.
4. Ensuring **respect** for the basic **human rights.**
5. Instituting measures to ensure the **economic sustainability** of home and community care support.

6. Building and **supporting referral networks/linkages** and collaboration among participating entities.
7. **Building capacity** at the household, community and institutional levels.
8. Addressing the **differential gender impact** of the HIV/AIDS epidemic and other chronic illnesses and care.
9. Developing the vital role of **home and community based care** as the link between prevention and care.
10. Taking a **multi-sector approach** to care and support.
11. Addressing the **reproductive health needs** of persons living with chronic illnesses.
12. Targeting **social assistance** to all affected families especially children.
13. **Caring for caregivers**, in order to minimise the physical and spiritual exhaustion that can come with the prolonged care of the terminally ill (Avoid burn-out).

HOME AND COMMUNITY BASED CARE NEEDS

1. Physical Needs.

- Drugs.
- Clinical care such as regular check-ups.
- Basic needs e.g. clothing, housing, food, fuel/energy, water, education for children and income.
- General nursing care - toilet needs, observation of vital signs, care of wounds, personal and oral hygiene and comfort.
- Nutritional needs.
- Physical therapies.
- Information, education and communication (IEC), including up-to-date, accurate information on the disease, on writing a will and on preparing for the eventuality of death, on how to take prescribed drugs, prevention and care of the clients' illness.

2. Spiritual / Pastoral Needs.

- Need to repent and be forgiven.
- Needs to forgive others.
- Need reassurance that God accepts them.
- Needs religious groups support.
- Need freedom of worship according to faith.
- Need for sacraments and fulfilment of other religious needs – e.g. anointing of the sick.

3. Social needs.

- Respect.
- Love and acceptance from others.
- Company of those around them.

- Source of income/income-generating activity.
- Right to own, inherit and give property.
- Confidentiality regarding their condition by all who know about it.
- Help with the activities of daily living.

4. Psychological Needs.

- Love.
- Encouragement.
- Warmth and appreciation.
- Reassurance and help in coping with the disease.

HCBC COMPONENTS.

1. Clinical care.
2. Nursing Care.
3. Counseling and psycho spiritual care.
4. Social support.

Components 1: Clinical Care.

It is a continuation of medical care in the home.

- Early diagnosis
- Rational and targeted treatment
- Planning for the care.

Clinical care activities

- Ensuring early detection, treatment of opportunistic infections and other complications.
- Reducing the suffering
- Protecting the client against further infections.
- Preventing transmission of HIV or other opportunistic infections
- Ensuring that drugs prescribed to the client by the clinician are administered at home according to the regimen of intake.

Component 2: Nursing Care.

This aims to promote and maintain:

- Good health.
- Hygiene.
- Nutrition.
- Training family and community members to give care to those that require it.

Nursing care activities.

- Activities to ensure good personal hygiene; bed bathing, assisted bathing, oral care, care of the nails and hair etc.
- Care for the client's environment.
- Preventing the transmission of pathogenic micro-organism.

- Physical therapy.
- Maintenance of skin integrity through care of pressure areas and pressure sores.
- Wound care.
- Pain management.
- Administering drugs as per prescription to ensure compliance and relieve symptoms.
- Maintaining the nutritional status of the client.
- Observing of clients to detect problems like dehydration, dyspnoea (shortage of breath), dysphagia (difficult in swallowing), oedema or fever.

Related conditions that need attention include:

- Diarrhoea and vomiting, which may easily lead to dehydration.
- Pain and discomfort.
- Chest problems like chronic coughs, colds and infections.
- Skin conditions.
- Bed sores.
- Nausea, mouth and throat infections.

NB: It is important to;

- Take the patient/client to the hospital or health facility when need arises.
- Reassure the client at all times.

Component 3: Counselling and Psycho-spiritual Care.

- This will prolong their life and make it bearable by;
  - Positive living and making decisions on the basis of informed choice.
  - Reducing stress and anxiety for both the patients and their families.
- Helps people to understand and deal with their problems and communicate better with those around them.
- Helps clients to cope with their feelings.

Component 4: Social Support.

- Information and referral to support groups such as church organisations, youth groups and other social organisations.
- Clients need assurance and acceptance by their families and the community.
- They should get involved in family/community activities depending on their capabilities.
- They should be provided with legal advice and material assistance.
- Should be given opportunities to write their own wills.

ADVANTAGES OF HCBC

Patient.

- The patient is cared for in a familiar environment hence less stress and more ability to bear the illness.
- When people are in their homes, they continue to participate in family matters.
- When one is at home close to family members, friends and relatives, there is a sense of belonging.
- one is in close contact with familiar people they are likely to accept their conditions and illnesses.

Family and community.

- Caring for sick people at home prevents separation and holds family members together.
- Less expensive.
- Helps them to understand these diseases better and accept the patients.
- Community cohesiveness is maintained.

Health institutions.

- less cost and pressure on resources.

PLAYERS IN HCBC.

1. Patient-Identifies care giver, gives consent, participates in care.
2. Family Members and Caregiver.
3. Health care Team.
4. Health facility.
5. Community.
6. Government.

Resources Needed for Home-based Care.

1. Money.
2. Materials.
3. Time.
4. Manpower.

Networking for Home-based Care.

Network- is a group of individuals or organisations that work together, undertake joint activities, or exchange information in order to strengthen and extend their individual capacities.

Reasons for referring a patient

1. When services or resources within reach are not able to meet the patients' immediate needs.
2. In cases where the acute phase of the disease has been dealt with, and it is considered safe to transfer care to other caring services/organisations within the community.
3. When the caregiver experiences burnout and has no access to counselling services for personal growth.
4. When the caregiver has limitations in meeting certain needs of the patient, for example, based on religious beliefs.
5. For better, more competent management in the next stage of referral.
6. For specialized care in a hospital setting, especially if the patient is deteriorating.

Referral constraints

1. Competition among various organisations, so that they do not disclose what they are doing and which services are offered. They prefer to work in isolation.
2. Lack of evenly distributed community HCBC programmes, with the result that some areas lack services and some are overcrowded.
3. Lack of resources needed for patients to travel from one point to another.
4. Lack of referral and networking guidelines as well as standardized referral procedures.
5. Ignorance among family members about HCBC due to lack of awareness and proper guidance.
6. Fear of breach of confidentiality.

COMMUNITY MOBILIZATION

- The process of getting the community incorporated to fully participate in the programmes for the purpose of ownership and sustainability. The community must participate and get involved in the decision making process, planning, organisation, and implementation and monitoring of activities associated with HCBC.

The importance of Community Mobilization

1. Prepare the community for participatory action.
2. Create awareness about their health problems, causes, prevention and care required.
3. Identify problems together with the community and seek means of solving them.
4. Gather information about the community's beliefs', feelings, myths and misconception of their problems.
5. Identify available resource and how the resources can be used to solve the problems.
6. Establish relationships within the community.
7. Ownership and sustainability of the programme.

Factors that can hinder Community Mobilization:

1. Lack of involvement in problem identification.
2. Lack of appropriate information.
3. Lack or mismanagement of resources.
4. Insecurity.
5. Lack of social structures.
6. Communication barriers.
7. Poor health.
8. Lack of ownership.
9. Lack of interest.
10. Poor infrastructure.
11. Lack of knowledge of other partners.
12. Social differences (religious, education, cultural, economic, political, tribal, etc).
13. Poor leadership.
14. Man-made or natural disasters.
15. Poor timing.

Mobilizers

1. Local administrative officers and leaders such as chiefs, assistant chiefs, councillors and area members of parliament.
2. Leaders of various programmes, for example, district AIDS control committee.
3. Religious leaders.
4. Organised groups, for example, religious groups (women's guild), youth groups, women groups (the Maendeleo ya Wanawake organisation).
5. Community based health workers.
6. Community Own Resource Persons (CORPs), for example, traditional birth attendants and traditional healers.
7. Other ministries workers like social workers, school teachers, etc.
8. Patients themselves.

Ways of mobilizing the community:

1. Meeting at specific prefixed times, e.g community barrazas.
2. Existing committees, such as the village
3. development committee.
4. Home visits to groups and individuals.
5. Announcements at church, mosque, temple, and school.
6. Use of mass media electronic/print.

Process of Mobilization.

1. Planning and organizing.
2. Community entry.
3. Conducting community mobilization sessions.
4. Evaluation and reinforcement.

COMMUNITY HEALTH STRATEGY.

- It is the mechanism through which households and communities strengthen their role in health and health development by increasing their knowledge, skills and participation.
- Community participation will eventually contribute to socio-economic development of their community and the Country Kenya.
- Approach also recognizes the pivotal role of the health system in supporting community efforts.

Service charter for community health strategy.

- **Vision:** The vision for community health strategy is "healthy people living healthy and good quality lives in robust and vibrant. A community that makes up a healthy and vibrant nation".
- **Mission:** The mission for community health strategy is for the community health approach to become the modality for social transformation for development from community level by establishing equitable, effective and efficient community units (CU's) all over Kenya.

Overall goal for community health strategy.

- "Address community health problems".

Aims of the community health strategy.

1. To empower Kenyan household and communities to take charge of improving their own health.
2. To build the capacity of households not only to demand services from all providers but to know and progressively realize their rights to equitable, good quality health care.

Strategic objectives of community health strategy.

Overall objective: Establish sustainable community level (Level 1) services aiming at promoting and empowering households and communities to take charge of their own health.

Specific objectives:

1. Provide level one health services as per national health sector strategic plan 2005/2010.
2. Strengthen the capacity of community health volunteers.
3. To strengthen the linkage between community and facility based services.

Challenges/ Rationale.

- Rising infant mortality rate from 64 per 1,000 live births in 1993, to 72 in 1998, 74 in 2000 and 77 per 1,000 live births in 2003 (KDS 2003).
- Rising under five mortality rate from 90.9 per 1,000 live births in 1989 to 115 per 1,000 live births in 2003 (KDS 2003).
- High maternal mortality rate of 590 per 100,000 in 1998 and 414 in 2002 per 100,000 live births (MOH 2005).

Specific challenges- KDHS 2003.

- 30.7% of the children under 5 years were stunted.
- Only 2.6% children were still exclusively breastfeeding at 6 months while 56.8% (of 2.6%) were still breastfeeding by end of 2003.
- Only 59.2 per cent of children in the second year of life were fully immunized.
- Only 4.3% under-fives and 4.5% pregnant mothers sleep under ITNs respectively.
- Only 40.8 per cent of deliveries were assisted by a health professional and only 39.4 per cent occur in health facilities.
- There were rising levels of communicable diseases (Malaria, TB, HIV etc).
- There was poor state of sanitation and water supply.
- Community members take care of preventive, promotive and some of the critically ill cases.

Justification of community health strategy.

- Studies in Tanzania and Malawi have shown that 70% of child deaths occur at home, caused by preventable or easily curable diseases such as malaria, measles, ARI, pneumonia, diarrhoea and malnutrition.
- Formal health providers are supply driven (assume what they advised or give has been accepted or is practical), usually not true.
- Traditional and non-formal care is the first option for many people and they compete with formal health care system at community level.
- An effort to strengthen community level health care has been scattered, uncoordinated and vertically managed by various actors resulting on weak public health interventions.
- These contributed to the deterioration of health indices.

What does community health strategy entail?

1. Establishing a level one care community unit to serve a local population of about 5000 people (CU).
2. Instituting a cadre of well-trained community health volunteers (CHVs) who will each provide level one service to about 20 households.
3. Supporting every 25 CHVs with a community health extension worker (CHEW) ensuring that the recruitment and management of CHVs is carried out by village and community health committees.

Community health strategy guiding principles.

1. Organize communities into functional units of 1000 households.
2. Use CHVs who will work on voluntary basis.
3. Incentives to CHVs to include protective wear, where necessary, drug kits, reimbursement of direct costs and periodic reward for excellent performance.
4. CHV to be nominated by the communities on the basis of pre-defined criteria.
5. Community heath extension workers (CHEWs) to be on government payroll and facilitated (e.g. transport and lunches).
6. Community to play a leading role in joint health actions.
7. Coordination structure to bring all actors at all levels.
8. Strengthen effective communication through advocacy, social mobilization and interactive communication.

Workforce involved in implementation of community health strategy.

- **CHVs -** Expected to be mature, responsible and respected members of the community, men or women chosen by the community to provide basic health care. They should be good communicators and leaders who have shown signs of healthy practices as a parent or caregiver in their own households.
- **CHEWs -** Are trained health personnel with certification in Nursing or Public health. They supervise CHVs and are ministry of health employees.
- **CHCs -** Community health committees are a group of people who are charged with responsibility of leading community health action at the community unit level. They are composed of 9 to 11 people selected from the community. The CHEW is the secretary to CHC and the CHV is the treasurer in the committee.

Norms and standards for the community units (CUs)

1. One CHV will serve 20 households or 100 people.
2. One community health extension worker- CHEW (trained PHT, PHO, Community Nurse, registered nurse) will supervise and support 25 CHVS.
3. One level one unit (Community Unit) will serve 5000 people and requires;

- 50 CHVs.
- 2 health extension workers.

Strategy.

- ❑ This is a new dimension of health service delivery.
- ❑ There is need to develop a comprehensive message (for all the services: including Malaria, HIV/AIDS, RH, etc) for a CHV to deliver for their catchment's population and covering different cohorts.
- ❑ Provide them with one comprehensive Kit to go with while providing health services.

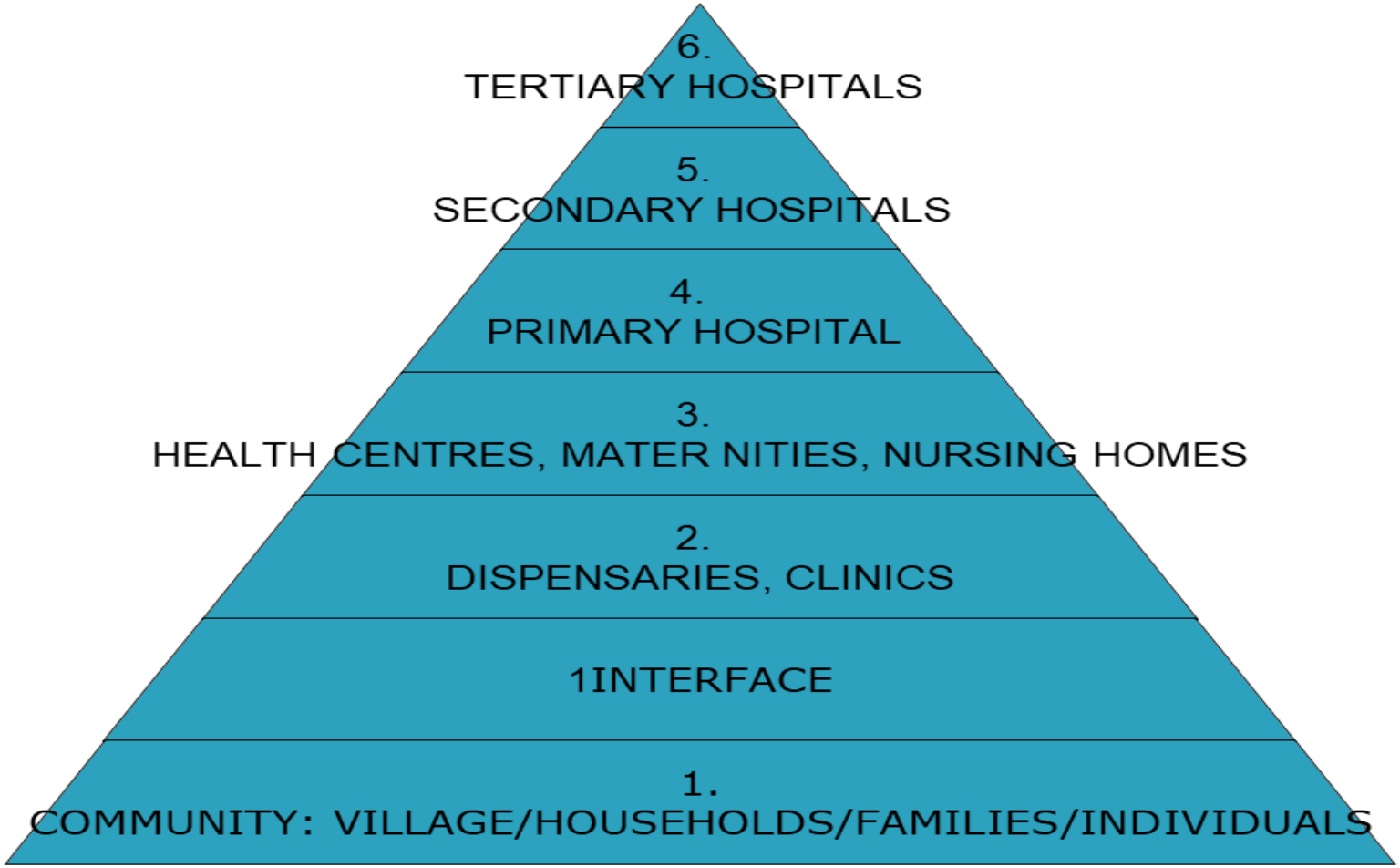
NB: Kenya's NHSSP II (2005-2010) defined a new approach to the way the health sector will deliver health care services to Kenyans by introducing Kenya essential package of health (KEPH).

Subsequently, KEPH introduced 6 lifecycle cohorts and 6 service delivery levels.

Life cycle cohorts.

1. Pregnancy and new born (Up-to 2wks of age).
2. Early childhood (2wks to 5years).
3. Late childhood (6 to 12 years).
4. Youth and adolescents (13 to 24 years).
5. Adulthood (25 to 59 years).
6. Elderly (60+ years).

Service delivery levels.



Level 1 services include the following;

1. Disease prevention and control to reduce morbidity, disability and mortality.

- Communicable disease control – HIV/AIDS, STI's, TB, Malaria, Epidemics.
- First Aid and emergency preparedness/ treatment of injuries/ trauma.
- IEC materials for community health promotion and disease prevention.

2. Family health services: Family planning, maternal, child and youth services.

- Promoting early initiation and exclusive breastfeeding for 6 months.
- Defaulter tracing on immunization and vitamin A supplementation.
- Growth monitoring and referral of moderately and severely malnourished children.

- Promoting utilization of MCH/FP services including ANC, skilled birth attendance, post natal care, immunization and nutrition.
- Non communicable diseases control, nutritional deficiencies, cardiovascular diseases, diabetes, neoplasms (tumors), anemia, mental health, etc.
- Community based referral system for women and children requiring intervention by skilled workers.

3. Hygiene and Environmental sanitation.

- Promotion of use of latrines for waste disposal.
- Protection of water supply, including protection of springs.
- Promotion of household water treatment, control of insects and rodents.
- Promotion of hand washing at critical times (before eating, after visiting toilets, before preparation of foods).
- Promoting Healthy home environment - environmental sanitation.
- Organize community health days.

Roles of households in health.

1. Disease prevention.
2. Care seeking and compliance with treatment and advice.
3. Health promotion within members.
4. Governance and management of health services.

Interventions.

- Establish L1 service package for each implementing unit.
- Distribute supplies according to guidelines and controls.
- Promote early service seeking behavior.
- Facilitate health promotion.
- Facilitate environmental sanitation, safe water supply and personal hygiene.
- Provide first aid and treatment of common ailments.
- Establish a referral mechanism and identify and refer clients.

Policy issues.

- All programs to buy into this strategy and minimise provision of messages vertically.
- PHTs, PHOs, RNs and ECHNs to be retrained and deployed as health extension workers.
- Allow committees to identify CHVs.
- Let there be a plan to retain the CHVs.
- Incentives for CHVs to be sustained.

VISION 2030, MILLENNIUM DEVELOPMENT GOALS AND SUSTAINABLE DEVELOPMENT GOALS.

The Kenya health policy 2012-2030.

Goal- Attaining the highest possible health standards in a manner responsible to the population needs.

Aims- To achieve this goal through supporting provision of equitable, affordable and quality health related services at the highest attainable standards to all Kenyans.

- This policy gives Kenyans direction to ensure significant improvement in overall status of health in line with vision 2030 and the constitution.
- The policy is based on three pillars;

1. Political.
2. Economical.
3. Social.

The 3 pillars of vision 2030.

The adoption of the vision 2030 by Kenya came after a successful implementation of the economic recovery strategy (ERS) for wealth and employment creation. This increased GDP from 0.6% in 2002 to 6.1% in 2006.

1. Economic pillar: The aim is to improve prosperity of all Kenyans through economic development programme in all regions of Kenya. It also aimed at achieving a GDP growth rate of 10% per annum beginning 2012.
2. Social pillar: Seeks to build a just and cohesive social equity in a clean and secure environment.
3. Political pillar: It aims to realize a democratic political system founded on issue based politics that respects the rule of law and protects the right and freedom of every individual in Kenyan society.

NB: The vision 2030 is to be implemented in successive five-year medium term plans;

Five year medium term plans;

1st period - 2008 - 2012.

2nd period - 2012 - 2017.

3rd period - 2017 - 2022.

4th period - 2022 - 2027.

5th period - 2027 - 2030.

MILLENNIUM DEVELOPMENT GOALS (MDGs)

The millennium development goals were eight in number, namely;

1. Eradicate extreme hunger and poverty.
2. Achieve universal primary education.
3. Gender equality and women empowerment.
4. Reduce child mortality indicators.
5. Combat HIV/AIDS, malaria and other diseases.
6. Improve maternal health.
7. Ensure environmental sustainability.
8. Develop a global partnership for development.

Change of MDGs to SDGs – (Sustainable development goals).

By 2015 the goals of MDG s were not met, thus a meeting was held in Sept 2015 and came up with the 17 sustainable development goals (SDG s).

- The new set of the Sustainable Development Goals (SDGs), aimed to end poverty and hunger by 2030.
- World leaders, recognizing the connection between people and planet, have set goals for the land, the oceans and the waterways.
- The world is also better connected now than it was in 2000, and is building a consensus about the future we want.
- That future is one where everybody has enough food, and can work, and where living on less than $1.25 a day is a thing of the past.

THE 17 SDGs.

1. SDG 1 No poverty.
2. SDG 2 Zero hunger.
3. SDG 3 Good health and well-being.
4. SDG 4 Quality education.
5. SDG 5 Gender equality.
6. SDG 6 Clean water and sanitation.
7. SDG 7 Affordable and clean energy.
8. SDG 8 Decent work and economic growth.
9. SDG 9 Industry innovation and infrastructure.
10. SDG 10 Reduced inequalities.
11. SDG 11 Sustainable cities and communities.
12. SDG 12 Responsible consumption and production.
13. SDG 13 Climate action.
14. SDG 14 Life below water.
15. SDG 15 Life on land.
16. SDG 16 Peace, justice and strong institutions.
17. SDG 17 Partnership for the goals.

1. **End poverty in all its forms.**

- End of extreme poverty in all forms by 2030.
- In 2000, the world committed to cutting the number of people living in extreme poverty by half in 15 years and we met this goal.
- However, more than 800 million people around the world still live on less than $1.25 a day, that's about the equivalent of the entire population of Europe living in extreme poverty.

2. **Improve food security and nutrition.**

- In the past 20 years, hunger has dropped by almost half.
- Many countries that used to suffer from famine and hunger can now meet the nutritional needs of their most vulnerable people.
- That means doing things such as promoting sustainable agriculture and supporting small farmers.
- It's a tall order but for the sake of the nearly 1 out of every 9 people on earth who go to bed hungry every night, we've got to try.

3. Ensure healthy lives and promote well-being.

- We all know how important it is to be in good health.
- Since 1990, we've made big strides, preventable child deaths are down by more than half, and maternal mortality is down by almost as much.
- Some other numbers remain tragically high, like every year 6 million children die before their fifth birthday.
- AIDS is the leading cause of death for adolescents in sub-Saharan Africa.
- We have the means to turn that around and make good health more than just a wish.

4. Ensure equitable quality education.

- Poverty, armed conflict and other emergencies keep many kids around the world out of school.
- In developing regions, kids from the poorest households are four times more likely to be out of school than those of the richest house- holds.
- Since 2000, there has been enormous progress on the goal to provide primary education to all children world- wide.
- The primary school enrolment rate in developing regions reached 91%.
- More girls are in school now compared to the year 2000.
- Most regions have reached gender parity in primary education.
- This goal aims to ensure that there is an end to discrimination against women and girls everywhere.

5. Ensure gender equality and women empowerment.

- Women and girls continue to suffer from distribution and violence in every part of the world.
- 1 in 5 women and girls between the ages 15-49 have reported experiencing physical or sexual violence by an intimate partner.
- Many countries have no laws protecting women from domestic violence.
- Providing women and girls with equal access to education, health care, decent work and representation in political and economic decision-making processes.
- Many countries have taken action to track budget allocation for gender equality.

6. Ensure availability of water and sanitation.

- Everyone on earth should have access to safe and affordable drinking water.
- That's the goal for 2030.
- Water scarcity affects more than 40 percent of people around the world, and that number is projected to go even higher as a result of climate change.
- If we continue the path we're on, by 2050 at least one in four people are likely to be affected by recurring water shortages.
- Diarrhea, caused by inadequate access to water and sanitation, is the fifth leading cause of death in the world.
- Unsafe water and sanitation facilities account for most of the 1.2 million deaths of children under five each year caused by diarrhea.
- They also cause great suffering in both adults and children through diseases associated with intestinal parasites.

7. Ensure access to affordable energy.

- Between 1990 and 2010, the number of people with access to electricity increased by 1.7 billion. That's progress to be proud of.
- As the world's population continues to rise, more people will need cheap energy to light their homes and streets, use phones and computers and do their everyday business.
- The way we get energy is an issue. Fossil fuels and greenhouse gas emissions (e.g Water vapour, CO2, methane, nitrous oxide, Ozone, etc) are making drastic changes in the climate, leading to big problems on every continent.

8. Promote sustainable economic growth.

- An important part of economic growth is that people should have jobs that pay enough to support themselves and their families.
- The middle class is growing worldwide, almost tripling in size in developing countries in the last 25 years.
- But in 2015, there was widening inequalities where over 200 million people had no jobs.
- We can promote policies that encourage entrepreneurship and job creation.

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9. Build infrastructure and sustainable industrialization.

- Technological progress helps us address big global challenges such as creating jobs and becoming more energy efficient.
- The world is becoming ever more interconnected and prosperous through internet.
- The more connected we are, the more we benefit from the wisdom and contributions of people everywhere on earth.

10. Reduce inequality among countries.

- The rich get richer, and the poor get poorer.
- We can and must adopt policies that create opportunity for everyone, regardless of whom they are or where they come from.
- Income inequality is a global problem that requires global solutions.
- That means improving the regulation of financial markets and institutions, sending development aid where it is most needed and helping people migrate safely so they can pursue opportunities.

11. Make cities and human settlements safe.

- More than half the world's population now lives in cities and that figure will go to about two- thirds of humanity by the year 2050.
- In 1990 there were ten "mega-cities" with 10 million inhabitants or more.
- In 2014, there were 28 mega-cities, home to 453 million people.
- To make cities sustainable for all, we can create good affordable public housing, upgrade slum settlements, invest in public transport, create green spaces and get involved in urban planning decisions.

12. Ensure sustainable consumption and production patterns.

- A big share of the world population is consuming too little to meet even their basic needs.
- We can have a world where everybody gets what they need to survive and thrive.
- We can consume in a way that preserves our natural resources so that our children can enjoy them.
- Help countries that have not consumed a lot to move towards more responsible consumption patterns.

13. Take action to combat climate change and its impacts.

- Every country in the world is seeing the drastic effects of climate change, some more than others.
- The impact of global warming is getting worse.
- On average, the annual losses from earthquakes, tsunamis, tropical cyclones and flooding count in hundreds of billions of dollars.
- This goal lays out a way for countries to work together to meet this urgent challenge.

14. Conserve and use marine resources for sustainable development.

- More than 3 billion people depend on marine and coastal diversity for their livelihoods.
- Today we are seeing nearly a third of the world's fish stocks overexploited.
- Oceans absorb about 30 percent of the carbon dioxide that humans produce.
- We are producing more carbon dioxide than ever before and that makes the oceans more acidic, 26% more, since the start of the industrial revolution.
- This goal targets for the managing and protecting the life below the water.

15. Protect and restore ecosystems.

- Humans and other animals rely on other forms of life on land for food, clean air, clean water, and as a means of combating climate change.
- Plant life makes up 80% of the human diet.
- Forests, which cover 30% of the earth's surface, help keep the air and water clean and the earth's climate in balance.
- Plants and forests are home to millions of animal species.
- Arable land is disappearing 30 to 35 times faster than it has historically.
- Deserts are spreading.
- Animal breeds are going extinct.
- This goals aims to conserve and restore the use of terrestrial ecosystems such as forests, wetlands, dry lands and mountains by 2020.

16. Promote peace, justice and strong institutions.

- People cannot eat, learn, work and raise families without peace.
- A country cannot have peace without justice, without human rights, without government based on the rule of law.
- This goals aims to reduce all forms of violence and propose that governments and communities find lasting solutions to conflict and insecurity.

17. Strengthen partnership for the goals.

- The world is more interconnected today than ever before by internet, travel and global institutions.
- 193 countries agreed on these Goals.
- This final goal lays out a way for Nations to work together to achieve all the other goals.

END

THANKS