HEALTH PROMOTION

**COURSE OUTLINE**

1. Definitions and concepts in health promotion
2. Ottawa charter for health promotion
3. Principles, aims and elements of health promotion
4. Methods of health promotion
5. Steps of an organized community dialogue
6. Health education; definitions, aims, objectives, principles, models
7. Theories of health education
8. Approaches of health education
9. Steps in carrying out health education programs
10. Methods of health education
11. Planning for a health education program
12. Behavior change and communication
13. Information, education and communication
14. Advocacy and networking
15. Growth monitoring, home management and disease prevention
16. Health seeking behavior and compliance
17. Behavior changes models (health belief models)
18. Steps in behavior change
19. Factors affecting behavior change

**AIMS OF HEALTH PROMOTION**

1. Help people to understand that Health is the most valuable community asset
2. To develop scientific knowledge, attitude , skills on health matters to help and enable people correct their risk habits
3. To educate people on proper use of health services in whatever form it is made available to them by the government
4. To change behaviour which may have directly influenced occurrence or spread of diseases in a given cultural setting
5. To help people achieve health by their own actions and efforts

**DEFINITIONS AND CONCEPTS OF HEALTH PROMOTION:**

HEALTH:

Medical definition

Health is the normal physical state i.e the state of being whole and free from physical and mental disease or pain, so that the part of the body can carry on their proper function

World Health Organization (WHO) definition

Health is a state of complete physical, mental and social well being and not merely the absence of disease (WHO)

Health is a positive concept emphasizing personal resources as well as physical capacities.

Health:

* Dynamic state and condition
* Multidimensional
* Results from interaction with the environment
* Is a resource for living?
* Exists in varying degrees

Wellness: A purposeful, enjoyable and deliberately lifestyle choice characterized by personal responsibility and optimal enhancement of physical, mental, emotional, social and spiritual health.

Personal health activities:These are activities that promote, protect and preserve health of self and family.

Community health:

* Health status of a defined group
* Public and private actions and conditions to promote , protect and preserve the health of the group.

Public health:

* Health status is a defined group
* Governmental actions and conditions to promote , protect and preserve the health of the group.

Health Education

1. Any combination of planned learning experiences based on sound theories that provide individuals, groups and communities the opportunity to acquire information and skills needed to make quality health decisions.
2. According to smith (1979)health education refers to sum total of all influences that collectively knowledge belief and behavior related to promotion; maintenance and restoration of health in individuals and communities.
3. According to Dowme et al 1990 health education is communication activity aimed at enhancing positive health and preventing or diminishing ill health in individuals and groups, through influencing the belief attitudes and behavior of the community at large.
4. Technical definition of health education according to tones and Tilford ,health or illness related learning I.e. some relatively permanent change in an individual capability or disposition.

Health promotion:

1. Any planned combination of education, political, environmental, regulatory or organizational mechanisms that support actions and conditions of living conducive to the health of individuals, groups and communities (Joint committee 2001)
2. The process of enabling people to increase control over, and improve their health (WHO EURO 1984)
3. The process of enabling people to increase control over and improve their health, by creating living and working conditions that enable people to make Healthy choices, and support them in their choices (WHO 1986)
4. Health Promotion include strengthening the skills of individuals to encourage healthy behaviour and also include building the healthy social and physical environments to support these behaviour (Health Canada 2005)

Health promotion is a process of helping people to take control over their lives so that they can choose options that are health giving rather than those that are health risky (Vetter, N, Matthews 1 Epidemiology and Public Health Medicine .Churchill Livingstone 1999:216)DEFINITIONS:

Advocacy: this is a process of influencing political commitment, policy support, social acceptance, and system support for a particular health goal or programme

Health communication: This is a key strategy to inform the public about health concerns and to maintain important health issues on the public agenda. The use of mass media, multi media and other technological innovations to disseminate useful in formation to the public, increase awareness of specific aspects of individual and collective health as well as importance of health development.

Collaboration: A recognized relationship among different sectors or groups, which has been formed to take action on an issue in a way that is more effective or sustainable than might be achieved by the sector or group acting alone.

Health promotion approaches: these are interventions undertaken to solve health issues. This include; medical/disease prevention approach, behavioral approach, educational approach, empowerment and social change.

Health Protection

Defined as protecting individuals, groups and population from single cases of infectious disease, incidents and outbreaks and non-infectious environmental hazards such as chemical and radiation

**CONCEPTS OF HEALTH PROMOTION**

1. Medical approach I ( Traditional, Biomedical)

Health concept is Biomedical, absence of disease and/disability.

Leading Health problems defined in terms of disease categories and physiological risk factors such as physiological deviation from the norm: cardiovascular diseases, AIDS, diabetes mellitus, obesity, arthritis, mental diseases, hypertension etc.

Medical approach II

Principal strategies: surgical interventions, drugs and other therapies, health care, medically managed health behaviour( change diet, exercise, patient education, patient compliance), screening for physiological and genetic risk factors.

Target: high risk individuals

General approach: individualized

Actors: physicians, nurses, allied health workers

1. Behavioral approach I (lifestyle, Public Health)

Health concept is individualized, Health as energy functional ability, disease preventing lifestyle choices

Leading Health problems defined in terms of behavioral risk factors; smoking, poor eating habits, lack of fitness, drug abuse, alcohol abuse, poor stress coping, lack of life skills etc.

Behavioral approach II

Principal strategies: health education, social marketing, advocacy for public policies supporting lifestyle choices ( e.g. smoking bans, low fat meat production,, bicycle paths and bans)

Target: High risk groups, children and youths

General approach: Individualized, elements of societal focus are related to public policy

Actors: Public Health workers, illness related advocacy groups (cancer society), governments

1. Socio environmental approach I (structural)

Health concept is a positive state defined in connectedness to one’s family/friends/community, being in control, ability to do things that are important or having meaning to community and structures supporting human development.

Leading health problems defined in terms of psycho-social risk factors and socio environmental risk conditions. Poverty, income gap, isolation, powerlessness, pollution, stressful environment, hazardous living and working conditions.

Socio- environmental approach II (structural)

Principal strategies: Small group development, community development, coalition building, political action and advocacy, societal change.

Target: High risk societal conditions

General approach: Structural focuses on organization of the communities and society, development of just political /economic policies.

Actors: Citizens, societal development and welfare organizations, political movements and parties

1. Health Field Concept:

Encompasses 4 main determinants of Health

* Human Biology
* Lifestyle
* Environment
* Health care
1. Human biology:

Every human being is made of genes. In addition there are factors which are genetically transmitted from parents to off springs. As a result, there is a chance of transferring defective traits. The modern medicine does not have significant role in these cases.

1. Genetic counseling: for instance during marriage , parents could be made aware of their genetic components in order to overcome the risks that could a rise.
2. Genetic engineering: may have a role in cases like breast cancer
3. Environment: this is all that is external to an individual human host. These are factors outside the human body. Environmental factors that could influence health include;
4. Life support, food, water air etc
5. Physical factors; climate and rainfall
6. Biological factors; micro- organisms, toxins, biological waste
7. Psycho - social and economic factors; crowding, income level, access to health care
8. Chemical factors; industrial waste e.g. agricultural wastes air pollution e.t.c
9. Lifestyle (behavioral)

This is an action that has specific frequency, duration and purpose whether conscious or unconscious.

It is associated with practice. It is what we do and how we act. Recently lifestyle received an increased amount of attention as a major determinant of health directly or indirectly. For example; cigarette smoking, unsafe sexual practices, eating contaminated food.

1. Health care organizations

Health care organization in terms of human power, equipment, money determine the health of the people. It is concerned with;

1. Availability of health care services:

People living in an area where there is no access to health services are affected by health problems and have lower health status than those with accessible health services.

1. Scarcity health care services: leads to inefficient health services resulting to poor quality of health status of the people
2. Acceptability of the services by the community
3. Accessibility in terms of physical distance, finance etc
4. Quality of care that mainly focuses on the comprehensiveness, continuity and integration of health care.

Lifestyle

Environment

biology

Health care

**DIMENSIONS/PERSPECTIVES OF HEALTH**

Physical health:it is concerned with anatomical integrity and physiological functioning of the body.It means the ability to perform routine tasks without any physical restriction e.g. physical fitness is needed to walk from one place to another.

Mental Health :is the ability to learn and think clearly and coherently e.g. a person who is not mentally fit could not learn something new at a pace in which an ordinary normal person learns.

Social health:is the ability to make and maintain acceptable interaction with other people. E.g.to celebrate during festivals, to mourn where a close family member dies, to create and maintain friendship and intimacy e.t.c.

Emotional Health: is the ability of expressing emotions in an appropriate way, for example to fear, to be happy and be angry. The response of the body congruent with that of the stimuli. Emotional health is related to mental health and includes of stressful situation such as depression, tension and anxiety.

Spiritual health:some people relate health with religion, for others it has to do with personal values, beliefs, principles and ways of achieving mental satisfaction in which all are related to their spiritual well being.

**OTTAWA CHARTER AND DEVELOPMENT OF HEALTH PROMOTION:**

The first international conference on health promotion was held in Ottawa, Canada in November 1986.

The conference was primarily a response to growing expectations for new public health movement around the world

Discussion focused on needs within industrialized countries, but to took in account similar concerns in all other regions

The aim of the conference was to identify action to achieve the objectives of the World Health Organization (WHO) on health for all by the year 2000 initiative, launched in 1981.

Health promotion was therefore defined as “the process of enabling people to increase control over and improve their health.”

Health is seen as a resource for everyday life but not an objective of living

Health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyle to well being

The fundamental conditions and resources needed for HEALTH are;

* Peace
* Shelter
* Education
* Food
* Income
* A stable ecosystem
* Social justice and equity
* Community of sustainable resources

**5 HEALTH PROMOTION PRIORITY AREAS/RECOMMENDATIONS**

Based on the OTTAWA CHARTER FOR HEALTH PROMOTION (WHO 1986) proposed 5 (five) Health Promotion recommendations/priority areas of action which are;

1. Developing Healthy public policies and private policies beyond the Health care sector that will improve health including a healthy and food policy.
* This puts health on the agenda for all policy makers, directing them to be aware of the health consequence of their decisions.
* Health promotion policy combines diverse and complimentary approaches including legislation, fiscal measures , taxation and organizational change .
* It is coordinated action that leads to health ,income and social policies that foster greater equity
* Joint action contributes to ensuring safer and healthier goods and services, healthier public services and cleaner, more enjoyable environment
* Health promotion policy requires the identification of obstacle to the adoption of healthy public policies in none health sectors and ways of removing them
* The aim must be to make the healthier choice ,the easier choice for policy makers.
1. Creating physical and social environments that are supportive to health
* Environments , whether physical,social , economic or political can be made more supportive for health and urges social action at community level with people as the driving force for development.
* Recognized the importance of environment for health and proposed a social-ecological approach to health.
* The guiding principle is the need to encourage reciprocal maintenance to take care of each other, our communities and our natural environment.
* The links between people and their environment constitutes the basis for a social-ecological approach to health.
* Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.
* Systematic assessment of the health impact of a rapidly changing environment particularly in areas of technology, work energy production and urbanization is essential and must be followed by action to ensure positive benefit to the health of the public
1. strengthening communities’ capacities and address health issues of significance to them and to mutually support their members in improving health.
* Health promotion requires community empowerment and involvement in setting priorities, planning and implementing strategies to achieve better health
* Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health.
* At the heart of this process is the empowerment of communities, their ownership and control of their own endeavour and destinies
* Community development draws an existing, human and material sources in the community to enhance self help and social support and to develop flexible systems for strengthening public participation and direction of health matters
1. Helping people to develop the skill they need to make healthy life choices and to care for themselves and their families minor and chronic ailments
* Health promotion supports personal and social development through providing information and enhancing life skills.
* By so doing it increases the option available to people to exercise more control over their own health and over their own environment and to make choices conducive to health.
* Enabling people to learn through out life to prepare themselves for all of its stages and to cope with chronic illness is essential.
* This has to be facilitated in school, work, home and community settings.
* Action is required through educational , professional, commercial and voluntary bodies and within institutions themselves.
1. where necessary re-orient health service to support health promotion , health protection and prevention of disease, disability and injury.
* Health promotion urges for shifting health resources towards a more equal distribution between health care and preventing disease
* Health care service should be expanded to include the four strategies above in addition to convectional medical care
* Responsibility for health promotion services should be shared among individuals , communities, groups , health professionals health services and management.
* The role of health sector move increasingly in health promotion direction, beyond its responsibility for providing clinical and curative services.
* The mandate should support the needs of individual and communities for healthier life and open channels between the health sector and broader social ,political, economic and physical environment components.
* Re-orienting health services also requires stronger attention to health research as well as changes in professional education and training.
* This must lead to a change of attitude and organization of health services which refocuses on the total needs of the individuals as a whole person

**HEALTH PROMOTION BASIC STRATEGIES**

The Ottawa charter identified 3 (three) basic strategies for Health Promotion

1. Advocacy for Health to create essential conditions for Health
2. Enabling all people to achieve their full Health potential
3. Mediating between the different interests in society in pursuit of health

Advocacy

* Advocacy is a combination of individual and social actions designed to gain political commitment, policy support, social acceptance and system support for a particular Health goal or programme
* It takes many forms including use of mass media and multi media, direct political lobbying, and community mobilization
* Health advocacy is the action of Health professionals and others with perceived in Health to influence the decisions and actions of communities and government which have some control over resources which influence Health.
* The Ottawa Charter puts Health on the agenda of policy makers in all sectors and at all levels in order to make the healthier choices the easier choices for all the policy.
* It also aims at sharing power with other sectors, other disciplines and most importantly with people themselves.

Enabling

* Enabling means taking action in partnership with individuals or groups to empower them, through the mobilization of human and material resources to promote and protect health.
* The Ottawa Charter focuses on enabling people to achieve the fullest Health potential in order to take control of those things that determine Health.
* People are acknowledged as the main Health resource
* The most important goal of all Health Promotion activities is to support and enable people to keep themselves healthy, as well as their families and friends through financial and other means
* Health Promotion activities have to turn to the community as the essential voice in matters of health, living conditions and well being.

Mediating:

* Mediating is a process through which different interests (personal, social, economic) of individuals and communities and different sectors (public and private ) are reconciled in ways that promote and protect Health.
* According to Ottawa Charter, politicians, professionals and Health Personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.
* Health Promotion action programs are to create supportive environments. Which means to generate living and working conditions that are safe, stimulating, satisfying and enjoyable by active participate of all people who are involved and addressed.
* To strengthen community actions is the heart of the process that can be called; empowerment of communities, their ownership and control their own endeavour and destinies.

**HEALTH PROMOTION PRINCIPLES:**

The Health Promotion principles are based on Human rights, seeing people as active participating subjects and professionals and people are mutually engaged in an empowering process.

1. Health is a positive value
* The Ottawa Charter goes beyond Healthy life cycles in that it defines health as a state of complete physical, mental and social well being.
* This is a positive concept of Health for it sees individual as a whole person in a social context. Health Promotion goes beyond life styles to well being in order to reach to a state of complete physical, mental and social well being.
* An individual and a group must be able to identify and to realize aspirations, to satisfy needs and change or cope with the environment
1. Health is not just an individual responsibility but involves the whole population
2. Equity in health:
* Health promotion aims at 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
1. Coordinated action and inter sectoral collaboration
* Health Promotion demands that all people are involved as individuals , families, professionals, communities and social groups and Health personnel have a major responsibility to mediate between different interests in society for the pursuit of Health
1. Health promotion strategies are based on local needs (setting perspective)
* Health promotion strategies and programs are adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic system
1. Participation and involvement
* Health promotion works through community action and hence involves public participation
* HP works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health
* At the heart of this process is the empowerment of communities and control of their own endeavors and destinies

**ELEMENTS OF HEALTH PROMOTION**

1. Prevention of diseases, injury and illness
2. Health education, anticipatory guidance and parenting skill development
3. Support that builds confidence and is reassuring for mothers, fathers and careers
4. Community capacity building

**IMPORTANCE OF HEALTH PROMOTION:**

* Health promotion improves the health status of individuals, families, communities, states and nations
* Health promotion enhances the quality of life for all people
* Health promotion reduces premature death
* By focusing on prevention, health promotion reduces the cost (financial and human) that individuals, employers, families, insurance companies, medical facilities, communities, the state and the Nation could spend on medical treatment.

**CORE FUNCTIONS OF HEALTH PROMOTION**

* Development and management of quality nation Public Health programs
* Regulation and enforcement of policies to protect the health of the public
* Health promotion, social participation and empowerment
* Health situation monitoring and analysis
* Epidemiological surveillance/disease prevention and control
* Human resource development and planning in public health
* Research development and implementation of innovative public Health solutions

METHODS OF HEALTHPROMOTION

Health promotion uses different methods to reduce health risks involving health as well as non health sectors (e.g Agriculture, education, housing e.t.c)

These methods/approaches include:

* Advocacy
* Health education
* Communication for behavioral change
* Social marketing
* Social mobilization
* Information, Education and Communication
* Legislation, Economic and Environmental policies

Advocacy:

This is a process of influencing political commitment, policy support, social acceptance and system support to solve/address a health issue.

This include persuading policy makers to come up with policies that address health issues/and political involvement in pushing for budgetary allocation to address the problem.

Health education:

This is a process of using different approaches to impart knowledge and skill on health to individuals, groups and community to make quality health decisions.

Behaviour change communication:

This is a process of working with individuals, families and communities through different communication channels to promote positive health behaviour and support environment that enables the community to maintain the positive behaviour taken on. Example, inform the community on the dangers of public cigarette smoking, with an aim of stopping smoking in public places

Social marketing:

This is an approach to persuade people to accept ideas and attitude, perform health behaviour, refer to health facilities and receive health products.

 Example is when a health practitioner tells the public about a health facility and the services that are available in the facility with an aim of increasing the individuals seeking/referring/bringing patients to the facility.

Social mobilization:

This is a process of bringing together all societal and personal influences to raise awareness of the demand for health care, assist in the delivery of resources and services , and cultivate sustainable individual and community involvement.

 Information, Education and Communication:

IEC is a health promotion approach aiming at changing or reinforcing health related behaviour in a target audience concerning a specific issue.

Example of IEC is the use if IEC materials such as posters, fryers, brochures, booklets messages for health education, radio shows or TV spots etc to pass health messages to the public.

Legislation, economic and environmental policies:

This involves use of policies/reinforce the set standards on a public health issue and if not followed, attract a punishment. E.g. wearing a face mask during the COVID19 pandemic period is a set public health rule, which need to be followed/adhered to when in a public place failure to which one can be prosecuted.

**COMMUNITY DIALOGUE**

Def: community dialogue is an interactive, participatory process of sharing information between people or groups of people aimed at reaching a common understanding and workable solution.

Community dialogue session is a way for members of the community to come together and discuss important issues.

Why community dialogue?

Community dialogue session promotes discussion of important issues and can clear up confusion about government programs. These events are also less time consuming than organizing a large community forum.

Who are the participants of a community dialogue session?

It is up to the one organizing the dialogue who he /she wants to invite.

It could be people of the inner circle and members from the community more so those having differing opinions but could bring new perspectives, ideas and experiences to the discussion.

Duration of community dialogue:

Community dialogue can be simple and others can be complex, so it depends on the nature of the dialogue/issue at hand to be discussed. Also it is up to the organizer to decide the time the dialogue can take.

**STEPS OF ORGANIZED COMMUNITY DIALOGUE**

1. Build a dialogue team to host the event:

A team approach to convene a dialogue, will help to bring a sense of ownership and division of tasks involved. The team can help to define goals for the project, and so need to identify people that you have worked with before and have the credibility with and invite them to the dialogue.

1. Determine your own goals for the dialogue:

Your community may have some specific goals for the dialogue itself and the information received from it. The design of the session should reflect this. Your community might want to deepen existing work in the community.

1. Determine the group participants:

- Partners with existing groups and use the network

- Bring new voices to the group

- Dialogue groups be as small as 5 people or as many as 500 people

- Determine by what you want to achieve

1. Select and prepare your facilitator:

Enlist an experienced facilitator/someone who is a good listener and can inspire conversation while remaining neutral

1. Set a place, date and time for the dialogue:

- Choose a spot that is comfortable and accessible (hospital, school, church..)

- Keeping site convenient to participants is key

- Be sure to give a minimum of 2 weeks notice

- Determine the time period (1-3 hours)

- A reminder call 2 weeks before the event

1. Create an inviting environment

- Sitting arrangements are important in a smaller group

- To ensure interaction make a circle/ U formation

- Refreshment/food is welcome and is a sign of appreciation

1. Invite participants:

Determine on how to access your desired participants

Contact friends, co workers, specific community groups

Make calls (telephone), write letters, use e-mails

1. Plan to record your dialogue:

- Designate a person to take notes and summarize important points

- Note areas of disagreement

- Obtain quotations and stories from participants

1. Conducting the dialogue:

- Greet participants to create rapport

- Introduce yourself and thank the participants for coming and state the purpose of the dialogue

- Initiate the dialogue

- Engage the media and document the event

- Conclude the dialogue

Next steps:

- Group may be excited about a particular idea (come up with an action plan)

- Group may decide to have in depth conversation and involve some missing voices

- Group may decide to have additional dialogue on other subjects

**HEALTH EDUCATION:**

**AIM OF HEALTH EDUCATION**

The ultimate goal of health education is to improve the Health of individuals and community, reduce incidence of disease and deaths

Health education presents information to target populations on particular health topics, including the health benefits/ threats they face and provide tools to build capacity and support behaviour change in an appropriate setting. Examples of health education; lectures, courses

**PRINCIPLES OF HEALTH EDUCATION**

1. Credibility
2. Interest
3. Participation
4. Motivation
5. Comprehension
6. Reinforcement
7. Learning by doing
8. Known to unknown

Credibility:

- credibility is the degree to which the message communicated is perceived as trustworthy by the receiver.

- good health education must be consistent and compatible with scientific knowledge and also with the local culture, educational system and social goals

Interest:

Health education should be related to the interest of the people.

Health programme should be based on the felt need so that it becomes people’s programme

Felt needs are the real health need of the people, that is the needs that the people themselves feel

Participation :

A high degree of participation tends to create a sense of involvement, personal acceptance and decision making

It provides maximum feedback

The Alma-ta Declaration states, the people have the right and duty to participate individually and collectively in planning and implementation of their health care

Health programme are unlikely to succeed if the community participation is not integral part

Motivation:

- In every person there is a fundamental desire to learn

- Awakening their desire is called motivation

- There are two types of motives;

1. primary motives which is a driving force initiating people into action
2. Secondary motives which is created by outside forces or incentives

- Need for incentives is the first step in learning to change

- Incentives may be positive or negative

- Main aim of motivation is contagious: one motivated person may spread motivation throughout a group

comprehension:

Health educator must know the level of understanding, education and literacy of the people whom the teaching is directed

Always communicate in the language that people understand

Teaching should be within the mental capacity of the audience

Reinforcement:

Repetition of message at intervals is necessary

If the message is repeated in different ways, people are more likely to remember it

Learning by doing:

The importance of learning by doing can best be illustrated by the Chinese proverb “if I hear, I forget, if I see, I remember, If I do, I know.

Known to unknown:

We must proceed from concrete to the abstract

From to particular to the general

From simple to more complicated

From easy to difficulty

From known to unknown

Here the health communicator uses the existing knowledge of the people as pegs on which to hang new knowledge

Feedback:

The health educator can modify the elements of the system ( e.g. message, channels) in the light of feedback from his audience.

For effective communication, feedback is of paramount importance

Leaders:

Leaders are agents of change and they can be made use of in health education work

The attributes of a leader are;

He understands the needs and demands of the community

He provides proper guidance , takes the initiative, is receptive to the views and suggestions of the people

Identifies himself with the community

Selfless, honest, impartial, considerate and sincere

Easily accessible to the people

Able to control and comprises the various factors in the community

Possesses the requisite skills and knowledge of eliciting cooperation and achieving coordination of various official and non official organizations.

**COMPONENTS OF HEALTH EDUCATION PROGRAMME**

 The health education programme is aimed at enhancing individual’s and community’s health.

The components of HE program include;

1. Planning
2. Participant involvement
3. Needs/resources assessment
4. A comprehensive programme
5. An integrated programme
6. Long term change
7. Altering community norms
8. Research and evaluation
9. Participant involvement

Community members should be involved in all phases of program development (identifying community needs, enlisting the aid of the community, planning , implementing program activities and evaluating results).

1. Planning

This involves identifying the health problems in the community that are preventable through community interventions, formulating goals, identifying targets behaviour and environmental characteristics that will be the focus of the intervention efforts, deciding on how to involve stakeholders and building a cohesive planning group.

1. Needs and resource assessment

Prior to implementing a health education initiative, attention is given to health needs and capacities ,of the community and resources available

1. A comprehensive programme

A programme that deals with multiple factor use different channels of programme delivery, target several different service levels (individual,families, social networks, organization, the community as a whole) and are designed to change both risk behaviors and factors and conditions that sustain this behavior

1. An integrated programme

Each component of the programme should reinforce the other components.

Programme should be physically integrated into settings where people live their lives (e.g work site)

1. Long term change

Health education program should be designed to produce stable and lasting changes in health behavior . this requires longer-term funding of programme and the development of a permanent health education infrastructure within the community.

1. Altering community aim

A health education must be able to alter community or organizational norms and standards of behavior .this requires that a substantial promotion of community’s or organization’s member is experienced to programme message or preferably be involved in programme activity in some way.

1. Research and evaluation

Comprehensive research and evaluation is necessary to document programme outcomes and its effectiveness and benefits.

**RESPONSIBITIES OF HEALTH EDUCATORS/NURSE EDUCATORS IN HEALTH EDUCATION PROGRAMME:**

* Assessing individuals and community needs for health educators
* Planning effective health education programme
* Implementing health education programme
* Evaluating the effectiveness of health education programme
* Communicating health and health education needs concerns and resources
* Coordinating the provision of health education services
* Acting as resource people in health education

**A FRAMEWORK OF NURSING AND PUBLIC HEALTH PROMOTION**

The three main frameworks for nursing and public health promotion as adapted from Royal College of Nursing in 2012 and these are;

1. Promote:

Means working with communities and engaging with individuals to promote health

1. Protect:

Referrers to addressing threats to health and responding to outbreaks of disease etc

1. Prevent:

This is ensuring of healthy development, enabling health behaviour, healthy living and working in healthy environments

**ROLES OF NURSES IN HEALTH PROMOTION:**

1. Model life style behaviour and attitude
2. Facilitate client involvement in assessment, implementation and evaluation of health goals
3. Teach clients self care strategies to enhance fitness, improve nutrition, manage stress and enhance relationships
4. Assist individuals, families and communities to increase their level of health
5. Educate clients to be effective consumers of health care
6. Guide client’s development in effective problem solving and decision making
7. Reinforce client’s personal and family health promoting behaviour
8. Advocate in the community for changes that promote a healthy environment

**HEALTH PROMOTION AND DISEASE PREVENTION THEORIES AND MODELS:**

* Prevention is defined as anticipatory action taken to reduce the likelihood of some future undesired events or condition, or to increase the likelihood of some future desired events or condition.
* Disease prevention covers measures not only to prevent the occurrence of the disease such as risk factor reduction but also to arrest its progress and reduce its consequences once established.
* The classic public health model identifies a disease agent a host for the disease and means (vector) through which the agent gets to the host.
* Understanding of infectious disease mechanism development of improved sanitation and supplies enhanced nutritional status and wide spread vaccination have had a profound effect on reducing or even eradicating infectious diseases.
* Disease prevention is sometimes used as a complementary term alongside health promotion
* Disease prevention deals with individuals and population identified as exhibiting identifiable risk factors often associated with different risk behavior.

Definition of terms

Incidence:

Incidence is the number of newly diagnosed cases of a disease within a specified period of time

Prevalence

Is the total number of cases of disease existing in a population both (new and old) within a specified period of time

Part of the nursing role is to prevent disease and promote the health of patients and clients. This can take place at three levels.

Levels of disease prevention;

1. Primary prevention
2. Secondary prevention
3. Tertiary prevention

Primary prevention (how do we keep ourselves well?)

The target population is large and its not possible to say with certainty who will develop the problem of concern

The programme focuses on improving everyone interest and capacity to maximize their own health and on environmental factors that enhance or impede health

Primary prevention decreases the number of new cases of a disorder,illness and premature death[reduces incidence]

Health problems have not developed

Primary prevention are interventions that are put in place before the onset of signs and symptoms /entry of micro organisms into an individual.

These interventions include;

* Vaccination
* Health education
* Use of mosquito nets
* Nutrition

Secondary prevention (if we get ill how can we detect these conditions early?

The target population is narrowly defined as some identifiable known to be likely to develop a problem,

Programme focus on characterizing these at risk sub groups and developing early detection method

Programme attend to both individuals and environmental issues

Health problems have developed

Secondary prevention reduces incidence as well as the rate of established case in community (reduces prevalence)

In secondary prevention the interventions put in place are aimed at reducing the progression of disease which an individual has.

Secondary prevention activities include;

* Treatment
* Nutrition
* Counseling
* Health education

Tertiary prevention (if we are ill, how can we get the best medical care)

Members of the target group are demonstrating clear pathology and require immediate intervention

Programme focus on specific therapeutic interventions, factors that affect treatment uptake, outcomes and risks to the general population posed by the pathology or offending agent(s)

In tertiary prevention the interventions put in place are aimed at reducing the possibility of complications.

Tertiary activities include;

* Rehabilitation
* Health education
* Physical exercise
* Treatment
* Palliative care

**STEPS IN CARRYING OUT A HEALTH EDUCATION PROGRAM**

1. Assessing individual and community needs for health education
2. Planning effective health promotion program
3. Implementing health promotion program
4. Evaluating the effectiveness of health promotion program

**RESONSIBILITIES OF NURSE IN HEALTH EDUCATION**

Coordinating provision of health education services

Acting as a resource person in health education

Communicating health and health education needs, concerns and resources

1. Assessing individual and community needs:

Obtaining health related data about social and cultural environments growth and development factors and interests

Distinguish between behaviour that fosters and that which hinders well being

Infer needs for health education on the basis of obtained data

1. Planning effective health education programme:

Recruit community organizations resource people and potential participants for support and assistance in programme planning .

Develop health education plan

Formulate appropriate and measurable programme objectives

1. Implementing health education programme:

Exhibit competence in carrying out planned educational programme

Select methods and media best suited to implement programme plans

Monitor programme adjusting objectives and activities as necessary

1. Evaluating effectiveness of health education programme

Assess achievement of programme objective

Carry out evaluation plans

Interpret results of programme evaluation

Infer implications from findings for future programme planning

Nurse Responsibilities in health education programme

1. Coordinating provision of health education services

Develop a plan for coordinating health education services

Facilitate cooperation between and among levels programme personnel

Formulate practical modes of collaboration among health agencies and organization

1. Acting as a resource person in health education

Use a computerized health information retrieval system

Establish effective consultative relationship with those requesting assistance in solving health related problems

Interpret and respond to requests for health information

Select effective educational resource materials for dissemination

1. Communicating health and health education needs concerns and resources

Interpret concepts, purposes and theories of health education

Predict the impact of societal value systems on health education programme

Select a range of communication method and techniques in providing health information

**HEALTH EDUCATION THEORIES/MODELS**

1. Rational model
2. Health belief model
3. Extended parallel process model
4. Trans theoretical model of change (stage of change)
5. Theory of planned behaviour
6. Social cognitive theory
7. Communication theory
8. Diffusion of innovation theory
9. Rational model (knowledge, attitude, practices model)

Educational strategies target individuals and groups of people to encourage positive and prevent negative health choices

This is done by presenting unbiased information

It is based on premises that increasing a person’s knowledge will prompt behaviour change

It assumes that only obstacle to acting “responsibly” and rationally is ignorance and that information a lone can influence behaviour by “correcting” this lack of knowledge.

Change in knowledge - change in attitude/belief - change in behaviour

1. The Health belief model

People’s belief about the severity and susceptibility to the disease influence their willingness to take preventive action.

The theory has six constructs to predict whether people will take action to prevent, screen for and control illness.

Constructs:

1. Perceive susceptibility
2. Perceived severity
3. Perceived benefits
4. Perceived barriers
5. Cues and actions
6. Self efficacy

Perceived susceptibility:

Beliefs about chances of getting a condition

Individual perception of personal susceptibility to specific illness or accidents often widely from the realistic appraisal of their statistic appraisal of their statistical probability

The nature and intensity of these perceptions may significantly affect their willingness to take preventive action

Perceived severity:

Belief abut the seriousness of a condition and its consequences

People may not respond to suggestions that they obtain flu shots because they do not view influenza as a serious disease

The person must perceive the potential seriousness in terms of pain or discomfort, time lost from work, economic difficulties etc

Perceived benefits:

Beliefs about the effectiveness of taking action to reduce risk or seriousness

Individuals must believe that the recommended health action will actually do some good if they are to comply

Perceived barriers:

Beliefs about material and psychological costs of taking action

If the change is perceived as difficult, unpleasant or in convenient and outweighs the perceived benefits, it is less likely to occur

Cues to action:

Factors that activate readiness to change a trigger mechanism

A reminder note from a dentist that it is time for a check up may be sufficient to prompt action

Self efficacy:

Confidence in one’s ability to take action

One’s opinion of what one is capable of doing is based largely on experience with similar actions or circumstances encountered or observed in the past.

1. The extended parallel process model: (fear management theory)

This model proposes that people when presented with a risk message, engage in two appraisal

Describes how rational considerations (efficacy beliefs) and emotional reactions (fear of health threat) combine to determine behavioral decisions

The degree to which a person feels threatened by a health issue determines his/her motivation to act

1. Trans theoretical theory model/stages of change model

Explains an individual’s readiness to change their behavior.

It describes the process of behaviour change as occurring in stages

1. Pre - contemplation: there is no intention of taking action
2. Contemplation : there is intention to take action and a plan to do so in the near future
3. Preparation: there is intention and and some steps have been taken
4. Action: behaviour has been changed for a short period of time
5. Maintenance: behaviour has been changed and continues to be maintained for the long term
6. Termination: there is no desire to return to prior negative behaviour
7. Social cognitive theory:

Describes the influence of individual experiences, the actions of others, and environmental factors on individual health behaviour.

Key components:

Self efficacy: the belief that an individual has control over and is able to execute a behaviour

Behavioral capability: determining the outcomes of behavior change

Expectations: expecting a benefit in behaviour change

Expectancy: assigning a value to the outcomes of behavior change

Self control: regulating and monitoring individual behaviour

Observation learning: watching and observing outcomes of other performing or modeling the desired behavior

Reinforcement: promoting incentives and rewards that encourage behaviour change

1. Theory of reasoned action:

Suggests that a person’s health behaviour is determined by the intention to perform a behaviour

A person’s intention to perform a behaviour is predicted by a person’s attitude towards behavior and suggestive norm regarding behavior.

Subjective norms are as a result of social and environmental surroundings and a person’s perceive control over behavior

7. health communication theory:

It encompasses the development and implementation of marketing and communication strategies designed to educate communities and individuals to encourage the adoption of better health practices.

Professionals who understand health communication theory can train health care providers the fundamentals of health literacy so they can communicate more effectively with patients

1. Diffusion of innovation theory

Seeks to explain how, why and at what rate new ideas and technology spread.

It is a process in which an innovation is communicated through certain channels over time among the members of a social system.

* Behavioral approach
* Self empowerment approach
* Social change
* Educational
* Medical and preventive approach

Behavioral approach

This approach is used to bring about changes in an individual’s thinking or perception

Method is used to change behaviour of individuals within their communities and help them make their health related decisions

Can be applied using locally available methods and media as leaflets and posters

Approach take into consideration individual perception of exposure to health risks and risky behavior

Covers benefit an individual can gain through health practices

Example:

You will be aware that smokers decide whether or not to give up smoking. They take the following into consideration

* To what extent they think they are susceptible to (high blood pressure, lung cancer, social and financial consequences
* That perception on how serious continuing to smoke may be in terms of their possible future morbidity/mortality
* The benefits of giving up smoking
* Potential negative consequences of giving up smoking

Self empowerment approach:

The approach is rooted in awareness and understanding that people can act to change their own lives on their own behalf

Provides tools participants will need to make their own choices about their health and increase control over their physical. Social and psychological environment.

Self empowerment technique include;

1. Group work
2. Problem solving
3. Client centred counselling
4. Assertive training
5. Social skills training
6. Educational drama

Preventive/medical approach:

It focuses on use of clinical interventions to assist the clients . Thus the participants are made to see the essence of going to a health facility to seek for medical care

It includes anything that a teacher implements to prevent undesirable behaviour

Instead of waiting for a problem behaviour to occur, proactive technique implemented successfully decrease the likelihood of behaviour and promote behaviour choices in the community/society

This approach seeks to persuade individuals to adopt healthy lifestyle behaviour, to use preventive services and to take responsibility for their own health.

The behavioral change model is a preventive approach and focuses on lifestyle behaviour that impact on health.

Educational approach:

The purpose of educational approach is to positively influence the behaviour of individuals and communities as well as the living and working condition that influence their health

Educational approach therefore improves health status of individuals, families, communities, states and the nation. The approach if well utilized, enhances the quality of life for all people.

Therefore the ultimate goal of health education is to promote, maintain and improve individual and community health.

Educational approach is aimed to reducing morbidity and mortality due to preventable health problems

Social environmental approach:

This is based on an argument that the determinants of health are highly complex and include individuals, social, economic, cultural and environmental influences and as such require complex responses.

The focus of this approach is to bring about change at a policy or structural level in order to create an environment in which it becomes both possible and realistic for individuals to make and sustain healthy choices and life style e.g,. baby-friendly hospitals

**ADVOCACY AND PUBLIC RELATIONS**

**ADVOCACY IN NURSING:**

Advocacy refers to speaking up for patients and the profession

Nurses can advocate for;

Vulnerable patients (orphans, mentally&physically handicapped, patients with chronic conditions)

Improvement of working conditions

Improved access to care

Remuneration

Professional well being

**WHY IS ADVOCACY NECESSARY**

Is a problem solving strategy in nursing

Achieves progress and improvements in the profession

To protect rights of clients

Change unfair treatment of colleagues or patients

To improve nursing services

To remove barriers in service provision/access

Tool to voice for special interest groups/marginalized/voiceless

**STEPS IN ADVOCACY PROCESS**

There are 10 steps in advocacy process

* Identification of advocacy issues
* Setting advocacy goals and objectives
* Identifying audience
* Develop targeted messages
* Identifying communication channel
* Build support and coalition
* Fund raising
* Implementation
* Data collection
* Monitoring and evaluation
1. Identification of advocacy issues

An advocacy issue is the problem that requires a policy action or change

It could be the patients or issues affecting the profession

May also include issues in the society such as access to health services

An example is:

Issue: Nurses working for long hours/shift

Advocating: increase number of nurses

An issue is a problem that is felt widely by the constituents/clients (people affected by the advocacy issues).

The advocates must identify the policy solution to the issue, then press/persuade the policy makers to act.

What are some advocacy issues affecting nurses in Kenya today?

1. Advocacy goals and objectives

A goal is a general statement of the general result you want to achieve in your advocacy campaign. It is a long term vision for change

Objectives are short term steps towards achieving the goal

Objectives should be SMART

S - specific

M - measurable

A - achievable

R - realistic

1. Time bound

A good advocacy objective has;

* Policy actor or decision maker
* Policy action
* Timeline

Example:

By 2023 the Government to employ an addition of 5000 nurses

Timeline policy actor policy action

1. Identify the target audience

The target audience is the policy maker or institution with direct power to affect the advocacy objective

Identify the policy makers you are trying to influence in your advocacy

It is essential to assess the audience’s knowledge values and beliefs about advocacy issues e.g. audience could be government, hospital.

1. Development of advocacy messages

Messages are statements tailored to the target audience

Effective messages are clear, concise and tailored to the target audience’s position

It is important to deliver a consistent message using multiple channels over time.

(appropriate, simple, concise/brief, appropriate format, consistent)

**5 elements of advocacy message:**

* Content
* Language
* Messenger/source
* Medium
* Time place
1. **Content:**

The main point that you want to communicate, this is the central idea of the message

1. **Language**
2. Should be clear
3. Appropriate for the target audience
4. Avoid jargon
5. Choose words to use to communicate your message
6. **Messenger/source**
7. The individual or constitution to deliver to deliver the message should be credible
8. May include a representative if nursing profession
9. Outstanding role models from within the profession with skills
10. **Medium**
11. Communication channel you are using for message delivery
12. Use the most appropriate to reach your target audience
13. **Time and place**

This is when and where to deliver the advocacy message

Consider events that you can link up your advocacy events with, e.g. World AIDS day if your advocacy is to see increased access to ARVS by PLWHA

Nurses week to advocate for issues affecting the profession

1. **Selecting channels of communication:**

 The means through which the message is delivered to various target audience

1. **Building support and coalitions**
* Formation of networks of like minded individuals
* Determine where you can get advice/help
* Who is on your side
* Form an advocacy team with a common interest
* Help to give the advocacy issue more credibility e.g. Nurses can form coalition with Doctors
* Many advocates increase their visibility by forming or joining networks and coalitions
* Networks are more effective when they have a common goal and a clear norm/role within the group.
1. **Fundraising**
2. Identifying and attracting resources for your advocacy activities campaigns (money, equipment)
3. **Implementation**
4. Carrying out a set of planned activities
5. Action plan
6. **Data collection:**
7. Gather information, analyze and use the information
8. **Monitoring and evaluation:**
9. Periodic assessment on the progress of the project/event towards achieving the set objectives
10. Evaluation end term assessment to ascertain whether the objective were achieved

**Role of nursing in advocacy:**

The nursing role in advocacy is 3 fold:

* Advocacy for patients
* Advocacy for subordinate
* Advocacy for profession
1. **Nurses as patients’ advocates:**

Common areas requiring nurse-patient advocacy include;

Specialized treatment for patients

Access for health care

Provider patient conflict

Medical errors

Patient grievance/complaints

Inadequate consent e.g. treatment for minors unconscious patients

Incompetent health care provider

Complex social problem e.g. poverty

The elderly patients

**Whistle blowing in patient advocacy:**

Reporting of wrong doing or corruption

There are two types of whistle blowing

1. **Internal whistle blowing**

Occurs within an organization

Example: reporting abusive language to the patients by another colleague to hospital managers

1. **External whistle blowing**

Reporting outside the organization

Use media

Elected persons e.g. reporting of fraud in the facility

Whistle blowers and patient advocacy often are seen as disloyal and often suffer from negative consequences.

1. **Subordinate advocacy**
* This is a workplace advocacy
* A critical role for the nurse managers
* The nurse manager ensures that work environment is safe

Advocacy issues for manager for their subordinates include(occupational health and safety to);

* Reduce worker exposure to workplace violence
* Reduce incidence of needle stick injury
* Reasonable work hours and schedule
* Adequate staffing ratios to support safe patient care
* Fair and equitable wages
* Participation in organizational decision making
1. **Professional advocacy**
* Leadership role
* Involves advocacy for issues that affect nursing as a profession
* Remuneration
* Nurse can use organizational organization to advocate for policy change e.g. NNAK
* Policy makers are more likely to listen to groups than individuals

There is more potential in collection influence

**GROWTH MONITORING AND PROMOTION:**

**Definitions**

**Growth monitoring** (GM is the process of following the growth rate of a child in

comparison to a standard by periodic anthropometric measurements in order to assess growth adequacy and identify faltering at early stages.

Assessing growth allows capturing growth faltering before the child reaches the status of under-nutrition. In addition to prevention of under-nutrition, the role of GMP in capturing over-nutrition especially in light of growing problem

of obesity needs to be further explored.

**Growth monitoring and promotion** (GMP)is a prevention activity that uses growth monitoring (GM), i.e. measuring and interpreting growth, to facilitate communication and interaction with caregiver and to generate adequate action to promote child growth through:

•Increased caregiver’s awareness about child growth

•Improved caring practices

•Increased demand for other services, as needed

**Process**

---The GMP process includes three stages:

1. measuring and interpreting growth adequacy,
2. Analysis of the reasons for adequate or inadequate growth, and

 iii) counseling; which corresponds to the triple-A approach (Assessment, Analysis, Action).

 This process must include the active engagement of the caregiver

in problem-solving about the child’s growth.

These conditions can best be met in the community setting, and have the best opportunity for producing results on a public health level if they reach all children 0-24 months in a defined catchment area.

GMP sessions should be linked to other health services in community and be designed to have an effective system in place to refer children to health services when needed.

The GMP process may also be possible in a clinic setting.

**Objective**: The objective of GMP is to determine inadequate growth early enough and undertake actions to prevent further faltering before the child reaches a status of under-nutrition; Hence it is primarily a preventive and promotive activity.

GMP alone is not sufficient to address under-nutrition at the community level, and it addresses only a narrow range of the causes of under-nutrition.

To address the problem of under-nutrition, comprehensive nutrition programs should be implemented based on causal analysis within the nutrition conceptual framework, where GMP can serve as a platform for these programs.

**Expected outcomes:**

The expected outcomes of GMP are:

•Heightened awareness of the importance of caregiver practices for adequate

growth and the link between adequate growth and child health

•Increased knowledge and skills and subsequent improved child feeding and health

care practices by caregivers

•Increased coverage of particular health services, if they are offered along with

GMP

•Improved care-seeking/utilization of services when these are promoted/supported

through the GMP counseling.

**Functions**

Growth monitoring and promotion can have multiple functions:

•As a screening process, it informs caregivers of the child’s growth rate and

motivates them to take action to promote child growth.

•As an educational and promotional activity, it provides the opportunity to

counsel about childcare, feeding, and other topics as needed. The major promotional component of GMP, however, is individual counseling; additional promotional activities are usually designed to link with and benefit from it.

•As a platform for building comprehensive community nutrition and health

programs, GMP serves as an entry point to motivating communities to take action to improve child growth when the community is informed of the results of GM and

involved in the process of GMP.

•As a contact point, it allows for delivering other essential health and nutrition

services and/or promoting the coverage and utilization of services.

These services vary by program and setting, and the outcomes from these actions need to be considered separately in evaluation of GMP outcomes.

**What cannot be categorized as GMP?**

1. Child anthropometric measurements for assessing nutritional status are not GM or GMP.
2. Periodic measurements at appropriate intervals are crucial to the GMP concept and
3. Assessment of nutritional status even at a quarterly or biannual rate does not have the ability to capture growth faltering and prevent under-nutrition.

GM and GMP thus should not be considered a surveillance, or just to be merely used to determine levels of under-nutrition to decide on eligibility for the correction of poor nutritional status (e.g. food supplementation, therapeutic feeding, etc).

 Both the monitoring of growth and using that growth information in counseling are essential to GMP.

It is important to emphasize that the GMP periodic measurements and counseling are primarily considered as preventive activity ensuring that the growth faltering is caught early enough so as not to reach the status of under-nutrition.

However, the framework of GMP may catch also children at different stages of

under-nutrition and refer to relevant services for additional interventions.

In addressing the full spectrum of malnutrition (i.e. under- and over-nutrition), the role of GMP in capturing over-nutrition especially through the use of new WHO standards need to be further explored.

**Important design factors associated with quality GMP include:**

•Coverage of GMP and participation of all the children in the age-range targeted

must be high.

•GMP should cover children from birth to 18 to 24 months (depending upon

local patterns of growth and faltering).

•Growth monitoring and promotion should be conducted monthly from birth to

12 months of age.

•GMP activities must be linked to health services in community and have an

effective system in place to refer children to health services when needed.

•Weight is the preferable indicator for measuring growth rates by community

health workers.

Length/height measurement can be included if quality of its measurements can be assured in the field setting.

For health facility-based growth monitoring, both would be possible options. If a decision on including height measurements is made, the appropriate frequency of measurements needs to be clarified.

**BEHAVIOUR CHANGE COMMUNICATION**:

**DEFINITION OF TERMS:**

**Behavior**: behavior is the expressed capacity of an individual/group of people which may be influenced by attitudes, knowledge and social factors.

**Change**: change is a process of transforming one’s attitude, knowledge, practices that affect his/her well being negatively.

**Communication**: The art/science of passing information from one person to another using a medium/channel and receive feedback

Components of communication include;

1. Sender
2. Channel
3. Message
4. Receiver
5. Feedback

**Channel:** This is a medium of communication that is used to send/deliver message/feedback

**Audience segmentation:** this is dividing and organizing population into smaller groups or audiences with similar communication related needs, preferences and characteristics

**Monitoring**: monitoring is a process of assessing the programs progress towards achieving its communication objectives

**Evaluation**: This is periodic assessment to investigate a program’s effectiveness in bringing about desired change.

What is SBCC?SBCC is the systematic application of interactive, theory-based and research-driven communication processes and strategies to address change at:i) Individualii) Community, andiii) Societal levels

SBCC seeks to address social and behavior changes:

a) **Social Change:**Includes changes in:-**Social order**: Shared beliefs, norms, values and cultural practices of a group of people) and institutions state, media, education, law enforcement exist to maintain social order

**-Social behaviors**: Interactions among individuals usually in the same species that are beneficial to one or more of the individuals -**Social Norms:** unwritten rules of behavior considered acceptable in a group or society

**b) Behavior change:**

Includes changes in:Human behavior: The potential and expressed capacity for physical, mental and social activity of individuals or groups to respond to external stimuli

 SBCC emphasizes analysis of behaviors and determinants to affect changes in-Knowledge-Attitudes-Practices

**Key Facts about Human Behavior** 1. People give meaning to information based on the context in which they live. For example: A married woman with three children may be more receptive to family planning information than a newly married woman who does not yet have children.

2. Culture and networks influence people’s behavior.For example: Contraceptive use in Kenya varies greatly by cultural and regions, though knowledge of contraception is nearly universal.

3. People cannot always control the issues that determine behavior.For example: A woman may not be able to plan and space her pregnancies if her husband does not support her use of contraception.

4. People’s decisions about health and well-being compete with other priorities.For example: Men who smoke and drink excessively may know that these practices are harmful for their health. But, they may continue to do so because it is perceived as macho behavior. The pressure to be seen as a ‘real man’ may override health considerations.

5. People often make decisions based on emotional factors, not logic. For example: Woman with repeated, closely spaced pregnancies may know that they are risking their lives. But, if their desire is a male child, they may keep trying until they achieve their goal.

**CHARACTERISTICS OF BCC**

SBCC is the systematic application of interactive, theory-based and research-driven communication processes and strategies to address change at individual, community, and societal levels.

Therefore, SBCC is a framework that has 3 distinct characteristics.

1. SBCC is a process.
2. SBCC uses a socio-ecological model.
3. SBCC operates through three key strategies.

 **Characteristic 1: SBCC is a Process**

The process is a five step process



**SITUATION ANALYSIS**

Helps to:

* Gain insight into the issue the program is addressing from many perspectives
* Organize and summarize what is known about the situation
* Check assumptions by looking at existing research
* Identify gaps and plan for formative research
* Focus energies and resources and make decisions
* Focus a program effectively on different groups of people (those affected and those who influence them)
* Address a problem and its context through complementary SBCC strategies (BCC, community mobilization, advocacy etc.)

**Characteristic 2**: **SBCC Uses a Socio-Ecological Model for Change**
Socio-ecological model addresses multiple levels for change.



**Characteristic 3: SBCC operates through 3 key strategies:**

**Advocacy**: to raise resources as well as political and social leadership commitment to development actions and goals

**Social mobilization**: for wider participation, coalition building, and ownership, including community mobilization

**Behavior change communication (BCC**): using mass and social media, community- level activities, and interpersonal communication for changes in knowledge, attitudes, and practices among specific audiences

**PRINCIPLES OF SBCC**

Principle 1: Follow a systematic approach (e.g., C-Planning).Principle 2: Use research, not assumptions to drive your program.Principle 3: Consider the social context.Principle 4: Keep the focus on your audience(s).Principle 5: Use theories and models to guide decisions (e.g., the socio- ecological model).Principle 6: Involve partners and communities throughout.Principle 7: Set realistic objectives and consider cost-effectiveness.Principle 8: Use mutually reinforcing materials and activities at many levels.Principle 9: Choose strategies that are motivational and action-oriented.Principle 10: Ensure quality at every step

**AUDIENCE SEGMENTS**

1. Self/individuals
2. Partners, family, peers
3. Leaders, providers
4. Leaders: government, NGO, private sector

 **WHY CHANGE:**

1. Reduce risk behavior that leads to disease
2. Reduce morbidity and mortality
3. Reduce crime
4. Change enhances economic development
5. Increases self esteem

 **WHY PEOPLE RESIST CHANGE**

1. People fear to change/fear of unknown/insecurity
2. Fear to lose friends
3. Ignorance
4. Skills acquired and experience may have no further value
5. Pride
6. Peer pressure
7. Culture/norms/beliefs
8. Myths and misconception

**BARRIERS OF BCC**

1. Language barrier
2. Age barrier
3. Culture/norms/beliefs
4. Myths and misconceptions
5. Budget allocation
6. Illiteracy

**FACTORS TO CONSIDER WHEN SELECTING A COMMUNICATION CHANNEL**

* Desired reach: who do you want to reach, area of coverage
* Media habits and preferences of intended audiences
* Media access
* Preferred listening times, stations, programs
* Media ownership
* Feasibility/budget available/cost
* Complexity
* Sensitivity of the issue
* Literacy levels

**FACTORS THAT AFFECT BEHAVIOR:**

Behavior is affected by factors relating to the person, including:

* physical factors - age, health, illness, pain, influence of a substance or medication
* personal and emotional factors - personality, beliefs, expectations, emotions, mental health
* life experiences - family, culture, friends, life events
* what the person needs and wants.

Behavior is also affected by the context, including:

* what is happening at the time
* the environment - heat, light, noise, privacy
* the response of other people, which is affected by their own physical factors, personal and emotional factors, life experiences, wants and needs.

Health seeking behavior (HSB) has been defined as any activity undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy.

Factors affecting health seeking behavior Review of the global literature suggests that these factors can be classified as cultural beliefs, socio-demographic status, women's autonomy, economic conditions, physical and financial accessibility, and disease pattern and health service issues

 **FACTORS INFLUENCING COMPLIANCE AND HEALTH SEEKING BEHAVIOR**

The factors influencing health seeking behavior and compliance include;

* 1. The health system factors
	2. The patient factors
	3. The socioeconomic and
	4. Structural environment.

 **Health System Factors**

Under the overarching theme of health system factors, five themes influencing compliance and HSB were identified:

(1) availability of medicines, personnel, and diagnostic supplies;

 (2) high burden of acute care at health facilities;

 (3) traditional medicines;

 (4) perceived provider abilities/behaviors and overall quality of care, and

(5) patient waiting times at the facilities.

**(1) Availability of Medicine, Personnel, and Diagnostic Supplies**

Medicines:Availability of or the assumption of [modern] medicines readily available at health facilities and related costs play a key role in the seeking behavior of clients

 In private health facilities and private pharmacies, patients report drugs were readily available, however, high costs of these medicines deter access. As such, only those who have money access the medicines.)

Finding medicines at the health facilities is a motivation for their health seeking behaviors. However, lack of medicines has a negative implication patients’ compliance and health seeking behavior.

Personnel**:** Finding a service provider at a health facility is also critical in influencing health seeking behavior of patients. Patients are motivated to go to a health facility where they are sure of finding health worker.

Patients are also motivated to seek health care services by specialists

Diagnostic Supplies**:** Supply issues entail the availability or lack of/or inadequacies in diagnostic equipment. Availability of diagnostic services is a motivation for health seeking behavior**.**

**(2) High Burden of Acute Care at Health Facilities:** It is interesting that some patients do not seek care because they think health workers cannot attend to them since they [patients] do not have severe symptoms to warrant attention.

 They feel that hospitals are full of the severely ill patients, meaning that a visit to health facilities for routine checkup can be an additional burden to an already overwhelmed system.

**(3) Traditional Medicine:** With respect to the challenges surrounding access to modern health services, some patients resort to using alternative medicines and seeking care from traditional practitioners.

 Most patients seeking complimentary medicines use herbs and some report that they consult traditional healers. Patients considered herbs easily accessible and to a certain extent comparably affordable.

**(4) Perceived Provider Abilities and Behaviors and Overall Quality of Care:**

 (1) patients’ perceptions about their providers’ abilities in terms of skills and knowledge competences;

(2) perceived providers’ attitudes towards work and the feeling of being treated with or without respect;

(3) providers’ advising role towards their patients’ health seeking behaviors; and

(4) perceived quality of care.

(i) Patients’ Perceptions about Their Providers’ Abilities in Terms of Skills and Knowledge Competences*.*

Whereas most patients perceive their providers to have sufficient knowledge and the required skills to manage their illnesses, some patients depicted their providers as not having sufficient competencies. They felt the providers focused on treating symptoms rather than conducting a proper disease diagnosis prior to treatment.

(ii) Perceived Provider Attitudes towards Work and the Feeling of Being Treated with or without Respect.

Patients noted that providers exhibited different attitudes towards their work and their patients. They felt very comfortable seeking care from providers who were friendly. Some providers are implicated in having unwelcoming behaviors and negative attitudes towards patients. They felt that providers exhibited unnecessary delays, which resulted in negative health outcomes.

(iii) Perceived Quality of Care: quality of care is a motivator to compliance and health seeking behavior

(iv) Patient Waiting Time at the Facility: Patients note that it was very stressful to spend the whole day at a health facility waiting to be treated. The long waiting time is attributed to

(1) High patient volume vis-a-vis the limited number of health workers

(2) Sluggishness and being unconcerned on the side of the healthcare workers, and

 (3) A lack of clear patient flow protocol that was characterized with favoritism and lack of respect.

As a consequence, some patients stop going to certain hospitals because of the long time they spend trying to get a service.

 **Patient Related Factors**

Another overarching theme influencing compliance and health seeking behavior for health services is patient related factors. These include;

 (1) awareness about having the disease

 (2) perceived severity or fear of the consequences of the disease

 (3) beliefs about the effectiveness of the therapy

 (4) concerns about adverse effects

(5) The fear of dependency on long-term medication.

Patients’ Awareness about Having the Disease: Awareness: The state of being aware or having knowledge that one is a certain disease plays critical role in HSB. Some patients are diagnosed with a disease without any signs and symptoms.

Perceived Severity or Fear of the Consequences of the Disease: Patients who have mild symptoms perceive themselves to be at low risk and are likely not to seek care for their illness.

Because of the low risk perceptions, such patients mainly depend on self-medication to treat symptoms or embraced a do nothing scenario. On the other hand, patients who perceived their disease to be severe especially after experiencing life-threatening symptoms are more likely to seek care promptly from bigger hospitals and avoid self-medication

The Patient Beliefs about the Effectiveness of the Therapy or RecommendedAdvice: Some patients’ HSB and compliance are dependent on their perceptions about the effectiveness of the treatment or recommended provider advice. Effective remedies encourage patients to return to their providers for refills.

Patients’ Concerns about Adverse Effects:

patients fear that some drugs are associated with unpleasant outcomes.

The Fear of Life Long Dependence on Medicine: Lifelong dependence on some drugs is perceived as a burden and some patients don’t believe that they are ready for such a course of action. As a result, some patients report that they swallow drugs occasionally to try and avoid over dependency on medicine in controlling their chronic condition.

 **The Socioeconomic and Structural and Cultural Environment**

Besides, the healthcare and the patient related factors other factors that influence HSBs are;

1. socioeconomic and structural/cultural environment issues.

More specifically,

 (1) Education, information, and marketing of traditional medicine,

(2) The patients’ financial and social status, and

(3) Distance and transport.

**Education, Information, and Marketing of Traditional Medicine***.* Education, information, and marketing greatly influence the use of alternative medicine for treatment in the population. Patients report that traditional practitioners, distributors, and proponents of herbal medicines embrace the power of socio-marketing, education, and active information sharing about their products. The most popular avenues of communication and promotion of herbal remedies include media houses such as radios and television, door-to-door information and drug distribution, and use of public address system in populated areas such as markets and assembly places

**(2) The Patient’s Financial and Social Status***.* Financial and socioeconomic status of the patients was critical in influencing compliance and HSBs of patients. Specifically, financial and social aspects include the ability of the patients to meet their healthcare needs, family support, and advice from significant others

Family members also provide patients with psychosocial and moral support as well as reminding them about their scheduled appointments, drug refills, and taking the medicines. Moreover, acquaintances such as friends, community members with similar challenges, or community resource persons such as religious leaders also support.

*(***3) Distance and Transport.** Transport, distance, and related costs influence health seeking behavior of patients. Moreover, means of transport are not always reliably available in some settings. Consequently, rural residents commonly report transport as a key barrier to seeking care, including adhering to scheduled hospital appointments.

**Information, education and communication**

* [Information, education and communication](http://www.emro.who.int/child-health/community/information-education-communication.html)
* [IEC lessons](http://www.emro.who.int/child-health/community/information-education-communication/IEC-lessons.html)

 Development of posters, flyers, leaflets, brochures, booklets, messages for health education sessions, radio broadcast or TV spots, etc. as a means of promoting desired, positive behaviors in the community.

In some cases, these activities are part of a communication plan within a comprehensive strategy, while in many others they are isolated actions.

These initiatives are commonly referred to broadly as “Information, education and communication (IEC)” activities.

“IEC” refers to a public health approach aiming at changing or reinforcing health-related behaviors in a target audience, concerning a specific problem and within a pre-defined period of time, through communication methods and principles.

This definition helps emphasize the need for IEC initiatives to:

Have a clear **objective** (the specific behavior to change or reinforce);

Target a specific **audience** (e.g., mothers of children below five years old);

Address a “**specific problem**” (e.g., offering increased fluids and continuing feeding a child with diarrhea), rather than attempt to change many problems at the same time;

Set a **timeframe** within which the results (“change in behavior”) are expected to occur.

The “**problem**” must be well defined, as that is what the IEC intervention aims to address.

 Thorough understanding of;

1. What people do
2. What prevents them from following the desired practices (“barriers”)
3. What facilitates them (“enabling factors”) is essential before designing a communication intervention.

It is obvious that this requires a detailed **plan**, the implementation of which needs to be monitored closely according to pre-set indicators, and then properly evaluated.

Activities following these principles and meeting the above definition can be considered IEC initiatives, with a higher potential to achieve the stated objective than the others.

Thus, for example, the development of a poster without the following elements would not be a structured IEC initiative:

i) Audience analysis;

ii) Testing;

iii) A plan with objectives,

iv) Indicators and targets;

v) A clear target audience

vi) A distribution plan with follow-up;

vii) Regular feedback through monitoring;

viii) A formal evaluation.

**Tips for creating and effective communication Material**

1. Selecting a channel that reaches the intended audience is important.
2. Creating effective materials is done after a communication strategy is complete
3. The process requires testing all SBCC materials before finalizing and producing them
4. Creating SBCC materials combines science and art
5. The science is creating materials based on the evidence and the situational analysis (as covered previously in this training).
6. The art is creating materials that evoke emotion, motivate the audience, and fit into the communication strategy
7. Remember, materials do not stand alone, they support the communication strategy

**Conducting a Materials Inventory**

**W**hat is a materials inventory?

1. A review of current and past materials developed
2. compilation of materials and activities that might inspire your program
3. materials you might consider adapting or complementing

**Why do you need to conduct a materials inventory?**

1. To reduce inefficiencies caused by developing materials that already exist
2. To learn from others in the field on what worked and what didn’t
3. Remember, most communication-related issues have been addressed for many years.

**How to conduct material inventory:**

1. Consider materials your program will need (from your communication strategy).
2. Explore and track down materials you’ve heard about or that might be useful.
3. After collecting the materials, ask yourself:

i) Which of these activities, tools, or materials are still in use and why?ii) What can you use or adapt for your purposes instead of reinventing the wheel?iii) What can be learned from others in the field?

**Some Ideas on Where to Find Materials**

1. Your own and other partners’ organizations
2. Government agencies, NGOs, universities
3. Global repositories for materials that have electronic files or other resources
4. C-Hub is a global repository of health and development communication resources.
5. www.c-hubonline.org
6. Ministry of health website, DHIS etc.

**The Creative Brief1.**  It is a short tool to guide the development of SBCC material

**2.** A guide for practitioners, creative agencies, and stakeholders to develop ideas for materials

**3.** A document used to keep team members on track

Key Message for considerations include:

**Effective Messages**

1. What is the desired change?
2. What are the barriers?
3. What are the communication objectives?
4. What do the key promise and support statement say?
5. What are the important themes?
6. What are the most important points or information to convey

**Seven Cs of Effective Messages  Command attention**The message stands out to the audience.The message is believable.

**Clarify the message**The message is simple and direct.The message focuses only on what the audience needs to know?The strongest points are given at the beginning of the message.

**Communicate a benefit**The message clearly states what the audience gets in return for taking action.The message conveys that the benefit outweighs the barriers.

**Consistency counts**Key messages are used appropriately and ensure consistency and support for all the programs materials.

**Cater to the heart and the head**The message uses an appropriate tone for the audience and appeals to emotions as well as logic.The appeal is appropriate as laid out in the creative brief.

**Create trust**The information comes from a credible source.

**Call to action**The call to action clearly states what the audience should do after seeing the communication

**DRAFTING AND REVIEWING MATERIALS**

**Key Content, Tone, and Media Mix**

**Key Content:**Provides the information and concepts that are essentialDescribes what is relevant to the audience to achieve the communication objective to bring about change**Tone or Appeal:**

-Conveys the key promise-Projects the feeling or personality your communication should have (e.g., humorous, logical, emotional, positive, or comic), based on the key promise

**Media Mix/Activities:**Describes how this material fits or relates to program activities and other materials

**Openings, Creative Considerations, Cost, and TimingOpenings**provides the information and concepts that are essential**Creative Considerations**What language will the material be in?What are the reading levels of your audiences?What is the preferred style for photos or illustrations? What else in particular regarding style, layout, or visuals should be considered?What logos need to be used?**Cost and Timing**How much will the activities or materials cost, and when do they need to be ready?

**Testing your SBCC Materials to Ensure Effectiveness**

**Why Test?-**To confirm that materials are effective, appropriate, understandable, attractive, and culturally relevant.**-**To gather feedback from intended audiences, who may suggest alternative formats and identify confusing or unclear content.**-**To identify revisions that can then be made so the materials will be effective.-Testing is easier and more cost effective to revise materials or activities during the material development stage than after they are finalized and disseminated

**Types of Testing**Concept testingPretestingStakeholder reviews

**HOME MANAGEMENT**

**Promoting Healthy Homes through Prevention**

Illnesses and injuries related to homes are not inevitable.

Many [housing](https://www.ncbi.nlm.nih.gov/books/n/ctahome/cta-home.glossary.gl1/def-item/cta-home.glossary.gl1-d3/) hazards and the injuries and illnesses resulting from them can be reduced or eliminated by proper design of new construction, modification of existing home structures, and changes in housing-related behaviors.

Successful prevention of housing-related disease and injuries through healthy homes depends on how architects, building inspectors, property owners, maintenance and remodeling workers, and residents incorporate healthy housing knowledge into their practices and into their day-to-day activities.

Many simple changes can promote health and safety at home. In addition, housing interventions can also improve the availability, accessibility, and environmental friendliness of homes. This section presents well-documented, evidence-based interventions.

**Improving Air Quality**

Two effective ways to reduce indoor air pollution levels are to;

1. Eliminate or reduce emissions from indoor sources
2. To improve ventilation.

Usually the most effective method is to control emissions, for example by;

1. Eliminating smoking,
2. Adjusting gas stoves to minimize emissions,
3. Using paints and coatings that emit low levels of volatile organic compounds,
4. Using low-emitting building materials such as wood products that emit low levels of formaldehyde,
5. Using cleaning products that emit low levels of air pollutants.
6. In typical houses, they require a mechanical ventilation rate of about 50 cubic feet per minute or 25 liters per second and in larger houses have a higher rate.
7. In some cases, proper ventilation can also be achieved by opening windows and doors for a period of time each day and by using exhaust fans in kitchens and bathrooms

**Smoke-free Homes:**

1. The best way to maintain a smoke-free house is to refrain from smoking.
2. In addition, adopting smoke-free rules in homes reduces involuntary exposure to secondhand smoke and improves health.
3. Opening a window; sitting in a separate area; or using ventilation, air conditioning, or a fan cannot eliminate secondhand smoke exposure.
4. The only way to fully protect yourself and your loved ones from the dangers of secondhand smoke is through 100% smoke-free environments

**Carbon Monoxide Poisoning Prevention**

Removing or controlling carbon monoxide sources in the home is the most important way to prevent carbon monoxide exposure.

For example, gas generators, gas grills, and other fuel-burning appliances should never be operated in the house.

Converting from wood stoves or kerosene heaters may decrease both carbon monoxide and particulates in the home, although this may not always be practical.

In addition, installing and maintaining carbon monoxide detectors can prevent death and injury from carbon monoxide exposure

**Reducing Allergens and Asthma**

Homes should be designed, operated, and maintained to prevent water intrusion and excessive moisture accumulation.

Moisture can be controlled by repairing water leaks, installing suitable insulation to avoid condensation, and ventilating rooms properly.

When water intrusion and moisture accumulation are discovered, the sources should be identified and eliminated quickly to reduce mold growth and to reduce infestations of cockroaches and rodents.

 Allergen levels can be controlled by vacuuming and cleaning hard surfaces.

Mold growth should be eliminated in a way that limits the possibility of recurrence and that limits exposure of the occupants and persons conducting the remediation.

Mold should not be cleaned using mixtures of ammonia and bleach, which may produce poisonous gas. Porous materials such as ceiling tiles, wall boards, and fabrics that cannot be cleaned should be removed and discarded.

Dead mold may still retain its allergic or toxic properties, replacing rather than cleaning is often the best mitigation option.

Frequent washing of plush toys and bedding, using mattress and pillow covers, and keeping pets out of bedrooms has been demonstrated to reduce exposure to allergens.

**Improving Water Quality**

There are several important things to know about homes that are connected to small community water systems or that have a private well:

1. Build wells away from septic systems and other waste water systems
2. Do not use wastewater systems to dispose of toxic chemicals, and know when and how to test wells.
3. Steps for proper maintenance and protection of private wells include periodic inspection of exposed parts of the wells to identify missing or worn parts or cracks
4. Annual disinfection using bleach or hypo chloride granules, and annual testing for bacteria and chemical contamination

**Reducing Harmful Chemicals**

**Pesticide Exposure Prevention**

A safer alternative to exclusive reliance on chemical pesticides is integrated pest management (IPM).

IPM uses the least toxic practical baits and insecticides, thus reducing both insect pests and reliance on chemical pesticides.

1. Household pests can be controlled by eliminating the pest’s habitat inside and outside the house
2. keeping pests out using building or screening techniques that prevent entry
3. Eliminating food from areas where pests can make their homes
4. when necessary, using pesticides appropriately

**Household Chemicals and Medicines**

A number of simple actions can help to assure that household chemicals including household cleaning products, pesticides, medicines, gasoline, car polishes, and pool-cleaning chemicals can be used safely.

1. Eliminate dangerous chemicals that do not need to be in the house.
2. Do not repackage chemicals.
3. Be sure all chemicals are labeled
4. read the labels on all products,
5. follow directions regarding use and disposal,
6. dispose of chemicals safely
7. Store household chemicals and medicines with “keep out of reach of children” labels in locked cabinets.
8. Use childproof caps on prescription medications to protect children.
9. Lock outbuildings that store chemicals such as automotive supplies
10. Pool cleaners, and agricultural pesticides and fertilizers

**Improving Housing Structure and Design**

How homes are designed, constructed, and maintained;

1. Their physical characteristics
2. The presence or absence of safety devices can promote the health of residents.
3. [Housing](https://www.ncbi.nlm.nih.gov/books/n/ctahome/cta-home.glossary.gl1/def-item/cta-home.glossary.gl1-d3/) structure has an impact on mental health and the occurrence of injuries and diseases, as well as promoting accessibility for elders and people with disabilities.

**Preventing Injuries**

**Fall Prevention**

By installing

1. Grab bars in bathtubs and showers
2. Handrails and
3. Good lighting in stairwells
4. Homes can be designed and constructed to protect elderly occupants from fall-related injuries.
5. Many homes currently do not have these simple safety features. For example, 35% of homes with stairs do not have handrails.
6. Interventions that can help to prevent childhood fall injuries include;

a) Window guards

b) Stair gates,

c) Balcony railings less than 4 inches apart

d) Window locks or guards for windows above ground level

**Fire and Burn Prevention**

The leading cause of residential fire deaths is smoking and so;

Smokers should be advised to quit.

 When a fire occurs in a home with a functioning smoke alarm, the risk for death is decreased by 40%–50%.

 To reduce the risk of deaths from fires;

Smoke alarm batteries should be checked regularly—for example, when clocks are reset to daylight or standard times.

New home construction should include hard-wired smoke alarms that do not depend solely on battery power.

Residential sprinklers may be a promising strategy to prevent deaths

Injuries due to fires Preparing and practicing a fire escape plan,

Teaching fire escape skills to children, can minimize injuries and death from fires

 Strategies to decrease burns include;

1. Reducing the temperature in water heaters to 120°F
2. Installing hot water temperature limiters at the faucet
3. Using roll-up cords for electric coffee pots
4. Installing covers on electrical outlets
5. And using pots, pans, and kettles designed to be less likely to tip and spill hot liquids

**Drowning Prevention**

Drowning at home can be prevented by having proper fencing around swimming pools.

When combined with self-closing and self-latching gates, four-sided fencing provides a passive intervention that prevents unintended access to pools by small children

 To help prevent drowning, parents should be within arm’s length of children who are bathing or playing around water.

**Suffocation and Strangulation prevention**

Parents and caregivers should be aware of the types of objects that pose a strangulation or suffocation risk for children and become familiar with methods to reduce this risk.

 Infants should be placed on a firm sleep surface, such as a safety-approved crib mattress, and soft objects or loose bedding should not be placed in a crib.

 Loop window blind and drapery cords should be tied up out of reach or the ends should be cut and retrofitted with safety tassels.

The inner cords of blinds should be fitted with cord stops.

**Firearm Injury Protection**

To prevent firearm injuries and deaths;

1. Firearms should be stored locked and out of reach of children
2. Should be equipped with trigger locks.
3. These simple measures are often not taken. For example

**Improving Mental Health**

Home design elements can foster improved mental health.

 For example, building designs with window placement that allows adequate light and views of natural landscapes may improve psychological well-being

Home design elements that increase the probability of social interaction among neighbors—for example, front porches—can enhance social cohesion and support.

 Crowding in [housing](https://www.ncbi.nlm.nih.gov/books/n/ctahome/cta-home.glossary.gl1/def-item/cta-home.glossary.gl1-d3/) units can be prevented by providing an adequate supply of affordable homes.

Certain design features such as greater ceiling height, windows, brighter lighting, and visual distractions such as pictures on walls can help reduce the perception of crowding.

 Other factors, such as social support, can help reduce the negative impact of.

Efforts to build social support may be a useful adjunct to design solutions.

**Improving Accessibility**

Designing and remodeling using wide doorways and building entrances without steps can help older persons and those with disabilities remain connected with their communities.

Creating an adequate supply of homes accessible for elders and for people with disabilities will result in significant public health improvements

**Encouraging Safe and Healthy Behaviors**

Individual resident behavior and prevention patterns with regard to home hazards contribute to health and safety at home.

Behaviors that affect health result from the interplay of many economic, social, and cultural factors. Still, changing behaviors is not easy, even when people are aware of the effects of certain behaviors on personal health or the health of their families. Behavior change needs to be understood in the context of large systems—social systems, cultural systems, education systems, and the public health system.

**Reducing Disparities in Access to Healthy and Safe Homes**

Focusing on properties that pose the greatest health risks; that is, those properties that are older, low-income, or in substandard condition, will yield the greatest improvement in health outcomes. This will also help address the striking health disparities borne by low-income and minority families. Indeed, for all important exposures and health problems, it is essential to emphasize making improvements among the most affected populations as well as in the population as a whole. Existing funds and policies for “home improvement” programs may, for example, provide effective strategies for improving individual- and community-level health disparities.

**Addressing Community Factors that Affect Health and Homes**

**Weather and Natural Disasters**

Siting and design of homes can protect against adverse health effects related to weather and disasters. Although no building can be completely disaster-proof, good design and materials will minimize structural damage and will safeguard the lives of occupants during a major disaster or extreme weather event. Disaster resistance is best achieved by following modern building codes and standards. Urban planning and zoning can ensure that homes are not built in locations at high risk for specific types of disasters.

People can minimize their risk for disaster-related adverse health effects by learning about the types of disasters that are most likely to occur where they live. People can learn about the local warning signals and systems. Developing home response plans can also minimize health risks by, for example, maintaining a disaster survival kit with an adequate supply of water and necessary prescription medications. Communities can help minimize consequences of disasters by adequate response planning.

Finally, the responses of people to natural events should avoid harm to themselves or the environment. For example, portable generators or supplemental heating devices should be used appropriately so that they do not release deadly carbon monoxide. Proper installation and maintenance of heating and cooling systems can prevent hypothermia and hyper-thermia when temperatures are extremely cold or hot.

**Noise**

Noise abatement [housing](https://www.ncbi.nlm.nih.gov/books/n/ctahome/cta-home.glossary.gl1/def-item/cta-home.glossary.gl1-d3/) design strategies have been proposed but have been inadequately tested. However, reducing the sources of noise in and around the home and designing buildings to control the transmission of sound may reduce noise and its adverse health consequences.