# MODULE: COMMUNITY HEALTH

# UNIT: PRIMARY HEALTH CARE (PHC) AND MILLENNIUM DEVELOPMENT GOALS (MDGS)

# By Kenneth Mwambila

# May/June 2013

**OUTLINE**

|  |  |  |
| --- | --- | --- |
|  | Introduction | Definition (WHO); Evolution of PHC; History of health services in Kenya |
|  | Primary Health Care (PHC)  | * Historical Background
* Principals of PHC
* Elements of PHC
 |
|  | Health Education | * Definition , Principles of Health education; Models of health education; Teaching methods in Health education
* Communication;
 |
|  | Communication  | * Components of communication process, Characteristics of good communication; Barriers of communication; Use of teaching aids in Health education; Role of community health workers in communication,
 |
|  | Community participation and Mobilization  | * Community participation – definition, factors
* Community mobilization strategies
* Community organizations
 |
|  | Health promotion and Community Based Health Care  | * Definitions, principles, strategies, role traditional health workers- recruitment, selection, training, community participation
 |
|  | Millennium Development Goals | * All MDGs but with emphasis on the 3 health related goals
	+ Goal 4 - Reduce child mortality
	+ Goal 5 - Improve Maternal Health
	+ Goal 6 - Combat HIV/AIDS
 |
|  | Immunization | * National immunization schedule; – Principles, Goals, Objectives; Immunizable diseases; Vaccines – types and administration
* Cold Chain system; Infection prevention; EPI disease surveillance – EPI targets, calculation of target population, National immunisation days
* AVI
 |
|  | Focused Antenatal Care | * Intermittent Preventive Therapy, Danger signs, Individualised Birth Plan, Antenatal examination, screening, 4 visits, PMTCT, infection prevention
 |
|  | School Health  | * Organization, objectives, planning and implementation, activities, evaluation
 |

# Topic 1: HISTORY OF MEDICAL SERVICES IN KENYA

# COLONIAL ERA

* The history of health services in Kenya dates back to the establishment of religious missions in the latter half of the 19th century and the arrival of the Imperial British East Africa Company (IBEA Co.) officials.
* In 1895, the medical staff of the company was taken over by the British Government
* In 1901 medical department set up as one of the eight departments with a staff of seven doctors, three nurses and seven hospital attendants.
* 1902 - Outbreak of an epidemic of plague in Nairobi which led to initiation of rat and malaria control programme.
* 1915 - The first attempt to introduce a public health act
* In 1924 African Native Council was given the responsibility of administering Health Centres.
* 1927 - The first formal Training of Paramedical staff – clinical officers
* The first census for Kenya was held in 1948, report published in 1953,
* 1950s - Rapid development of health services in Kenya with a range of paramedical programmes being started at KNH (King George IV Hospital)
* 1952 private family planning services was started at Mombasa.
* 1954, Family Planning Association of Mombasa and Nairobi were established.
* 1956 the Family Planning Association of Kenya (FPAK) was established
* 1960 formation of a Ministry of Health, which was renamed Ministry of Health and Housing in 1962.

# POST INDEPENDENCE ERA

* In 1963, Kenya gained independence.
* 1965, free medical treatment in Government facilities was introduced in line with the guideline of KANU manifesto.
* The long-term objective of the Kenya Government was the attainment of “Health for all by the year 2000” and the maintenance of better health for all thereafter.
* 1977 World Health Assembly the member states of WHO endorsed the world-wide social objective: “Attainment by all people of the World by the year 2000 of the level of health that will permit them to lead a socially and economically productive life.”
* In recognition of the fact that it is unlikely that any existing health service strategy could achieve this objective, the government endorsed the primary care strategy for providing health services to the Kenyan population with emphasis on the rural areas where over 80% of the population lives.
* 1967, the National Family Planning programme was started.
* 1970, the government took over the running of most of the services previously ran by local councils including the rural health services.
* 1971-72, a joint GOK/WHO mission formulated the “Proposal for the improvement of Rural Health Services in Kenya and establishment of six Rural Health Training Centres”. (Chulaimbo – Nyanza; Mbale – Western; Mosoriot – Rift valley; Maragua – Central; Karurumo – Eastern; Tiwi – Coast)
* 1974 - The MCH/FP programme was launched
* 1982 - The integrated Rural Health and Family Planning Project was launched.
* 1984 - A community Based Health care unit was set up.
* Health centres have increased from 187 in 1973 to 242 in 1982, dispensaries have increased from 416 to 872 in same period.
* Despite these increases, more than 75% of household in Kenya travel four or more kilometers to obtain health services and only about 30% of the population lives within easy reach (two kilometers or less) of a healthy facility.
* The main problem facing the delivery of rural health services continues to be the standard of services provided at the facilities, given constraints in the budget
* The concept of community participation in development activities, a major cornerstone in the PHC strategy, is not new in Kenya. The Harambee movement that has existed since independence has greatly contributed to the development especially in health care delivery and education. However, most of the Harambee efforts constitute a one-term effort from the community and have often been directed towards the construction of physical facilities, especially buildings, which the people hoped would be taken over and be run by the government or NGOs. What now remains is linking this abounding spirit of self-help among the people with sound policy in health care delivery through the new concept that has been embraced by the government that all people be closely involved in provision of health to Kenyans-the concept of primary health care as enunciated in Alma Ata in 1978.

# EVOLUTION OF PHC

* In 1976, a cadre of health workers known as Family Health Field Educators was started in the country which had the same function as community health workers and was supposed to be close to the community.
* However, since they were the GOK employees, they were not “community based” but “community oriented.”
* Local Health Committees were formed in 1976 and Community Based Health Care programmes by the NGOs were started by 1977.
* In 1977, the GOK with support of UNICEF and WHO launched a pilot project for community participation in health care delivery.
* The Alma-Ata conference and declaration in 1978 reinforced Government commitment to the implementation of the pilot project and Primary Health Care in general.
* In order to emphasize the focus on and the role of the community, the project was called community based healthcare (CBHC) reflecting the initiative, resources and responsibilities in the community.
* The project was however seen within the border approach of Primary Health Care.
* Recent efforts by the Ministry of Health in developing Primary Health Care have been undertaken within the framework of the long term objective of the attainment of “Health for all by the year 2000”.
* Emphasis was placed on improving family health with particular focus on mothers and children; increasing coverage and accessibility and improving the quality of the essential health service; pursuing an integrated, inter-sectoral and multi-disciplinary approach with community participation in the delivery of health care.
* 1986 CBHC project in 14 districts in Kenya and had established a CBHC unit within the ministry to co-ordinate all the CBHC activities in Kenya.
* Examples:
* AMREF: Has established the Community Health Workers Support Unit, organizes training of trainers courses and has a CBHC project in Kibwezi since 1978.
* Kenya Catholic Secretariat started in 1978 with a CBHC in Machakos District, is now also active in other parts of Kenya.
* Protestant Churches Medical Association
* Aga Khan Health Services: Kisumu.
* Kenya Red Cross: Kakamega and South Nyanza
* PHC was mooted after the International Health Conference held in September 1978 at Alma-ata.
* The conference expressed need for urgent action by government’s health development workers and the world community to protect and promote the health of all the people of the world.
* PHC is therefore the first level of contact of individuals, family and community which the national health system can use to bring health care as close as possible to where people live and work

# Topic 2: PRIMARY HEALTH CARE (PHC)

# Introduction

*PHC is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that community and the country can afford (Alma-Ata, 1978).* It includes the following health promotion, illness prevention, care of the sick, advocacy and community development

In the Alma Ata Declaration it means that: Primary health care (PHC) is *based upon practical, scientific, solid and social acceptance of methods and technology. It is fundamentally health care that is generally accessible to the individual and families in the community through their participation and with a cost that the being of the community life and the country can determine with sustainability in the spirit of self-confidence and self-determination. Primary Health Care systems whose main areas of concern are formed by the community, is dependent upon the general social and economic development of the country* (Diesfeld, Gesundheitversogung in Entwicklungsländer, 1996)

It forms an integral part of the country's health system, of which it is the central function and the main focus, and of the overall social and economic development of the community (WHO Health for All No. 1:3-4)

Primary Health Care gained the world’s attention after the 1978 International Conference on PHC held at Alma Ata in the USSR (now called Almaty in Kazakhstan). Since then many countries have started to follow the approach of PHC to reach rural communities where most of the health problems exist. PHC focuses on **disease prevention and health promotion**. It is the type of healthcare delivery sometimes described as ‘by the people, of the people and for the people.’ It involves the community in the whole process of healthcare delivery and encourages them to maintain their own health.

The ultimate goal of primary health care is better health for all. WHO has identified five key elements to achieving that goal:

1. Reducing exclusion and social disparities in health (universal coverage reforms);
2. Organizing health services around people's needs and expectations (service delivery reforms);
3. Integrating health into all sectors (public policy reforms);
4. Pursuing collaborative models of policy dialogue (leadership reforms); and
5. Increasing stakeholder participation.

# What Is PHC

PHC is essential health care that is a socially appropriate, universally accessible, scientifically sound first level care provided by a suitably trained workforce supported by integrated referral systems and in a way that gives priority to those most in need, maximises community and individual self-reliance and participation and involves collaboration with other sectors. Alma Ata Declaration (USSR, 1978)

‘The main goal of Governments and World Health Organization in the coming decades should be the attainment by all people of the world by the year 2000, a level of health that would permit them to lead a socially and economically productive life’

Primary health care became a core policy for WHO in 1978, with the adoption of the Declaration of Alma-Ata and the strategy of "Health for all by the year 2000". Twenty-five years later, international support for the values of primary health care remains strong. The commitment to global improvements in health, especially for the most disadvantaged populations, was renewed in 1998 by the World Health Assembly leaning to the ‘Health-for-All for the twenty-first Century’ policy and program, within which the commitment to PHC development is restated. The Alma Ata had 3000 delegates from 134 nations and 67 International NGO’s made this the biggest convergence of world leaders in history.

The 1978 Declaration of Alma-Ata proposed a set of PRINCIPLES for primary health care. PHC should:-

1. “Reflect and evolve from the economic conditions and socio-cultural and political characteristics of the country and its communities, and be based on the application of the relevant results of social, biomedical and health services research and public health experience”
2. “Address the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly”
3. “Involve, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works,
4. “Promote maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develop through appropriate education the ability of communities to participate”
5. Be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need”
6. “Rely, at local and referral levels, on health workers, including physicians, clinical officers, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.”

Three key ideas saturate the declaration of Alma Ata namely-:

1. A preference for non-technological interventions (such as nutrition and sanitation)
2. Opposition to medical elitism through genuine community involvement in health care strategies
3. The notion that health care was inseparable from socio-economic development. Indeed,

Primary Health Care as envisioned at Alma Ata had very strong socio-political implications. It specifically stated that we must address the underlying social, economic, and political causes of poor health if the goal of “Health for All” was to be attained by the year 2000. It strongly emphasised disease prevention, health promotion, community participation, self-reliance, and intersectoral collaboration whilst, like the Lalonde Report before it, acknowledged that poverty, social unrest, the environment, and a lack of basic hygiene and nutrition contribute more significantly to poor health status than access to medical intervention alone.

## Core Activities

There is a set of activities, which were normally defined nationally or locally. According to the 1978 Declaration of Alma-Ata proposed that these activities should include:

1. Education concerning prevailing health problems and the methods of preventing and controlling them
2. Promotion of food supply and proper nutrition
3. An adequate supply of safe water and basic sanitation
4. Maternal and child health care, including family planning
5. Immunization against the major infectious diseases
6. Prevention and control of locally endemic diseases
7. Appropriate treatment of common diseases and injuries
8. Basic laboratory services and provision of essential drugs.
9. Training of health guides, health workers and health assistants.
10. Referral services mental health, physical handicaps, health and social care of the elderly

## WHO Strategies OF PHC

1. Reducing excess mortality of poor marginalized populations:
* PHC must ensure access to health services for the most disadvantaged populations, and focus on interventions which will directly impact on the major causes of mortality, morbidity and disability for those populations.
1. Reducing the leading risk factors to human health:
* PHC, through its preventative and health promotion roles, must address those known risk factors, which are the major determinants of health outcomes for local populations.

3. Developing Sustainable Health Systems:

* PHC as a component of health systems must develop in ways, which are financially sustainable, supported by political leaders, and supported by the populations served.

4, Developing an enabling policy and institutional environment:

# History of PHC

At the end of 60’s and during 70’s of the last century it was increasingly clear that the health services in developing countries could not be perceived or oriented according to the western industrial states and societies. Western medicine was one-sided emphasizing only curative aspects and being limited to the health services in the hospitals, medical practice and pharmacies based on medicine technology. Prevention (prevention of diseases) had a relatively little place value. Such a one-sided understanding and a one-sided system of health services affected even the young independent states of Africa in which financing health facilities of this system is difficult and has had little success. All diseases in the developing countries were diseases that could be protected (e.g. Diarrhoea, lung inflammations, tuberculosis, malaria, to mention just a few).

The transference of western medicine views to the developing countries proved itself to have attained little success regarding its goals. Reasons why the western system of health cannot be absolutely applied in all situations of the developing countries include:

1. Western systems are one-sided oriented, oriented to curative dimensions while neglecting prevention and aspects of social medicine.
2. They are too expensive,
3. Lack of specialists who can handle the high-technical medicine.
4. Understanding of medicine in the west does not consider the traditional views concerning experiences about diseases and health that has spiritual background of the inhabitants.

The WHO responded by developing the policy of health as a response to the problems of health in the developing countries by establishing the concept of PHC which was given a central meaning. The strategy was introduced in 1978 in the first conference of WHO for health in Alma Ata/Kazakhstan (in the former Soviet Union). Most of the countries that participated in this conference supported the “Alma Ata Declaration” of 1978 that was supposed to be implemented. “Health for all” was the vision of the conference.

This concept is heavily concerned with people, especially with the principles of social justice, accessibility, appropriateness and acceptance of medical services with consideration of the needs of people in the communities, their participation and orientation to the concept of health services. The community oriented health service with focus on the basic needs and primary causes of diseases can solve various problems of health services in the developing countries.

“Primary Health Care portrays the general approach of improving health situation at the community level. Around the health sector there are other health related and community related areas of nutrition, agriculture, water supply, sewage- and waste disposal, education, and communication, which should be addressed.

## “**Selective” Primary Health Care** (SPHC)

Despite The Alma Ata Declaration being universally accepted alongside other great humanitarian declarations after it was formally endorsed at the 32nd World Health Assembly, it very quickly came under attack from the corporate sector and medical right wing, and in less than twelve months an alternative system had been proposed. The Rockefeller Conference of 1979 was held to address “disturbing signs of declining interest in population issues” and was attended by a much smaller list of delegates headed by industry leaders such as the President of the Ford Foundation, and the President of the World Bank and former Secretary for US Defense, Robert McNamara. It was here that an interim model known as “Selective Primary Health Care” was formerly endorsed. Rather than broad reaching policies that addressed health through social justice and economic equity, the worst diseases would be selectively targeted according to their prevalence, morbidity, mortality, and feasibility of control (including efficacy and cost).

Four basic services were then to be provided in International Aid; this was defined as the **G.O.B.I**. approach (Growth Monitoring, Oral Rehydration, Breast Feeding and Immunisation)

* Rather than
	+ Implement costly interventions to eradicate world hunger Growth monitoring would be implemented, to see which infants were worst affected.
	+ Solve basic sanitation issues that resulted in many dying of dehydration from dysentery and diarrhoea, Oral rehydration sachets would be distributed.
	+ Engage in long term programs of economic development and education to slow down population explosion in developing countries, Breast feeding would be promoted to increase birth intervals
	+ Actively promote health as defined by Alma Ata, specific diseases would be ‘selectively’ targeted by Immunisation campaigns.

## Holistic Primary Health Care

In 2008, to commemorate the 30th anniversary of the Alma Ata Declaration, One Health Organisation (OHO) formally defined the principles of Holistic Primary health Care in light of the lessons learned over the last three decades under the “interim” approach of Selective Primary Health Care. This was in view the declarations listed above, WHO Constitution, the Geneva Convention, The Ottawa Charter, the Hippocratic Oath, The UN Declaration on the Rights of Indigenous People, and the vast array of wisdom contained in traditional medical systems from around the world. This is due to OHO’s firm conviction that Primary Health Care was never really given a trial, and that it is even more necessary today than in 1978.

### Lessons learnt

* Economic development does not safe guard health
* High immunisation rates alone do not guarantee low infant mortality and morbidity,
* Genuine community involvement is also necessary in developed countries and urban environments
* Natural systems have a finely based ecological balance and must be intervened with gently and cautiously to avoid dangerous and unwanted repercussions
* Affluence and industrialisation brings its own challenges to health
* True cost of failing to prioritise this most inalienable human right with national health care costs spiralling out of control in most developed

## The Principles of Holistic Primary Health Care (HPHC)

* The principles guiding all of One Health Organization (OHO’s) activities are summarised in a model for global community health entitled Holistic Primary Health Care, (HPHC). They are based on unification of four of the most important international declarations which summarizes OHO’s vision of
1. The interdependence of human rights
2. Community health and ecological harmony
3. Necessity of a multi-sectoral integrative approach to world health.
* HPHC is built upon the three pillars namely: -
1. Humanitarian pillar – asserts the following rights
	* The Universal Declaration of Human Rights (1948) – which upholds the rights of the individual in relation to health.
	* That the provision of healthcare should do no harm
	* That health is a basic and inalienable right of life
	* That health entails and requires the right of access to education
2. Health care pillar
	* Central pillar of PHC and asserts the following principles
	* The Alma Ata Declaration of Primary Health Care (1978) – which upholds the rights of communities in relation to health.
3. The Ecological pillar
	* The Earth Charter (2000) – which upholds the rights and importance of the environment in relation to health.
	* An ecologically informed model
	* A view towards sustainable initiatives
	* A precautionary approach

And rests upon the following platform:

* The Beijing Declaration on Traditional Medicine (2008) – which upholds the value of holistic medical practices from around the globe and the necessity for them to work in an integrated fashion with existing healthcare services.
* The provision of healthcare should be community oriented
* Healthcare strategies should be positive, preventative and promotive
* Adequate Healthcare entails a strong nutritional emphasis

## Origins and History of HPHC

### The Barefoot Doctors

HPHC is not a new or novel idea, but rather traces its roots to the very core of 20th century international health care policy. The story begins on the eve of China’s cultural revolution in 1949 when the entering government found itself facing a health care crisis: for every 10 000 people there was only one registered and qualified medical doctor. China’s unique response to this was the now famous ‘Barefoot Doctors’. Whilst incorporating Traditional Chinese Medicine the general focus was on basic hygiene, preventative medicine, family planning and simple treatments for common ailments, and ultimately came to accommodate 80% of China’s population with a massive 1.8 million community based health care workers. The system was highly praised by the World Bank and World Health Organisation at the time and was considered to be a viable alternative to the western hospital based system. It is for this reason that OHO originally traded and was incorporated under the company name of ‘The Barefoot Doctors Project’.

### A Crumbling Health Care Model

At this point in time, with The WHO and UNICEF having just been formed out of the ruins of post WW2 Europe, international development and health care policies were under serious criticism from many respected authorities, as the previous colonial era approaches came under close scrutiny in the light of 20th century changes in ideology. WHO’s constitution had already radically redefined health to be more than simply the absence of disease, prompting the then president of WHO Mr M. Mahler to state “The scientific and technological structures of public health are crumbling”.

# HEALTH FOR ALL

1. The First Pillar –the rights based approach to healthcare
* The Universal Declaration of Human Rights (UDHR) represents the first global expression of the rights to which all human beings are entitled to and is based upon a deep ‘*recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world’.* A rights based approach in general, and the right to safe, harmless and educational healthcare in particular are therefore upheld as the primary pillars of a holistic approach to primary health care.
* That the provision of healthcare should do no harm.
* That health is a basic and inalienable right (Article 25 of the UDHR states that everyone has the right to medical care to a standard adequate for the health and well-being of himself and of his family)
* That health entails and requires the right of access to education (Article 26 of the UDHR states that ‘everyone has the right to education)

1. The Second Pillar – the principles of community health
* The Declaration of Alma-Ata (1978), adopted at the First International Conference on Primary Health Care is where the Primary Health Care (PHC) model was first codified. It expressed the need “to extend the first level of the health system from sick care to the development of health” and emphasized the importance of community involvement. The creation of health, as defined by the WHO, through community focused programs as espoused by the Alma Ata Declaration is therefore the central pillar of a holistic approach to primary health care.
* The provision of healthcare should be community oriented ( Ottawa Charter of Health Promotion (1986) acknowledged “people as the main health resource supporting and enabling them to keep themselves, their families and friends healthy and to accept the community as the essential voice in matters of its health, living conditions and wellbeing”.
* Healthcare strategies should be positive, preventative and promotive.
* Adequate Healthcare entails a strong nutritional and lifestyle emphasis

1. The Third Pillar – the values of ecological sustainability
* The Earth Charter was a United Nations initiative that was finalized and then launched as a people’s charter before being approved at UNESCO headquarters in Paris in March 2000. The purpose of this charter was “to inspire in all peoples a sense of global interdependence and shared responsibility for the well-being of the human family, the greater community of life, and future generations.” As the creation of health at an individual and community level is inseparable from the creation of healthy global ecologies, the values of ecological sustainability form the third pillar of a holistic approach to primary health care\*.
* An ecologically informed model (ecology is the study of the relation of living organisms to each other and their surroundings and highlights the interdependence and interconnection of seemingly disparate phenomenon within the broader system in which they are placed)
* A view towards sustainable initiatives (emphasized that healthcare services must be implemented and maintained “at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination).
* A precautionary approach

# NATURAL HISTORY OF DISEASE

* Life cycle or natural history of a particular disease varies from individual to individual, and different diseases but four common stages manifest
1. Stage of susceptibility
2. Stage of pre-symptomatic disease
3. Stage of clinical disease
4. Stage of diminished capacity/disability/death/chronicity



# DISEASE PREVENTION

* Disease prevention applies to measures taken to prevent diseases before they occur as well as measures taken to prevent disease progression
* There are four levels of disease prevention namely
1. Primordial
2. Primary
3. Secondary
4. Tertiary

**Primordial Level**

* Primordial prevention is defined as prevention of risk factors themselves, beginning with change in social and environmental conditions in which these factors are observed to develop, and continuing for high risk children, adolescents and young adults
* Primordial prevention, a relatively new concept, is receiving special attention in the prevention of chronic diseases. For example, many adult health problems (e.g. obesity, hypertension) have their early origins in childhood, because this is the time when lifestyles are formed
* Examples of primordial prevention actions - National policies and programmes on nutrition involving the agricultural sector, the food industry, and the food import-export sector
* Responsibility lies on the government. professional and non-governmental organizations, industry, hospitals, health clinics, health practitioners and health-care workers

**Primary Level**

* Also called primary intervention
* Entails measures taken to prevent diseases before they occur
* Primary prevention strategies emphasize general health promotion, risk factor reduction, and other health protective measures
* These strategies include: -
	+ Health education and health promotion programs designed to foster healthier lifestyles and environmental health programs designed to improve environmental quality
	+ Specific examples of primary prevention measures include immunization against communicable diseases; public health education about good nutrition, exercise, stress management, and individual responsibility for health; chlorination and filtration of public water supplies; and legislation requiring child restraints in motor vehicles.
	+ Examples
		- General health promotion strategies taken at home, working places and in institutions e.g. promotion of good nutrition, provision of basic needs (food, clothing, shelter), recreation facilities
		- Specific measures - immunization, avoidance of substances (e.g. drugs), prevention of accidents

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

**Secondary Level**

* Also called curative level
* Entails early detection of disease followed by prompt intervention
* It is important in preventing complications, disabilities and communicability of disease
* Secondary prevention focuses on early detection and swift treatment of disease
* Its purpose is to cure disease, slow its progression, or reduce its impact on individuals or communities
* A common approach to **secondary prevention is screening for disease**, such as the non-invasive computerized test for the early detection of heart disease. This test uses computerized tomography scans to look for calcium deposition in the arteries, which can signal previously undetected heart disease. Other examples of screening include mammography for breast cancer detection; eye tests for glaucoma; blood tests for lead exposure; occult blood tests for colorectal cancer; the Pap test for cervical concrete breath test for Helicobacter pylori, the bacterium implicated in duodenal and gastric ulcers; and the Prostate-Specific Antigen(PSA) test for prostate cancer. In each case, screening is performed to detect disease early so prompt treatment can be initiated. Examples of other secondary prevention methods include treatment of hypertension to prevent complications and removal of skin cancer lesions as they occur
* Protects healthy members of the community against certain diseases

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

**Tertiary Level**

* Also called rehabilitative intervention
* Consists of various attempts made to improve the quality of life of an individual after a disease has occurred and caused damage to the person
* Involves both therapeutic and rehabilitative measures once disease is firmly established.
* Examples include treatment of diabetics to prevent complications; management of chronic heart disease patients with medication, diet, exercise, and periodic examination; improving functioning of stroke patients through rehabilitation by occupational and physical therapy, nursing care, speech therapy, counselling, and so forth, and treating those suffering from complications of diseases such as meningitis, multiple sclerosis, or Parkinson’s disease.
* May involve modification of working and home environments and funding affected persons to start IGAs

What strategies has the government employed to facilitate tertiary/rehabilitative intervention? Discuss using specific examples

# ROLES OF CLINICIANS

1. Treatment- Restoration of the sick- curative
2. Prevention of diseases
	1. Primordial prevention
	2. Primary - prevention
	3. Secondary prevention
	4. Tertiary prevention

# PHC GLOBAL TARGETS

1. All people in every country will have ready access at least to essential health care and to first-level referral facilities
2. All people will be actively involved in caring for themselves & their families, as far as they can, in community action for health
3. Communities throughout the world will share government’s responsibility for the health care of their members
4. All governments will assume the overall responsibility for the health of their people
5. Safe drinking water & sanitation will be available to all people
6. All people will be adequately nourished
7. All children will be immunizes against the major diseases of childhood
8. Communicable diseases in the developing countries will be of no greater public health significance in the year 2000 than they were in the developed countries in the year 1980
9. All possible ways will be applied to prevent and control non-communicable diseases & promote mental health through influencing the life styles & controlling the physical & psychological environment
10. Essential drugs will be available to all

## Obstacles to PHC Implementation

1. Misinterpretation of the PHC Concept
2. Misconception that PHC is a 2nd rate health care for the poor
3. Selective PHC Strategies
4. Resistance to Change
5. Lack of political will
6. Centralized Planning & Management Infrastructure

## BAMAKO INITIATIVE

The Bamako initiative was sponsored by UNICEF & WHO and adopted by African ministers of health in 1987 based on the realization that, despite accepting comprehensive primary health care, by the late 1980s many countries were burdened by a lack of resources and practical implementation strategies. Many health facilities lacked the resources and supplies to function effectively and the health workers were prescribing drugs to be bought from private outlets, often unlicensed. Many patients had lost confidence in the inefficient and under-resourced public health facilities.

**Challenges**

1. To promote additional donor investment
2. Stop and reverse decline of government expenditure on social spending and health in
3. Attract the money spent in the private and informal sectors back into the public system.

**Aims of Bamako**

To increase access to primary health care by raising;

* Effectiveness
* Efficiency
* Financial viability and
* Equity of health services
* Bamako health centres implemented an integrated health system to meet basic community health needs, with focus on access to drugs and regular contact between health-care providers and communities.
* The concept was communities should participate directly in the management and funding of essential drug supplies, village committees engaged in all aspects of health-facility management, with positive results for child health in West Africa in particular.
* The purpose of community financing was to capture funds that households were spending in the informal sector and combine them with government and donor funding to revitalize health services and improve their quality.
	+ Immunization and oral rehydration therapy were supplied free of charge and
	+ Local criteria for exempting the poor were established by the communities.
	+ Community participation in the management and control of resources at the health-facility level was the main mechanism for ensuring accountability of public health services to users.
	+ Health committees representing communities were able to hold monitoring sessions during which coverage targets, inputs and expenditures were set, reviewed, analysed and compared
* It is estimated that the initiative;
	+ Improved access, availability, affordability and use of health services in large parts of Africa
	+ Raised and sustained immunization coverage
	+ Increased the use of services among children and women in the poorest fifth of the population

# PILARS OF PHC

1. Social justice
* Equal distribution of available resources
1. Preventive health care
* Prevention of diseases in the sense of primary prevention
* Involves all the important issues of health education, nutrition, sanitation, maternal and child health, and prevention and control of endemic diseases.
* Through health promotion individuals and families build an understanding of the determinants of health and develop skills to improve and maintain their health and wellbeing.
1. Community participation
* Participation of the intended groups in planning and carrying out issues related to people’s health
* Includes meaningful involvement of the community in planning, implementing and maintaining their health services
* Through the involvement of the community, maximum utilisation of local resources, such as manpower, money and materials, can be utilised to fulfil the goals of PHC.
1. Inter-sector cooperation
* Health support outside the medical services
* To be able to improve the health of local people the PHC programme needs not only the health sector, but also the involvement of other sectors, like agriculture, education and housing
1. Appropriate Technology
* Technology that marches with the context: favourable or affordable price and local technology. technology that is scientifically sound, adaptable to local needs, and acceptable to those who apply it and for whom it is used
1. Sustainability of the measures
* Guaranteeing curative services including services of medicines (self-reliance)

# PRINCIPLES OF PHC

1. Equity
2. Inter-sectoral collaboration
3. Community participation
4. Decentralization
5. Accessibility
6. Affordability
7. Health promotion and disease prevention
8. Effectiveness and efficiency
9. integration of health programmes
10. Appropriate technology

## Equity

* Equitable distribution
* This means health services must be more equally accessible without discrimination, neglect of those in rural, peri-urban and urban areas (healthcare services must be equally shared by all the people of the community irrespective of their race, creed or economic status)
* This accessibility should be based on need and should also target those originally without access.
* This concept helps to shift the accessibility of healthcare from the cities to the rural areas where the most needy and vulnerable groups of the population live

## Inter-Sectoral Collaboration

* There is need to put all key players in held or other sectors which directly or indirectly affect the delivery or health services to apply together.
* Sectors affecting health services directlye.g.
* Transport/infrastructure of roads
* Finance and poverty levels
* Security
* Agriculture
* Sports
* Education
* NGOs
* Local government
* Water department

## Community participation and involvement

* Community participation refers to active involvement of the community in decision making
* It is done through problem identification mobilization of local resources and implementation
* It lays emphasis on problem identification-prioritization-allocation of resources-implementation with active involvement of the community

## Decentralization

* The transfer of authority for planning, decision making and management from higher to a lower level eg ministry to district level
* The aim is to promote local participation and services to be more responsive to local needs

## Accessibility

* Reachable, convenient services
* Geographic, economic, cultural accessibility
* The ability to utilize a service either by its physical availability, cost affordability or social acceptability

## Health Promotion and Disease Prevention

* Includes behaviour change in relation to many activities eg nutrition, environment and recreation

## Effectivensess and Efficiency

* The methods used to achieve a certain result use the minimum resources (effectiveness)
* To get our outputs using the least possible resource inputs (efficiency)
* The technologies and strategies used in health care work(do what they are supposed to do) – reduce risk, prevent disease or cure disease

## Integration

* The individual patient, family and community must understand how to use the care system when they need it – the system must be friendly and accessible

## Appropriate Technology

* The method and materials used should be acceptable and relevant to the community at the cost they can afford.
* They should also be of appropriate technology, simple, accessible, cost effective and locally available.
* New developments in vaccines, techniques, drugs, mosquito nets, communications etc should be included

# ELEMENTS

* The Alma Atta conference of 1978 identified elements of PHC; - **ELEMENTS**
1. **E**ducation (Health Education)
2. **L**ocal Disease Control (endemic disease)
3. **E**PI (Expanded programme on Immunization)
4. **M**CH/FP
5. **E**ssential Drugs supply
6. **N**utrition and Food Supply
7. **T**reatment of common conditions
8. **S**anitation and clean water supply

 In Kenya initially two elements were added which have since increased to 13

1. Dental Oral Health
2. Mental health
3. Malaria
4. HIV / AIDS
5. CBR (community based rehabilitation)
* For each element, strengthening and integration is necessary at different levels.

## Health Education

* Addresses prevailing health problems and methods of prevention and control
* Education for the promotion of health and prevention of diseases remains a critical element.
* Emphasizes that the community /individual determines his/her health by accepting health measures and works for the promotion of health through their personal lifestyles and behavior

## Local Disease Control

* Include malaria, schistosomiasis, filariasis, hookworm, trachoma and kala azar

## Immunization

* Has been intensified in Kenya through DVI/KEPI
* The number of Immunizable diseases have increased
* Vitamin A has also been in-cooperated as part of immunization schedule up to five years.

## Maternal, Child Health & Family Planning (MCH/FP)

* Children <15 years and women 15-49 years constitute about 75% of the total population
* MCH/FP services aimed at promoting health of mothers and children, reducing maternal and child morbidity and mortality, enabling females to have pregnancies only when desired, limiting the number of pregnancies to the desired level
* Includes antenatal care, perinatal care, post natal care and family planning

## Essential Drug Supply

* The kitting system being replaced by KEMSA system where the drugs supply is based on need.
* Provide KEMSA with the autonomy to perform its legal mandate as the agency to procure, warehouse and distribute medical commodities to the entire health sector in accordance with good distribution practices, including:
	+ Evidence-based selection of essential medicines and medical supplies in the health sector.
* In addition there are drug manufacturing industries, pharmacies, shops and commercial outlets for public use.

## Nutrition and Food Supply

* Through co-ordination of other sectors like Ministry of Health, Agriculture, education and Community Development

## Treatment of Common Conditions

* Curative services offered at all the levels of the health care delivery system
* Provide a powerful mechanism for teaching preventive and promotive care.
* Common conditions include diarrheal diseases, ARI, skin disease, eye conditions, injuries, anaemia and worms.

## Sanitation and Clean Water Supply

* Linked with infant mortality and poor quality of life.
* Piped water and protected springs and wells.
* Quantity of water available at home, storage and use for personal hygiene are of utmost importance
* Critical in prevention of diseases such as water-related, water-based, water-washed, water-borne
* Ensure proper waste disposal

## Dental Health

Explain how the government of Kenya is implementing this element?

## Mental Health

Explain how the government of Kenya is implementing this element?

## Malaria

Explain how the government of Kenya is implementing this element?

## HIV/AIDS

## Community Based Rehabilitation

Explain how the government of Kenya is implementing this element?

# Topic 3: HEALTH EDUCATION

# Introduction

Health education is a social science that draws from the biological, environmental, psychological, physical and medical sciences to promote health and prevent disease, disability and premature death by educating individuals and communities to voluntarily change their behaviours to improve their health and well-being. Health education is the development of individual, group, institutional, community and systemic strategies to improve health knowledge, attitudes, skills and behaviour. The purpose of health education is to positively influence the health behaviour of individuals and communities as well as the living and working conditions that influence their health.

Health education improves the health status of individuals, families, communities, states, and the nation. Health education enhances the quality of life for all people and reduces premature deaths. By focusing on prevention, health education reduces the costs (both financial and human) that individuals, employers, families, insurance companies, medical facilities, communities, the state and the nation would spend on medical treatment.

# Definition

1. It is a process of giving information and advice and facilitating development of knowledge and skills in order to change health behaviour
2. Health education is the process by which individuals and group of people learn to Promote, Maintain, and Restore health. Education for health begins with people as they are, with whatever interests they may have in improving their living conditions
* Can also be defined as “any combination of learning experiences designed to facilitate voluntary adaptation of behavior conducive to health”.
* It is the part of health care that is concerned with promoting positive health behaviour. A person’s behaviour may be the main cause of health problem but it may also be the main solution of the problems e.g. a teenager who smokes, a mother with malnourished child. By changing their behaviour, these individuals solve and prevent many of their problems.

# Aims of Health Education

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

# Why Health Education

* To provide awareness
* To achieve quality healthcare.
* To reduce mortality and morbidity.
* To reduce work load in health institutions e.g. hospitals.
* To reduce amount spent on healthcare.

# Specific Objectives

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

# Health Education Philosophies

* Health promotion is a mediating strategy between people and their environment, incorporating both personal choice and social responsibilities in health.

**Health education is part of, but not the sum of health promotion**

* The function of health education is neither to transform society nor to change behaviour rather, it is a practical endeavour focused on improving the understanding of the determinants of health nor diseases and helping people to develop the skills they need to bring about change.
* It enables and supports people to set their own health agendas so that they can be implemented in ways they decide for themselves, collectively or as individuals.
* Health education should be concerned with ensuring that high quality health information is available in an understandable format to anyone who needs it (French, 1990).

**Health education is considered a partnership action between the clients and health professionals**

* Health professionals assist clients in gaining increased insight and critical consciousness of their concerns. The two parties develop trust and rapport to enhance further deep exploration of issues and concerns.
* The final product is an established goal and action.
* This whole process encourages independence and clients become self-reliant in the decision making process and make changes.

**Health information versus health education**

* It is crucial that health workers differentiate between health information and health education.
* MacDonald (1992) stated that health information is a series of messages transmitted to the public by knowledgeable professionals. The public’s role is to listen, understand the message and try to carry out the informed action. Health information is just about behaviour change and ignores the context. Because it is acknowledged that the contexts where clients live and work can often help or hinder their acceptance of suggested changes, health educators must give careful consideration to client context.
* For example, let’s examine how context affects health promotion workers working with a pregnant woman who smokes. If the health promotion workers only focus on behavioural change, they may simply give the client information illustrating the risk of smoking to the fetus. However, if they look into the woman’s life context and investigate the reasons for her smoking behaviour, then together with the client they can work out a programme to decrease cigarette smoking and working towards the subsequent goal of complete cessation.

# Process of Health Education

Dissemination of scientific knowledge (about how to promote and maintain health), leads to changes in KAP related to such changes.

# Steps for Adopting New Ideas and Practices

1. Awareness (know about new ideas)
2. Interest (seeks more details)
3. Evaluation (advantages vs disadvantages and testing usefulness)
4. Trial (decision put into practice)
5. Adoption (person feels new idea is good and adopts it)

# Contents of Health Education

* Nutrition
* Healthy habits
* Personal hygiene
* Safety rules
* Basic knowledge of disease & preventive measures
* Mental health
* Proper use of health services
* Sex education
* Special education for groups (food handlers, mothers, school health etc.)
* Principles of healthy life style e.g. sleep, exercise

# Principles of Health Education

1. Interest
2. Participation
3. Proceed from known to unknown
4. Comprehension
5. Reinforcement by repetition
6. Motivation
7. Learning by doing
8. People, facts and media
9. Good human relations
10. Leaders

# Stages of Health Education

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

# Methods of Health Education

* Health education uses a variety of methods to help people understand their own situations and choose actions that will improve their health.
* It encourages involvement and choice by the people themselves
* Methods include:-
1. One to one counselling
2. Lecture method
3. Demonstrations
4. Composing songs and poems
5. Role play
6. Theatre/drama
7. Mass media either print or electronic
8. Discussions e.g. Focused group discussions

# Approach/opportunities in health Education

* Communities can be educated through;
1. Home visiting
2. Groups e.g. chief’s baraza
3. Self-help groups e.g. youth, women groups
4. In the market
5. At the market place
6. Group training session e.g. seminar workshops
7. Classrooms e.g. in schools
8. Funerals (gathering)
9. Church/mosque/temples
10. Health campaigns

# Teaching AIDS in Health Education

* These are tools/materials which facilitate perception of a message through common senses.
* Teaching AIDS can be;
1. Audio –aids - you only hear but do not see e.g. radio, cassette recorder
2. Audio-visual - Message can be heard and seen at the same time e.g. Film, TV
3. Visual - Consist of materials that can be seen and read e.g. posters, newspaper.

# Common teaching aids in Health Education

1. Models e.g. penis models used in demonstration on how to wear male condoms.
2. Film/videos (VCD/CD’S)
3. Billboards
4. Flip charts
5. Publication
6. Charts
7. IEC materials
8. Posters

# Community Skills in Health Education

* Procedure of sharing message in Health Education.
* Welcoming the client and introducing oneself.
* Creating conducive environment for the client and remove any barrier.
* Ask the client about their problems.
* Asses the client’s knowledge concerning his/her problems.
* Give a health problem.
* Stimulate communication.
* Where possible use teaching aids.
* Give sometime for the client to ask some questions and respond to them.
* Summarise the main points of the session.
* Give an appointment if there is need for a follow up.
* Thank the client for his/her cooperation.

# Process of Health Education Design

* Identifying educational needs
* Establish educational goals
* Select an appropriate educational method
* Implement educational plan
* Evaluation of process and products

# Identifying educational needs

* Identify client needs by performing a client’s needs assessment – collect data to assess readiness to learn, situational & psychological factors influencing learning
* Prioritize the needs
* Identify what the client wants to know
* Determine how the client wants to learn
* Identify what will enhance the clients ability and motivation - try to come down to their level
* Know when they are free
* Encourage client participation

# Establish educational goals

* This is to guide educational programmes i.e. preparation of a lesson plan for guidance when giving health education
* Objectives
	+ They are specific short term criteria that need to be met as steps towards achieving a long term goal
	+ They must be SMART – Specific, Measurable, Achievable, Realistic, Time bound
	+ Must be stated clearly and expected outcome should define a minimum degree of knowledge

# Select an appropriate educational method

* The educator should choose the simplest and clearest manner of presentation
* The educator should be proficient in using a broad array of tools
* The teaching aids include;
	+ Written materials e.g. hand-outs, flip charts
	+ Role play
	+ Peer presentation
	+ PowerPoint
	+ Audio visual

# Implement educational plan

* Involves control over starting, sustaining and stopping each method and strategy in the most appropriate manner
* Involves coordination and control of environmental factors
* Keep the materials logically related with core theme
* Be flexible to allow breaks for rest
* Methods

# Role Play

* Referred to as social drama
* Involves dramatising by a group
* Consists of about 25 members and is useful to school children and usually followed by a discussion of the problem and also assesses if they understood

# Mass Media

* Radio
* Has a broader audience
* Can be used by the illiterate
* Can transmit health information
* Newspapers
* Are widely disseminated
* Limitation in the rural areas
* Costly illiterate can read them

# Printed materials

* Journals, magazines, pamphlets, booklets
* Posters, billboards, and signs
* Must be simple and artistic
* Humour and fear are introduced to hold attention
* Messages must be short and clear
* Should be changed frequently because may be destroyed by weather

# Evaluation of process and products

* It provides a systematic and logical method for making decisions to improve educational programmes and involves 3 areas;
	+ Educational evaluation
	+ Process evaluation
	+ Product evaluation

# Educational evaluation

* Feedback with the educator allowing for modification in the teaching process so as to meet the learner’s needs
* Learner’s evaluation of the educator occurs throughout education programmes e.g. facial expression

# Process evaluation

* This is to examine the dynamic component of educational programmes
* It follows and assesses the movement of information, transfer and attempts to keep the objectives on track
* Ongoing evaluation allows the teacher to correct misinterpretation, misinformation and confusion
* Uses information gathered from the educator as well as the learner, evaluates and assesses the dynamics of the interaction

# Product evaluation

* Is the outcome of educational process
* Measured both quantitatively and qualitatively
* Can be;
	+ Evaluation of health and behaviour change
	+ Short term evaluation
	+ Long term evaluation

# HEALTH EDUCATION BEHAVIOUR MODELS AND THEORIES

# Health Belief Model (HBM)

* One of the first models to adapt theories from the behavioural sciences to examine health problems
* One of the most widely recognized and used models in health behaviour applications
* Introduced by a group of psychologists in the 1950's to help explain why people would or would not use available preventive services, such as CXR for TB screening and immunizations for influenza. The researchers assumed that people feared diseases and that the health actions of people were motivated by the degree of fear (perceived threat) and the expected fear reduction of actions, as long as that possible reduction outweighed practical and psychological barriers to taking action (net benefits).
* The HBM can be outlined as follows;
1. Perceived susceptibility - a person's opinion of the chances of getting a certain condition
2. Perceived severity - a person's opinion of how serious this condition is
3. Perceived benefits - a person's opinion of the effectiveness of some advised action to reduce the risk or seriousness of the impact
4. Perceived barriers - a person's opinion of the concrete and psychological costs of this advised action. Even though the HBM was originally developed to help explain certain health related behaviours, it has also helped to guide the search for "why" these behaviours occur and to identify points for possible change.
* HBM has been used to help in developing messages that are likely to persuade an individual to make a healthy decision. Messages that are suitable to health education for such topics as hypertension, eating disorders, contraceptive use, or breast self-examination have been developed.

# Stages of Change Model (Transtheoretical Model)

* Initially published in 1979 by Prochaska
* Model evolved from research in smoking cessation and the treatment of drug and alcohol addiction and more recently it has been applied to other health behaviours, such as dietary changes
* Behaviour change is viewed as a process, not an event, with individuals at various levels of motivation or "readiness" to change. Since people are at different points in this process, planned interventions should match their stage.
* Six stages have been identified in the model:

# Pre-contemplation

* The person is unaware of the problem or has not thought seriously about change

# Contemplation

* The person is seriously thinking about a change (in the near future)

# Preparation

* The person is planning to take action and is making final adjustments before changing behaviour

# Action

* The person implements some specific action plan to overtly modify behaviour and surroundings

# Maintenance

* The person continues with desirable actions (repeating the periodic recommended steps while struggling to prevent lapses and relapse)

# Termination

* The person has zero temptation and the ability to resist relapse
* In relapse, the person reverts back to old behaviour which can occur during either action or maintenance.

# Consumer Information Processing Model (CIP)

* Developed out of the study of human problem solving and information processing
* Has many useful applications in the area of health education
* Information is a necessary tool in health education. However, just as knowledge is necessary but not sufficient for behaviour change, information is necessary but not sufficient for knowledge.
* There are limits to any person's information processing capacity (limitations upon individuals in the amount of information they can acquire, use and remember)
* By understanding the key concepts and processes of CIP, health educators can examine why people use or fail to use health information, and then design informational strategies that have better chances for success.
* The search for information is the process of acquiring and evaluating information. This process is affected by the person's motivation, attention and perception at that point in time.
* In general, consumers do not to engage in extended information searches because there are two assumptions of CIP;
	+ Individuals are limited to how much information they can process
	+ In order to increase the usability of information, individuals combine little pieces or bits of information into "chunks" and make decision rules to make choices faster and more easily.
* These are the rules which are developed and used to help consumers select more easily among alternatives.
* James Bettman created one of the best known models of CIP; which shows a cyclical process of information search, choice, use and learning, and feedback for future decision-making. There are several feedback loops throughout the model.
* The consumption and learning processes involve internal feedback based on the outcome of choices and their use in future decisions.
* Bettman's version of this model has now been extended to consider that the information environment affects how easily people obtain process and use information. This includes the amount, location, format, readability, and ability to process relevant information.
* There are some basic CIP concepts that can be applied to health education. Before people will use health information, it must be:

# Available

# Seen as useful and new

# Processable or in a friendly format

# It is necessary to choose the most important and useful points to communicate and place this information first and/or last in the presentation in order to be remembered best.

* + The information should take little effort to obtain, draw the consumer's attention, and be clear.
	+ Key ways to synthesize information that has meaning and appeal for the target population should be formulated.
	+ In the learning process, keep in mind that participants have probably made related choices before and are not necessarily starting from scratch. The information designed specifically for the target population must be placed conveniently for their use.

# Theory of Reasoned Action (Fishbein and Ajzen)

* Was designed to explain all volitional behaviours. This theory is based on the assumption that most behaviours of social relevance are under volitional (wilful) control.
* In addition, a person's intention to perform (or not perform) the behaviour is the immediate determinant of that behaviour. The goal is to not only predict human behaviour but also to understand it.
* According to this theory, a person's intention to perform a specific behaviour is a function of two factors:
1. Attitude (positive or negative) toward the behaviour
2. The influence of the social environment (general subjective norms) on the behaviour.
* The attitude toward the behaviour is determined by the person's belief that a given outcome will occur if he/she performs the behaviour and by an evaluation of the outcome.
* The social or subjective norm is determined by a person's belief about what is important or what "significant" others think s(he) should do and by the individual's motivation to comply with those other people's wishes or desires.
* Attitudes are a function of beliefs in this theory. If a person believes that performing a given behaviour will lead to positive outcomes, then s(he) will hold a favourable attitude toward performing that behaviour. On the other hand, a person who believes that performing the behaviour will lead to mostly negative outcomes will hold an unfavourable attitude. These beliefs that form the foundation of a person's attitude toward the behaviour are referred to as behavioural beliefs.
* Subjective norms are also a function of beliefs. These are the person's beliefs that certain individuals or groups think (s)he should or should not perform the behaviour. If the person believes that most of these significant others think s(he) should perform the behaviour, the social pressure to perform it will increase the more s(he) is motivated to comply with these others.
* If s(he) believes that most of this reference group is opposed to performing the behaviour, the perception of the social pressure not to perform the behaviour will increase along with her/his motivation to comply with these referents

# Social Learning Theory or Social Cognitive Theory (Rotter and Bandura)

* In this theory, human behaviour is explained using a theory in which personal factors, behaviour, and environmental influences continually interact.
* These are dynamic relationships where the person can shape the environment as well as environment shaping the person i.e. change is bi-directional.
* According to this theory, reinforcement contributes to learning, but reinforcement along with an individual's expectations of the consequences of behaviour determine the behaviour.
* Behaviour is seen as a function of the subjective value of an outcome and the expectation that a particular action will achieve that outcome. This type of approach has been referred to as "value-expectancy theory."
* According to SLT, reinforcement can be accomplished in one of three ways:
1. Direct reinforcement
* Reinforcement is supplied directly to the person
1. Vicarious reinforcement
* The participant observes someone else being reinforced for behaving in an appropriate or inappropriate manner.
* This has also been called social modelling or observational learning
1. Through self-management.
* Involves record-keeping by the participant of her/his own behaviour.
* When the behaviour is performed correctly, the person would reinforce or reward her/himself
* Self-control goes along with this type of reinforcement since it reflects the idea that individuals may gain control of their own behaviour by monitoring it
* Self-efficacy is the single most important aspect of the sense of self that determines one's effort to change behaviour. This internal state is very situation specific. For example, a person may experience a high level of self-efficacy in exercise but very little when attempting to reduce the amount of fat in her/his diet

# Social Networks/Social Support Theories

* Most health educators recognize the critical importance of the social environment and advocate changes in the social ecology which is supportive of individual change leading to better health and a higher quality of life.
* However, within the community, long-term behaviour change depends on the level of participation and ownership felt by those being served.
* Social networks can be kin or non-kin (church or work groups, friends or neighbours)

**Characteristics of Social networks**

1. Structural
* Such as size (number of people) and extent to which members really know one another
1. Interactional
* Which include mutual sharing, durability (length of time in relationship), frequency of interactions between members, and dispersion (ease with which members can contact each other)
1. Functional
* Such as providing social support, connections to social contacts and resources, and maintenance of social identity.
* Social support refers to the varying types of aid that are given to members of a social network.
	+ Supportive behaviours or acts:
	+ Emotional support - listening, showing trust and concern
	+ Instrumental support - real aid in the form of labour, money, time
	+ Informational support - providing advice, suggestions, directives, referrals
	+ Appraisal support -affirming each other and giving feedback.
* This social support is given and received through the individual's social network.
* It is important to remember that "some or all network ties may or may not be supportive."
* Social support may also be offered through community health worker, caregiver, Community health advocate, Community health opinion leader

# Topic 4: COMMUNICATION

# Introduction

* Communication is the exchange of information between two or more persons who are interacting with each other in such a way that the information is understood.
* It can, therefore, be concluded that communication is the transfer of meaningful information and the establishment of commonality with the audience.

# Types of Communication

* Communication can be formal, informal or unconscious.

## Formal Communication

* This is any official method of communicating with people (employees) in an organisation.
* The communication may be oral or written. The message flows from top to bottom, e.g. from the top management to staff at the lower levels, following the chain of command in the particular organisation
* Formal communication flows in three directions:
1. Downward communication
2. Upward communication
3. Horizontal communication

### Downward Communication

* Communication flow comes from top management to the lowest level.
* Channels used include oral messages, telephone calls, and written communication
* The main advantage of downward communication is that it is received immediately and is not distorted.
* The main disadvantage of downward communication is that it is unidirectional, that is, there is no return path for communication, this delays feedback.

### Upward Communication

* Flows from staff at lower and middle levels to the top management.
* Provides feedback
* The main advantage is that it helps to maintain the discipline of staff at lower levels. It also protects the seniority of staff at the middle levels.
* The main disadvantage is that the middle level staff management may refuse to forward the grievances coming from the lower level staff.

### Horizontal Communication

* Flow occurs between heads of departments or supervisors who are at the same level.
* The main advantages of this type of communication are that it encourages free communication by all staff in the departments all the time and ensures that staff do not fear each other, thus improving interpersonal relationships.

## Informal Communication

* An unofficial form of communication between groups of people in an organisation.
* The messages are discussed casually and are not recognised by the management.
* Informal communication is also known as the 'grapevine'.
* The grapevine is a form of information containing some half-truths and may emanate from the staff at the lower or middle levels.
* The grapevine is common in organisations where a certain cadre of staff feels that their needs are not being addressed or where top management fails to clarify issues or communicate effectively with the middle and lower level staff. The grapevine should not be ignored because it gives a warning of impending issues of concern to the employees

## Unconscious Communication

Unconscious communication is where a wrong meaning has been transferred because of the way the communication has been conveyed unconsciously to the receiver.

Usually the sender of the message is unaware that their behaviour is sending the wrong signals. For example, if you appear quite casual when giving important information, the recipient will misinterpret the importance of the information because of the manner in which you speak.

****

# Communication Process

# Message

* This is the information intended to be passed to the audience.
* The message needs to have a purpose and relevant facts to be communicated to the audience.
* The message content should suit the level of the audience.

# Source

* Refers to the origin of the message. The source (or sender) of the message determines the clarity of the message to the audience..
* The source of the message should consider the environment before communicating. The environment should cause no interruptions during the time of conveying the message.
* Important characteristics of the source which influence communication include; mood, knowledge of the subject matter, attitude, language, knowledge of the audience, social cultural background, economic status, age, sex, and religion.
* These characteristics should be considered when you are sending a health

# Message Channel

* Channel is the medium that is used to convey a message from the source to the receiver.
* The communication channel used to send the message should suit the needs of the audience receiving it.
* Communication is achieved through three main channels (methods).
	+ Verbal communication
	+ Non-verbal communication – body position, gestures and facial expressions. Also referred as body language e.g. winking, beckoning, crying, dilated pupils, yawning
	+ Written communication

# Feedback Channel

* Effective communication occurs when the receiver is able to restate the original message as given by the sender.
* Feedback is the process of finding out whether the communicated message is understood as intended.
* To ensure the receiver has understood the message, you should ask them to paraphrase the message.

# Receiver

* The person or persons who receive the message conveyed from the source.
* The receiver (or audience) should be psychologically ready to receive the message sent.
* The message conveyed is influenced by; the mood of the receiver, the attitude towards the message, language used, level of education and economic/social/cultural background of the audience.
* An example of the latter, is when you organise to share a health message on a Sunday when the patients (audience) are going to church, communication will be ineffective.

# Effects

* The impact or outcomes after sending the message to the receiver.
* The impact or outcomes are observed after individuals/families/community acquire the desired knowledge, attitudes and change their behaviour.

# Social Setting

* The environment in which the message is conveyed from the source and that of the receiver
* It is important to consider the social setting when you are selecting a venue to share a health message with the community.
* The social setting selected should be free from unnecessary noises or disturbances.

# BARRIERS TO COMMUNICATION

* Barriers are the factors that prevent effective communication.
* Barriers to effective communication may be due to any breakdown in the six elements of the communication process: source, message, channel, receiver, effects and social setting

# Barriers

1. Unfamiliar language – including dialects & accents
2. Improper timing
3. Noise and distractions in the environment
4. Attitude of both the source and the receiver
5. Differences between people – gender, age, culture, education, intelligence, etc.
6. Relationship between the sender and the receiver boss-employee, parent-child, etc.
7. Physical barriers – climate - very cold or very hot weather, windy
8. Filtering – manipulation of information so that it will seem more favorably to the receiver.
9. Selective Perception – receiver hears message based on his/her interests, needs, motivations, experience, background and other personal characteristics.
10. Defensiveness – response when receiver interprets message as threatening
11. Language – Words mean different things to different people
12. System overload - sends or receives too much information at the same time.

# Communication Enhancers

# Speaker

# Voice inflections

# Gestures

# Body language

# Listener

# Active listening

# Eye contact

# Good communication requires

* Seek to clarify your ideas before communicating
* Examine the true purpose of each communication
* Consider the total physical and human setting
* Consult with others in planning communications
* Be mindful of the overtones as well as the basic content of your message
* Take the opportunity to convey something of help or value to the receiver
* Follow-up your communication
* Communicate for tomorrow as well as today
* Be sure your actions support your communications
* Seek not only to be understood but to understand - be a good listener

# Topic 5: HEALTH PROMOTION, PROTECTION AND ADVOCACY

# Introduction

Health promotion may be defined as any combination of educational and social efforts designed to help people take greater control of and improve their health. Health protection and health services differ from health promotion in the nature or timing of the actions taken. Health protection and services include the implementing of laws, rules, or policies approved in a community as a result of health promotion or legislation. An example of health protection would be a law to restrict the sale of hand guns, while an example of health services would be a policy offering free flu shots for the elderly by a local health department. Both of these actions could be the result of health promotion efforts such as a letter writing campaign or members of a community lobbying their board of health.

According to Green & Kreuter (1999), health promotion is the combination of educational and environmental supports (organizational, political and economic) for actions conducive to health.

Tones (1994) defined health promotion as any combination of educational, legal, fiscal, economic, environmental and organizational interventions designed to facilitate the achievement of health and the prevention of diseases.

To conclude, health promotion refers to ‘**health enhancing activities**’. The activities can focus on individuals, groups or the whole population. Health promotion is not just confined to health professionals and health care services but everyone in different sectors of society.

Health promotion is broadly categorized into 3 major categories, namely health education, prevention and health protection (Tannahill, 1985).



1. **Health education**
* Is considered the core component of health promotion
* Health education activity provides adequate, accurate and reflective information and knowledge to recipients
* Recipients are influenced and able to make their own rational decisions through the empowerment process. A top down approach to health education is inappropriate. Instead, information is provided according to the recipients’ needs, with providers and recipients learning from each other.
1. **Prevention**
* Reduces the risk of occurrence of a disease process, illness, injuries, disability, handicap or some other unwanted events
* There are three levels of prevention, namely primary, secondary and tertiary. Examples include healthy lifestyle, immunization, health screening, maternal and child health, rehabilitation programmes and sexuality education.
* Prevention programmes can be done on face-to-face basis or through mass media.
1. **Health protection**
* Consists of regulations, policies, or voluntary practices that are aimed at improving the living and working environment and prevention of ill health. For example, the proposed new ordinance for a total ban on smoking in restaurants and most indoor public areas aims to reduce heart disease and lung cancer in the population. Automobile seat belt legislation ensures that passengers are protected from injuries in case of motor vehicle accidents.
* Policy on mandatory food labelling enables consumer to make healthy and rational choices on food. Health promotion is concerned with the whole of life.
* Various terms such as holistic, ecological, systems, interdisciplinary and inter-sectoral grasp this dimension.
* The seven domains of health promotion are:
1. Preventive services
2. Preventive health education
3. Preventive health protection
4. Health education for preventive health protection
5. Positive health education
6. Positive health protection
7. Health education aimed at positive health protection

# Principles of Health Promotion (WHO)

1. **Empowerment**
* Health promotion initiatives should enable individuals and communities to assume more power over the personal, socio-economic and environmental factors that affect their health.
1. **Participation**
* Health promotion initiatives should involve those concerned in all stages of planning, implementation and evaluation.
1. **Holistic**
* Health promotion initiatives should foster physical, mental, social and spiritual health.
1. **Inter-sectoral**
* Health promotion initiatives should involve the collaboration of agencies from relevant sectors.
1. **Equitable**
* Health promotion initiatives should be guided by a concern for equity and social justice.
1. **Sustainable**
* Health promotion initiatives should bring about changes that individuals and communities can maintain once initial funding has ended.
1. **Multi-strategy**
* Health promotion initiatives should use a variety of approaches in combination with one another, including policy development, organisational change, community development, legislation, advocacy, education and communication

# Approaches to Health Promotion

There are five different approaches to health promotion (Naidoo & Wills, 2000)

1. The medical approach
* Aims at freeing clients from disease
* In this approach, clients remain passive recipients led by experts or professionals.
* The crucial value is patient compliance. Examples are patients’ compliance with medical treatments, these include drug compliance or compliance with medical interventions.
1. The behavioural change approach
* Implies that clients are responsible for their own health
* The approach aims at attitude and behaviour change leading ultimately to changes in lifestyle. The value of the approach is a healthy lifestyle, which is determined by the health promoter. For example, programmes on healthy eating to prevent heart disease.
1. The empowerment approach
* Aims to work with clients or the community to meet their perceived needs.
* Health workers advocate for clients, allow for discussion, facilitate for them and give them the freedom to choose, and support clients’ decisions.
* The health promoter facilitates client empowerment. An example is when dealing with controversial sex issues such as pregnancy termination or premarital sex; the sex educator provides adequate information and facilitates in-depth discussions with the client.
* Approach provides clients with the freedom to make their desired choice based on rational thinking. Health professionals then respect their choices.
1. The social change model
* Aims to address inequalities in health that are based on class, race, disabilities, disease or gender.
* This is a top down approach using political action to change the physical and social environment. For example, everyone should have equal access to information, education, employment, services and facilities, and has the right to be treated fairly.
1. Education Model

# Health Promotion Models (Strategies)

Different health promotion models are described in the health promotion literature. In fact, most of the ideas and concepts in these models overlap. However, since the models might guide your thinking in a theoretical way, they are considered essential in deciding health promotion strategies.

1. Health Persuasion
* Health professionals normally lead health persuasion activities focused at individuals.
* The approach is authoritative and individuals are not given any choices for decisions. An example is a nurse persuading a patient with emphysema to quit smoking for the sake of his health.

1. Legislative actions
* Are interventions initiated by experts or professionals to protect the health and welfare of the community. An example is the proposed new ordinance to totally ban smoking in restaurants and most indoor public areas.
1. Personal counselling
* Focuses on the client’s specific needs and normally works on one to one basis.
* The health worker acts as a facilitator to discuss and negotiate client needs. Decisions are made based on the client’s wishes. For example, the counsellor works with drug abusers to discuss choices between methadone and conventional drug detoxification programs.
1. Community development
* Focuses on interventions targeted at the community level.
* The community identifies their health needs, seeks to empower and makes the best rational choice.

# Health Promotion Setting

There are three key settings around which the framework of community mobilization is based on that is **health services**, **community** and **education**. It also looks at the evidence base for addressing health promotion using the settings approach and describes how topics, population groups and chronic illness can also be addressed using this approach

## The settings approach

The World Health Organization (1998) defines a setting for health as ‘The place or social context in which people engage in daily activities in which environmental, organizational and personal factors interact to affect health and wellbeing’.

The settings approach adopts an ecological approach to health that sees health as the dynamic product of interactions between individuals and their environments (Dooris, 2004). It recognises the links and connections that exist between different settings and recognises that people do not live or interact in just one setting, their lives straddle a range of different settings. The settings approach reinforces the need for a ‘joined up’ approach between the various settings at every level to enable effective health promotion action to happen.

**Health promotion and the settings approach**

The settings approach is an important development in health promotion theory and practice. The approach has its roots in the Ottawa Charter (WHO, 1986), which introduced the concept of ‘supportive environments for health’. This was further developed in the Sundsvall Statement on Supportive Environments for Health (WHO, 1991) which reiterated that: ‘*Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love (WHO, 1986).*

The settings approach facilitates health promotion interventions to focus more on the broader determinants of health rather than simply addressing individual and/or population behavioural risk factors. Settings are *‘major social structures that provide channels and mechanisms of influence for reaching defined population groups’* (Mullen et al., 1995).

The approach is supported by key health promotion values such as empowerment, public participation, equity and partnership.

Key features of a settings approach include:

* Developing personal competencies
* Implementing policies effectively
* Re-shaping environments
* Building partnerships for sustainable change
* Facilitating ownership of change throughout the setting (Whitelaw et al., 2001).

## Health services

Ottawa Charter (1986) which called for a re-orientation of health services towards health promotion and presented a way to enlarge the scope of health care interventions.

### Disease-based planning

* National policy statements and related clinical programmes generally focus on a single disease or disease group, for example, a coronary heart disease programme, a stroke programme, a cancer programme.
* Many issue-specific approaches to disease prevention can be limited in effectiveness. This is particularly the case when patients often live with more than one long-term condition.
* Many diseases have risk factors in common and these risk factors are caused by underlying determinants of health.
* Treatment of disease and health promotion are generally seen as two specialist functions, however both are intrinsically interlinked.
* Effective treatment of diseases requires a holistic, whole-system approach, in which the underlying causes of disease, at both an individual and population level, are as much a focus of concern as diagnosis and treatment. An example of this is the management of long-term conditions which require a major re-orientation away from cure, towards information, self-help, shared care and community support.

.

### Health care and health inequalities

* People with greater need should receive more help than those with less need.
* Assessment of need, therefore, must extend beyond clinical issues, to a greater range of support needs.
* When health care services fail to take an empowering approach, this can actually increase the gap in health outcomes between population groups (HSE, 2009).

### The primary care setting

* The Primary Care Strategy (DoHC, 2001) sets out an expansion of primary care so that it becomes ‘the main setting for delivery of health and personal social services and a key component of health education, early intervention and disease prevention’. The strategy makes commitments beyond the delivery of individual patient education: Primary care teams (PCTs) will be facilitated and funded to develop activities which can promote and protect the health of people and families ...through, for example, school and community-based health education...[and] links to local area action plans to provide integrated information and services, as well as links to community development projects. (DoHC, 2001).
* To do this, regional and local service area management will be required to assign staff and allocate additional resources to support interventions and collaborative partnerships which recognise and act upon the socio-environmental conditions that shape our health:
* Commitment to change at many levels will be required to meet the challenges and build the appropriate capacity into the future. (DoHC, 2001). Currently, health promotion staff work at national and regional level with primary care managers and practitioners.

### The hospital (and other residential care) settings

* As highlighted earlier, health care is a determinant of health. Institutional health care offers a particular and unique opportunity to promote health and the hospital and other residential care settings are critical for further development in relation to health promotion.
* A Health Promoting Hospital (HPH) is defined as one that *‘incorporates the concepts of health promotion into its organizational structure and culture by means of organizational development’* (WHO, 2005).

### The health of the HSE workforce

* The Integrated Employee Wellbeing and Welfare Strategy 2009-2014 as part of a long-term strategic approach to developing the HSE as a healthy workplace (HSE, 2009).
* The strategy aims to identify and prioritise initiatives to promote the health and wellbeing of HSE staff. It provides the opportunity to integrate Occupational Health, Employee Assistance, Health Promotion and Health and Safety Services throughout the HSE and seeks to embed workplace health promotion into the management processes of the organisation. The HPSF will further support the implementation of this strategy through the development of a Health Promoting Health Service.

## Community Setting

* The community as a setting for health promotion includes a broad range of population groups such as women, men, children, families, friendship networks and particular interest groups, as well as neighbourhoods, villages, towns, cities, and community and voluntary organisations. Community includes physical spaces and the nature of human relationships within those spaces.
* The health of people living in disadvantaged communities is determined by structural and environmental conditions such as poverty, poor housing, social discrimination and powerlessness.
* The Ottawa Charter (WHO, 1986) highlighted the need for active community involvement in matters that affect health, rather than communities merely being passive recipients of professional interventions. At the heart of this participatory approach to health is the empowerment of communities, strengthening their capacity to take collaborative action.
* Two distinct community health promotion practices exist
1. Community-based approaches
2. Community development approaches
* A community based approach community is a venue for health behaviour and lifestyle programmes while the community development approach is organising and mobilising people to address the challenges that affect their health. Successful community interventions depend on an understanding and a sharing of power between the community and external agencies. While both approaches can and do co-exist, they differ in a number of important respects as indicated below (Poland et. al., 2000).

### The community-based approach

* Individual responsibility for own health
* There is a problem or deficit in the community
* Problem is defined by agencies or government
* Social marketing is the main approach used
* Professionals are key to solving the problem

### The community development approach

* Empowerment of individuals and communities
* There are strengths and competencies in the community
* Problem is defined by the community
* Social justice is the main approach used
* Professionals are a resource to the community
* An example of a community as a setting for health promotion is the Healthy City initiative. A healthy city seeks to promote policies and action for health and sustainable development, with an emphasis on the determinants of health, on people living in poverty and the needs of vulnerable groups. Above the level of community or neighbourhood, the town or city offers many structural and cultural opportunities for health-related development. Many cities have pioneered their own healthy city vision and others have participated in the WHO Healthy City initiative, for example, Dublin and Galway.

## Education Setting

* The education setting refers to pre-school, primary school, post-primary school and third level. It also includes formal and informal youth education settings
* Education is one of the most important predictors of individual levels of health and reported health behaviour (St. Leger, 2001; Kelleher et al.,2003). From a health perspective, it can be argued that good health is a prerequisite for educational achievement and that the school setting, because of the focus on education, is an ideal setting for young people to learn about the influences on personal and social health. Furthermore, from an educational perspective, the role of health education and health promotion contributes to the preparation of young people for participation in society.
* Examples of health improvement opportunities within the HPS model include:-
1. **Teacher training**
* Up-skilling teachers through in-service training programmes, for example, summer schools, policy development workshops, SPHE support.
1. **Parent initiatives**
* Out-of-school programmes can be provided to parents to enhance general health and wellbeing, for example, Being Well programmes, parenting programmes, mental health promotion programmes.
1. **Student involvement and participation**
* Opportunities are created for students to become more involved in their school community through participating in the health promoting school process, thereby enhancing self-esteem and self-confidence.
* It also supports students to take on roles that can enable them to contribute more to their school, their community and to society in general. Through the development of an HPS, school completion is further enhanced.

23

# HEALTH PROTECTION

Community and population health protection revolve around environmental health and safety. Community health personnel work to identify environmental risks and problems so they can take the necessary actions to protect the community or population.

Such protective measures include the control of unintentional and intentional injuries; the control of vectors; the assurance that the air, water, and food are safe to consume; the proper disposal of wastes; and the safety of residential, occupational, and other environments. These protective measures are often the result of educational programs, including self-defense classes; policy development, such as the Safe Drinking Water Act or the Clean Air Act; environmental changes,

Discuss the various health protection measures in Kenya giving examples

# ADVOCACY

# Introduction

Advocacy is a key health promotion activity for overcoming major barriers to public health and occupational health. The barriers addressed by advocacy are poor living and working conditions, rather than individual or behavioral barriers. The modern use of the term advocacy gained momentum from the Ottawa Charter on Health Promotion (a landmark definition of health promotion): “Political, economic, social, cultural, environmental, behavioral and biological factors can all favor health or be harmful to good health. Health promotion aims at making these conditions favorable through **advocacy for health**”. (WHO, 2013)

*Health advocacy* is defined as “the processes by which the actions of individuals or groups attempt to bring about social and/or organizational change on behalf of a particular health goal, program, interest, or population” (2000 Joint Committee on Health Education and Promotion Terminology, 2002, p. 3). *Lobbying* is any attempt to influence specific legislation (Vernick, 1999). *Grassroots lobbying* is any attempt to influence the public or segment of the public to take action on specific legislation (Vernick,1999). Grassroots activity is considered lobbying when the public is asked to contact their representative to create, support, or oppose legislation (Vernick, 1999). *Electioneering*, is any attempt to influence an election (Vernick, 1999).

Advocacy is functioning (speaking, acting, writing) with minimum conflict of interest on behalf of the sincerely perceived interests of a person or group, in order to promote, protect or defend the welfare of, and justice for, either individuals or groups, in a fashion which strives to be emphatic and vigorous, and/or which is actually, or very likely to be, costly to the advocate or advocacy group (Wolfensberger, 2010)

# A 10-step advocacy framework

Advocacy is about:

1. Taking action—overcoming obstacles to action;
2. Selecting your issue—identifying and drawing attention to an issue;
3. Understanding your political context—identifying the key people you need to influence;
4. Building your evidence base—doing your homework on the issue and mapping the potential roles of relevant players
5. Engaging others—winning the support of key individuals/organisations
6. Elaborating strategic plans—collectively identifying goals and objectives and best ways to achieve them
7. Communicating messages and implementing plans—delivering your messages and counteracting the efforts of opposing interest groups;
8. Seizing opportunities—timing interventions and actions for maximum impact;
9. Being accountable—monitoring and evaluating process and impact; and
10. Catalysing health development—building sustainable capacity throughout the process.

# Advocacy Tools and Processes

1. Framing
2. Formative research
3. Working with media
4. Media interviews
5. Networking
6. Social marketing
7. Media advocacy
8. Lobbying
9. Internet based advocacy

# Benefits of health advocacy

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

# Principles for Effective Advocacy

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

# Advocacy approaches

A range of advocacy approaches are currently practiced in both individual and systemic advocacy, including:

1. Self-advocacy
2. Citizen advocacy
3. Peer advocacy
4. Parent advocacy
5. Family/group advocacy
6. Self-advocacy
* ‘Self advocacy’ is a process in which an individual or a group of people speak or act on their behalf in pursuit of their own needs and interests
1. Citizen advocacy
* Citizen advocacy seeks to ‘promote, protect and defend the rights and interests of people who have intellectual disability
1. Peer advocacy
* Peer advocacy involves ‘one-on-one support by a service user, past or present, to help another to express and fulfill their wishes
1. Parent advocacy
* Parent advocacy is concerned with ‘advocating on issues that affect the person with a disability and their family. The focus is on the needs of the person with a disability, not the parents or family. However, some parent advocacy focuses on the needs of parents first
1. Family/group advocacy

# Health advocates

• Individual consumer,

• Friends/family/carers/volunteers,

• Independent patient advocates,

• Non-profit organisations,

• Non-government policy/advocacy organisations,

• Statutory authorities,

• Health professionals and patient liaison officers, and

• Public servants

# Topic 6: COMMUNITY PARTICIPATION AND MOBILIZATION

# COMMUNITY PARTICIPATION

# Introduction

* It is the process in which communities are actively involved in all stages of a project or programme implementation
* E.g. project cycle, Needs assessment (community diagnosis), planning and implementation.
* Involve communities in defining their needs and planning how to meet them within the national policy framework, in implementation and evaluation

**Self-reliance & self determination**

**Building consensus**

**No involvement**

**Create awareness**

**Seeking opinion**

## Importance of community partcipation

1. It helps community members to identify and prioritize their felt needs.
2. Enhances sense of ownership.
3. Empowers the community to manage their own projects.
4. Helps to change people’s attitude
5. It reduces project costs
6. It promotes utilization of locally available resources
7. It promotes intra and inter sectoral collaboration

## How to promote community participation

1. Conduct dialogue based on evidence
2. Conduct regular meetings to give feedback at all stages of implementation
3. By strengthening existing structures rather than forming new ones
4. Creating awareness at all levels of implementation
5. By applying appropriate but effective technology
6. Involving everyone in the participation
7. Capacity building of the community

## Factors hindering community participation

1. Inadequate awareness creation
2. Poor leadership
3. Dependency syndrome-people expect handouts before participation
4. Political influence
5. False promises from implementing agencies
6. Lack of prioritization of community needs
7. Gender bias
8. Application of inappropriate technology
9. Poor timing of activities/seasonal priorities
10. Lack of transparency
11. Use of unskilled agents
12. Lack of decentralization in decision making
13. Poor extension policies and methodology
14. Cultural
15. Poverty

## Community Strategy

* The National Health Sector Strategic Plan II 2005-2010(NHHSSP II 2005-2010) was formulated with an aim reversing declining health trends in the country with the aim of reducing health inequalities and reversing the downward trends in health-related outcome and impact indicators.
* The plan has the following objectives:
1. Increase equitable access to health services
2. Improve the quality and responsiveness of services
3. Foster partnerships in improving health and delivering services
4. Improve the efficiency and effectiveness of service delivery
5. Improve financing of the health sector
* The Kenya Essential Package for Health (KEPH) is a new approach through which the goals of NHSSP 2 would be accomplished.
* Realizing the importance of empowering households and communities in delivery of KEPH at level 1, MOH and other sector partners developed and launched a community strategy in 2006
* The strategy outlines the type of human resources required to deliver the services and support required of level 1 services.
* It also provides for the minimum kit and the management structure to be used.

### Essential Elements Of The Community Strategy

### Community units.

* Approximately 1000 households or 5000 people who live in the same geographical area sharing resources and challenges.
* Each should have 25 community workers each to serve 40 households or approximately 200 people.
* Community health workers report to the community health extension worker.
* Workers can either be a trained community worker or trained technician.
* Community Health extension workers - trained health personnel eg ECN or PHT. They supervise the community health workers and are paid by the government.

### Community health committee

* Is a committee which is elected for the whole unit or sub location and each village of the unit is represented
* It has 12 members and is chaired by respected members of the community and community health extension worker (CHEW) is the secretary

### Health Facility Management Committee

* Comprises14 members representing at least 2 units serviced by the health facility
* Facility in charge is the secretary
* The chair and treasurer should be elected during DOs baraza and a member of District Management team should be present.

# Obstacles to Communty Participation

1. Diversity of interest and perception
2. Adminstrative resistnace to decentralization and distribution of benefits
3. Difficulties in mobilzing previosly un-involved populations

# COMMUNITY BASED HEALTH CARE (CBHC)

* It is the transfer of health care from hospital/health facilities to the patient’s home through family and community participation and involvement
* It flows from PHC and it relies on family members, community/health care workers (HCW)
* CBHC relies on available resources within the community.

### Home and Community Based Health Care

* This is the care given to the persons affected and infected by HIV/AIDS or any other chronic disease that is extended from hospitals to patient’s home via family participation and community involvement with available resources in collaboration with health care workers.

### Importance of HCBC

1. The sick person learns safe health care skills & positive living.
2. The family or care giver learns new skills to cope more effectively with the condition.
3. The community health workers link the family and patients to other health services.
4. The health care system is less burdened

### Objectives of Home and Community base Programmes

1. To facilitate continuity of care from the health facilities to the home and community
2. To promote family and community awareness of HIV/AIDS prevention and care.
3. To empower the family/community with knowledge needed to ensure long-term care and support.
4. To raise the acceptability levels of PLWAHS by the family & community in order to reduce the stigma associated with HIV/AIDS.
5. To streamline the patient/client referral from the institution into the community and from the community to appropriate health and social facilities.

## Key Players in HBC

# Health facility

* Make initial dx and also deliver technical care.
* Recruiting the sick into the programme, identifying needs at various levels and also prepares sick discharge to homes.
* Prepare family/care giver for caring responsibility at home.
* Supplying simple drugs and basic home supplies.
* Facilitate training and supervision of CHWS.

# Family

* Their responsibilities include;-
	+ Caring for the sick at home collaborating with other care providers e.g. religious institutions, health and social institutions
	+ Consulting and involving the sick on matters concerning them
	+ Help them to accept the reality of the situation i.e. the sick to accept the reality.
	+ In case of terminal illness, family can also help the sick person to prepare for death.

# The sick

* Roles include;
	+ Identify the primary or alternative care giver of choice.
	+ Participate in care process, planning for the future by writing a will.
	+ Identifying spiritual/pastoral needs.
	+ Resolving in taking personal responsibility to stop further transmission of HIV.
	+ Advocate for behaviour change and informing the partners of one’s HIV status.
1. Community
* Accepting the situation of the sick and accepting them in the family without stigma
* Collaborating with the existing agencies to meet the needs of those affected.
* Support the family of the sick
1. Government
* Creating a supportive policy and environment
* Providing /coordinating home based training and care standards.
* Providing essential drugs and commodities.

**Care Needs of Chronically ill**

1. Assistance with general household chores
2. Psychological support - stress & anxiety reduction, promoting positive living and helping the individual make informed decisions e.g. HIV/AIDS test, planning for the future and behaviour change involving their sexual partners in the decision.
3. Nursing care - e.g. personal hygiene, nutrition and comfort to ensure a cheerful life despite the illness.
4. Food
5. Clinical care - diagnosis, treatment, supportive, follow up
6. Social support-information and referral to support welfare and legal advices for individuals and families and where possible provision of material assistance.
7. Environmental cleanliness
8. Referral

# COMMUNITY MOBILIZATION

# Definition

* Community mobilization is the process of engaging a group of people in joint action in order to achieve societal goals through self-reliant efforts (Dale, 2000)
* Community mobilization is defined as a process through which action is stimulated by a community itself, or by others, that is planned, carried out, and evaluated by a community’s indi­viduals, groups, and organizations on a participa­tory and sustained basis to improve health

Community organizing is a long-term process in which issues surface directly from the grassroots com­munity. In this model, the “organizer” is gener­ally issue neutral and engages in a structured listening process to surface and define an issue. This process focuses heavily on developing last­ing personal relationships among community members that yield a consensus on the issue to be addressed. It can be described as an “inside-out” process.

Community mobilizing is more short term in nature and specific issues or concerns are brought to the community and action is urged. The mobilizing process is generally driven by a subject “expert” who has predefined the issue, has a solution in mind, and is trying to encourage the people in the community to support the solu­tion by working together for change. It can be de­scribed as an “outside-in” process.

Commu­nity organizing is “a process that draws on the power and persua­sion of diverse stakeholders to identify and define common problems, mobilize resources and work together to improve health and quality of life

# Objectives of Community Mobilization

1. Creating awareness
2. Building local organizations
3. Strengthen peoples’ analytical capacity
4. Promote peoples’ confidence
5. Mobilize underutilized or non-utilized resources
6. Establish linkages
7. Building Leadership
8. Increasing Civic Engagement
9. Enhancing Member Participation

# Empowerment

* Empowerment is the process whereby people acquire more influence over factors that shape their lives
* Is the primary goal of community mobilization
* Focus is mostly on the disadvantaged people with the expectation that they will attain more equal conditions in society
* Principles of effective empowerment
1. Facilitate process of learning
2. Actively promote/insist on genuine discussions and consultations before decisions which affect more than one person are made
3. Promote engagement in concrete development activities
4. Community mobilizer to act as a linkage person
5. Promote role of change agent in the community

# SOCIAL ACTION MODELS (APPROACHES)

The overall gaol of community development is action for bringing about planned social change through full participation of people in the community. Different strategies can be used to stimulate the needed action (strategy = process by which individuals, groups or communities arrive at a chosen object)

The main strategies include

* Power strategy – ability of members to assume power and influence decisions
* Self-help strategy – efforts made to assist the community to change through volunteer efforts
* Communication strategy – communicate problems of the community to the larger society compelling assistance
* Political strategy – develop viable political organizations

The strategies can be implemented at 3 levels

1. General strategies – extension, community development
2. Intermediate strategies
3. Specific strategy

Models of community mobilization include:

1. Induced social action model
2. Spontaneous social action model
3. Quasi stationary equilibrium model
4. Social advocacy model
5. Diffusion of innovations model
6. Induced social action model
* Used by outside agents to bring change
* Stages
	+ Exploration
	+ Organization – set nucleus or initiating set, training
	+ Discussion
	+ Group decision making
	+ Planning for social change
	+ Action
	+ Evaluation
	+ Subsequent action
1. Spontaneous social action model
* Idea conceived by a single individual
* Steps
	+ Job step
	+ I step
	+ We step
	+ Group step
	+ Do step
1. Quasi stationary equilibrium model
* Work is done in groups particularly in crises situations
* 3 steps
	+ Unfreezing
	+ Moving
	+ Freezing
1. Social advocacy model
* A disadvantaged segment of the community needs to be organized and mobilized to gain power and resources
* In line with principle of democracy and social justice

1. Diffusion of innovations model

# Community Mobilization Plan

* This is a general description of how a change agent and his/her team wish to assist the community of interest to mobilize around a given issue
* Defines the overall program goals and objectives
* Elements of CMP
1. Background information
2. Program goal
3. Program objectives
4. Community action cycle (community mobilization process)
	1. Sensitization and clearance
	2. Unity organizing
	3. Mobilizer training
	4. Management training
	5. Participatory assessment
	6. Defining priorities and problems
	7. Community action plan
	8. Community project design
	9. Negotiation
	10. Implementation
	11. Monitoring and evaluation
	12. Compeletion ceremony
	13. Repeat the cycle
5. Monitoring and evaluation plan
6. Management plan
7. Budget

# Identification and Mobilization of Resources

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

# Institutions for Community Mobilization

1. State/government
	1. Political organizations
	2. Administrative organizations
2. Civil society
	1. NGOs
	2. CBOs
	3. Trade unions
	4. Lobby movements
	5. Self-help groups
	6. Youth groups
3. Market oriented/based institutions

# Outcomes of Mobilization

* The principal outcome is participation
* Models of participation
1. Extractionsit model
* Used by government planners
* People drawn into participation of implementation of a pre-determined development goals
* People participate through financial and material resources
* People dictated upon
1. Vertical model
* Power brokers develop mutually beneficial relations with elites or government officials
1. Hand out induced model
* Associated with economists and technocrats who consider themselves superior
1. Authentic model
* Empowers the powerless to assume full responsibility of their own destiny

# Barriers to Mobilization

1. Personal characteristics
	1. Perceived sensitive issues
	2. Social fear or shyness
	3. Feelings of inadequacy
	4. Fear of conflict or consequences of action taken
2. Role characteristics
	1. Role conflict
	2. Role overload
3. Community characteristics
	1. Economically disadvantaged
	2. An aging population
	3. Too few volunteers
	4. Shortage of human resource

# Leadership in Community Mobilization

* Leadership is the art of organizing people and managing the process that enables people to set individual and collective goals as well as priorities in life
* Leadership
1. Facilitates creation of appropriate structures of operation and governance
2. Help in mobilization, organization and guidance in resources
3. Influence the community to reach identified goals
* Assigning leadership
1. Constituency of electorates
2. Nomination
3. Institutional appointment
4. Situational leadership
5. Manipulation or self-imposition
* Leadership styles
1. Dictatorial leadership
* Characterized by orders and instructions directed at the people who are expected to comply without questioning
1. Consultative leadership
* Promotes individual thinking and initiative
* Useful when brain storming on issues
1. Laissez-Faire
* Leaves people to do whatever they want at their own time and convenience
* Leader has no control (leader by name)
1. Democratic or Enabling leadership
* Promotes participatory decision making
* Each person is considered equal and opinion of each accepted and considered in the process of decision making

# COMMUNITY ORGANIZATIONS

# Introduction

* All people are involved in organizations of all kinds everyday of their lives
* Our lives are affected by the products and decisions of organizations
* An organization is a a group of persons who are working together to achieve a common objective
* Organizations are goal oriented and boundary maintain activity systems
* Can be formal ( name, officials, constitution, formal procedures) or informal (mutual agreement with few formal procedures)

# Features of Organizations

1. Composition
* Individuals or groups
1. Orientation towards goals
2. Differentiated functions
3. Rational coordination
4. Continuity through time

# Community Organization

* This is the process by which a community identifies its needs or objectives, orders, finds the resources, takes action and by so doing develops cooperative and collaborative attitudes and practices in the community
* Is a process of bringing about and maintain an effective link between social resources and social needs within a given locality
* Focus is on the needs of the people(e.g. health needs) and means of meeting the needs in a consistent way

# Community Organizations

## Introduction

* Are non-profit making organizations that operate within a single locality
* Are run on a voluntary basis and are often self-funding
* Are resources that enable members of a community to work together to meet their needs
* Can be formal or informal
	+ Formal organizations are patterns of social interactions and shared perspectives that are deliberately formed or established for certain purposes i.e. the organs are formed for achievement of specific objectives. Within formal organs are find groups (a group is a number persons who communicate with one another over a period of time)
	+ Informal groups are formed when people interested in a problem come together and are direct action groups that get directly to the problem at hand

## Nature of Organizations

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

## **Levels** of Organizations

* There are two levels
	+ Locally based organizations
	+ Outside Agencies

### Locally based Organizations

* These are the formal or informal types of organizations found in communities
* Life cycle of local organizations
1. Stimulation period
* People with interest are made aware by outside agencies of through local influence of the need to form a group
1. The rise period
* Involves frequent meetings to discuss important matters
* Officials/committee members chosen
* Constitution drawn
1. Carrying on period
* Group carries out its activities
* Longest period
* Group deals with many problems and aims at focusing and re-focusing
1. Decline period
* Some groups decline fast while others persist for a long time

**Task**

* Identify local based organizations dealing with health related issues in your community.
* State their activities

### Outside Agencies

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

## Types of NGOs

* Are classified according to orientation and level of operation

### NGOs by Orientation

1. Charitable organizations
* Operate from top-down
* Have little participation by beneficiaries
* Most involved in activities directed in meeting the needs of the poor e.g. food, medicines, shelter
* Carry out relief activities during disasters
* Examples – World Vision, Red Cross

1. Service orientation
* Involved in activities such as provision of health, family planning, education
* Programs designed by the NGO and people are expected to participate in its implementation and receiving the service
* Examples – Red Cross, AMREF (flying doctors), WFP, MSF, World Vision,
1. Participatory orientation
* Characterized by self-help projects whereby local people are involved especially in implementation of projects
* People contribute cash, tools, materials, labour
* Examples – Habitat International, FARM[[1]](#footnote-1) Africa (Moyale, Marsabit), COW[[2]](#footnote-2)
1. Empowering orientation
* Aim is to help the poor to develop clear understanding of the social, political and economic factors affecting their lives
* There is strengthening of the awareness of the people of their own potential power to control their lives

### Level of Operation

1. Community based organizations (CBOs)
* Arise out of peoples’ initiative
* Some may be supported by national or international agencies
1. Citywide organizations
* May be created for the sole purpose of helping the poor
* Examples – Rotary clubs, Lions clubs, Associations of community organizations, ethnically based groups, educational groups
1. National NGOs
* Examples – Red Cross, YMCA, YWCA, professional organizations
1. International NGOs
* Include organizations like Save the Children, CARE, Oxfam, Ford Foundation, Rockfellor Foundation
* They fund local NGOs and institutions and also implement their own projects

### Importance of Organizations

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

### Benefits of Working with Organizations

1. Durability
2. Reliability
3. Accountability

### Elements of Organizations

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

# Role of NGOs in Kenya

# Prophetic roles

* Speak out in injustice and importance of human dignity

# Supplemental roles

* Provide alternative mechanisms for offering services to needy people
* Support the community to improve their standards of living by developing their own initiatives and encouraging use of available resources

# Modelling role

* Seen through experimentation and innovation in new forms of organizations and practices
* Initiate small scale projects using innovative methods
* Their models and experiences have serves as models and influenced policy on rural development

## Aims of NGOs

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

## Types of NGO Projects

1. Education
2. Health e.g. Merlin, Hospice, Catholic church
3. Agriculture and Livestock
4. Water – CDN
5. Income generation

## Community Goals and Objectives

1. Economic growth
2. Economic development
3. Economic stability
4. Economic justice
5. Economic freedom

# Topic 7: MILLENNIUM DEVELOPMENT GOALS (MDGs)

Goal 1:  End extreme poverty and hunger

Goal 2:  Achieve universal primary education

Goal 3:  Promote gender equality and empower women

Goal 4:  Reduce child mortality

Goal 5:  Improve maternal health

Goal 6:  Combat HIV/AIDS, malaria and other diseases

Goal 7:  Ensure environmental sustainability

Goal 8:  Develop a global partnership for development.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **MDGs** | **Targets**  | **Indicators**  | **Strategies**  |
|  | Eradicate extreme hunger and Poverty reduction  | **Target 1**: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day | * 1. Proportion of population below $1 (PPP) per day
	2. Poverty gap ratio [incidence x depth of poverty]
	3. Share of poorest quintile in national consumption
 | * KKK; Women enterprise fund; Youth enterprise fund
* Gender empowerment; Supporting the farmers; Relief food; National initiatives – Njaa marafuku, Kilimo biashara; Stimulus package
 |
| **Target 2**: Halve, between 1990 and 2015, the proportion of people who suffer from hunger | * 1. Prevalence of underweight children under-five years of age
	2. Proportion of population below minimum level of dietary energy consumption
 |  |
|  | Universal primary education  | **Target 3**: Ensure that, by 2015, childreneverywhere, boys and girls alike, will be able to complete a full course of primary schooling 15-24 year-olds | * 1. Net enrolment ratio in primary education
	2. Proportion of pupils starting grade 1 who reach grade 5
	3. Literacy rate of 15 – 24 years old
 | * Free primary education
* Free tuition at secondary school
* Model schools
* CDF construction of schools
* School feeding programmes
 |
|  | Promote gender equality and empowerment of women  | **Target 4**: Eliminate gender disparity in primary and secondary education preferably by 2005and to all levels of education no later than 2015 | * 1. Ratios of girls to boys in primary, secondary and tertiary education
	2. Ratio of literate females to males of 15-24 year-olds
	3. Share of women in wage employment in the non-agricultural sector
	4. Proportion of seats held by women in national parliament
 | * Education – cut off points; Affirmative action;
* Employment; Promoting girl child issues;
* Constitutional changes and legislation; Policy – ministry; Enterprise funds – women, KWFT
 |
|  | Reduce Child Mortality  | **Target 5**: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate | * 1. Under-five mortality rate
	2. Infant mortality rate
	3. Proportion of 1 year-old children immunised against measles
 | * Immunization; Free medical services for under 5’s
* Child welfare clinics; Training of health workers
 |
|  | Improve Maternal and child health  | **Target 6**: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio | * 1. Maternal mortality ratio
	2. Proportion of births attended be skilled health personnel
 | * Immunization; Special clinics – ANC/FANC, HRC,
* MCH/FP; Safe motherhood programmes
* Cancer screening
 |
|  | Combat HIV/AIDS, TB, malaria and other diseases  | **Target 7**: Have halted by 2015 and begun toreverse the spread of HIV/AIDS | * 1. HIV prevalence among 15-24 year old pregnant women
	2. Condom use rate of the contraceptive prevalence rate
	3. Number of children orphaned by HIV/AIDS
 | * Malaria – free treatment, ITNS, campaigns; Stop TB strategy ; ARVs/ART; VCT/TDC/PITC; PMTCT; PEP
* Supply of condoms;
* Community mobilization
 |
| **Target 8**: Have halted by 2015 and begun toreverse the incidence of malaria andother major diseasesshort course (DOTS) | * 1. Prevalence and death rates associated with malaria
	2. Proportion of population in malaria risk areas using effective malaria prevention and treatment measured
	3. Prevalence and death rates associated with tuberculosis
	4. Proportion of tuberculosis cases detected and cured under directly observed treatment
 |  |
|  | Ensure Environmental sustainability  | **Target 9**: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources | * 1. Proportion of land area covered by forest
	2. Ratio of area protected to maintain biological diversity to surface area
	3. Energy use (kg oil equivalent) per $1 GDP (PPP)
	4. Carbon dioxide emissions (per capita) and consumption of ozone-depleting CFCs (ODP tons)
	5. Proportion of population using solid fuels
 | * The Environmental Management and Coordination Act (EMCA)
* National Environment Management Authority (NEMA),
* Environmental Action Plans (EAPs) at district, provincial and national levels
* Ratification and domestication of various multilateral environmental agreements.
* National and sector plans to integrate environmental concerns into development planning in Kenya, e.g. Vision 2030, Medium Term Plan 2008-2012, and the Environment, Water and Sanitation sector plan for 2008-2012.
* In addition, environmental education and awareness creation continue to be undertaken countrywide.
* National climate change response strategy
* Regulations on environmental management e.g. Air Quality 2009, Ozone Depleting Substances 2007, Environment Impact Assessment (EIA)/Environmental Audit (EA) 2003, Noise Control and Vibration 2009, and Biodiversity 2006.
* Reforestation – Mau
 |
| **Target 10**: Halve, by 2015, the proportion of peoplewithout sustainable access to safe drinking water | * 1. Proportion of population with sustainable access to an improved water source, urban and rural
 |
| **Target 11** By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers | * 1. Proportion of urban population with access to improved sanitation
	2. Proportion of households with access to secure tenure (owned or rented)
 |
|  | Develop a Global partnerships for development  | **Target 12**: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Includes a commitment to good governance, development, and poverty reduction – bothnationally and internationally**Target 13**: Address the special needs of the least developed countriesIncludes: tariff and quota free access for least developed countries' exports; enhancedprogramme of debt relief for HIPC and cancellation of official bilateral debt; and moregenerous ODA for countries committed to poverty reduction**Target 14:**Address the special needs of landlocked countries and small island developing States(through the Programme of Action for the Sustainable Development of Small IslandDeveloping States and the outcome of the twenty-second special session of the GeneralAssembly)**Target 15:** Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term | *Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa,**Landlocked countries and small island developing States.**Official development assistance** 1. Net ODA, total and to LDCs, as percentage of OECD/DAC donors’ gross national income
	2. Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation)
	3. Proportion of bilateral ODA of OECD/DAC donors that is untied
	4. ODA received in landlocked countries as proportion of their GNIs
	5. ODA received in small island developing States as proportion of their GNIs

*Market access** 1. Proportion of total developed country imports (by value and excluding arms) from developing countries and LDCs, admitted free of duties
	2. Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries
	3. Agricultural support estimate for OECD countries as percentage of their GDP
	4. Proportion of ODA provided to help build trade capacity

*Debt sustainability** 1. Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative)
	2. Debt relief committed under HIPC initiative, US$
	3. Debt service as a percentage of exports of goods and services
 | * Collaboration with;
* Friendly countries
* International agencies
* NGOs
 |
|  | **Target 16:** In co-operation with developing countries, develop and implement strategies for decent and productivework for youth | * 1. nemployment rate of 15-24 year-olds, each sex and total
 |  |
|  | **Target 17:** In co-operation with pharmaceutical companies, provide access to affordable,essential drugs in developing countries | * 1. Proportion of population with access to affordable essential drugs on a sustainable basis
 |  |
|  |  | **Target 18:** In co-operation with the private sector, make available the benefits of new technologies, especially information andcommunications | * 1. Telephone lines and cellular subscribers per 100 population
	2. Personal computers in use per 100 population and Internet users per 100 population
 |  |

1. Food Agriculture Resource Management [↑](#footnote-ref-1)
2. Children of the World [↑](#footnote-ref-2)