COMPILED BY EFFIE NAILA

BY: PROF. J. OLENJA

WHAT IS A COMMUNITY? ▪This is a fluid term.

▪ It is a social grouping

▪A geographical, as well as, cultural grouping with shared values and practices.

▪This is the dominant community grouping in Kenya.

▪80% of the population lives in the rural areas and therefore efforts are geared at expanding the urban community.

▪A community is defined by socio - economic as well as multi - ethnic groupings.

SOCIAL DIMENSIONS OF HEALTH: 

Meeting global challenges through inter - disciplinarity **Environment** 

**Health** 

**Wellbeing**

**Demographics**

**Participation**

**Technology**

**Economy**

****SOCIAL DETERMINANTS OF HEALTH ▪Social determinants of health are the conditions in which people are born, grow, live, work and age. ▪These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. (WHO 2010). 

▪Country data consistently document significant disparities in utilization of health services and health outcomes defined by wealth, ethnicity, residence education, age, and other social factors.

▪**Health inequity** is defined as "inequalities in health deemed to be unfair or to stem from some form of injustice.”

Cont. ▪Since 2005, CSDH has provided information critical for understanding the role social status and context play in determining health.

▪ WHO Director - General DR. Margaret Chan (2013) reminded Member States that

▪“Factors that contribute to good health at low cost include a commitment to equity, effective governance systems, and context-specific programmes that address the wider social and environmental determinants of health”

Community health problems in Kenya that are dependent on the environment: 

▪Communicable and non - communicable diseases are on the rise.

▪Reproductive health needs and challenges.

▪Food insecurity: malnutrition is a major problem

▪Poverty and increased vulnerability

Vulnerable/ special social groups in a community include: 

▪Youth/ adolescents

▪Elderly

▪Persons with disability

▪People living in hard to reach areas – including urban slums

▪People living with HIV/ AIDs

▪Women of reproductive age

▪NB: one can belong to more than one of these categories

Adolescents/Youth ▪More than 36% of the population (the “bulge”)

▪A challenge to development and service delivery

▪Poor access to services due to social stigma

▪Experience unmet need for services especially reproductive health services

▪Experience poor service provider attitude ▪Unplanned pregnancy and early marriage

Vulnerable women and girls ▪Poor young mothers and often school dropouts with no prospects of employment

▪Can be heads of households

▪Though not designated as FSWs, are often engaged with multiple sexual partners to meet economic needs.

▪Have no power to negotiate for condom use

▪Highly vulnerable to HIV infection and victims of gender based violence

The urban poor ▪Also classified as **people in hard to reach areas**

▪Poor access to services for a cross - section of the population

▪Poor environment and services

▪Poverty/unemployment

▪ Insecurity

▪ Inadequate of food

▪Predominantly use local/traditional service providers

Persons living with HIV/ AIDs ▪Often poor

▪ In spite of the availability of ART - there is poor adherence to medication

▪Stigma and fear of discrimination

▪Fear of disclosure - keeps them away from services that are otherwise free

▪ Ironically access to health services becomes expensive as they incur transport to seek care elsewhere

Persons living with disability ▪Are not taken into acount when planning for services 

▪Communities do not generally seek care for persons with disability

▪Advocacy for services for persons with disability is low

▪We are just beginning to create awareness

The Elderly ▪ Growing population - more people are living longer

▪ Suffer from chronic conditions

▪ Poor knowledge of these conditions

▪ Inadequate advocacy for services for the elderly ▪ High costs of services

▪ Depend on a social support system that may not cope with high costs of treatment and care.

Gender Based Violence ▪ Immediate social factors

▪ Economic inequality between men and women ▪ Attitude towards gender roles and violence against women ▪ Normalization of the culture of violence against women KDHS 2014

▪ Physical violence

▪ 38% of women (9% for men) reported experiencing physical violence

▪ Sexual violence

▪ 14 % of women (4% men) reported experiencing sexual violence

SOCIAL CHANGES (GLOBALIZATION) IN HEALTH 

▪ Changes are happening in the following sectors: ▪ Culture

▪ Economic

▪ Political etc.

▪ There are changes that are driven by exposure to education ▪ The influence of globalization has also played a role.

What is globalization? ▪The spread of knowledge, science & telecommunications resulting in:

▪Cultural and behavioral adaptations ▪Increased trade

▪Wider consumer choices

▪Access to health innovations

Lifestyle & health issues ▪ Influence of globalization

▪ Sedentary lifestyles and lack of exercise

▪ Adoption of Habits such as of Smoking and Alcoholism

▪ Urbanization and changes in living environments that limit movement(physical activity)

▪ Nutritional transitions and changes in life style ▪ Changes in food variety and dietary practices ▪ The role of the supermarket- highly processed foods ▪ Global obesity epidemic- is fast growing in Africa)

The rise in NCDs ▪In both urban and rural settings ▪Across the social classes - rich or poor 

▪Obesity

▪Cardiovascular diseases

▪DM

▪Cancers

NCDs in Kenya ▪Non communicable diseases accounts for more than 50% of total hospital admissions and over 55% of hospital deaths in Kenya.

▪The major NCDs are:

▪Cardiovascular conditions, cancers, DM & COPD, along with their sequelae and their shared risk factors.

▪Equally contributing to the huge burden are violence and injuries, mental disorders, oral, eye and dental diseases

Examples ▪ This rise in DM is associated with demographic and social changes such as:

▪ Globalization, urbanization, aging population, adoption of unhealthy lifestyles such as consumption of unhealthy diets and physical inactivity.

▪ The prevalence of DM in adults is estimated to be 4.56% according to IDF, amounting to almost 750,000 persons and 20,000 annual deaths.

▪ There is a disparity in distribution with an estimate of approximately 10.7% among urban and 2.7% among rural dwellers (Diabetes Atlas 2014).

The burden of NCDs ▪ Besides the burden of deaths and disability, non communicable diseases pose a greater social and economic burden to the economy.

▪ NCDs threaten progress in the post - 2015 development agenda as poverty is closely linked with NCDs.

▪ The rapid rise in NCDs is predicted to impede poverty reduction initiatives in low - income countries, particularly by increasing household costs associated with health care.

▪ Vulnerable and socially disadvantaged people get sicker and die sooner than people of higher social positions, because they are at greater risk of being exposed to harmful products, such as tobacco or unhealthy food, and they have limited access to health services.

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Available health services ▪Multiple sources: medical pluralism

▪Historical perspective:

▪Traditional medicine was discouraged by the colonial government and the new religions ▪ It largely operates on the fringes of the health care system

▪ It is not regulated

▪There is therefore a dominance of the modern health system.

Community health resources ▪There is a whole array of community health resources located in both rural and urban centers.

▪These include:

▪Traditional healers

▪Diviners

▪Traditional circumcisers

▪Traditional birth attendants (TBAs): conduct 50 – over 90% of deliveries even though the current policy does not permit the use od TBAs.

Current community health practice ▪It is varied and based on a combination of factors, i.e.,

▪Location & access to services

▪Entrenchment of the cultural belief system and perception of certain conditions

▪What service is required for what condition & when?

▪What is the cause of the disease/ condition ▪The role of explanatory models (biomedical vs. cultural)

Health seeking ▪Health seeking behavior: what people do whenillness is recognized

▪Involves a decision making process based on the magnitude of the problem as perceived

▪Based on options available (Pluralism)

BARRIERS TO CARE – SEEKING: 

Structural

▪Socio-cultural factors (Perception of Health anddisease)

▪Role of stigma

▪Awareness and recognition of signs and symptoms

▪Awareness of availability of services ▪Gender and the decision-making process

BARRIERS TO CARE – SEEKING: 

Location & access

▪Communities in hard to reach areas inevitably use more of the local resources for health care

▪They have a more elaborate ethno medical system, out of necessity e.g. Pokot.

▪Poor road network in both rural areas and urban slums

What are the gender implications fo accessing health care



GENDER & HEALTH ▪Gender roles and relations can lead to differences in women’s and men’s: ✔Social conditions of vulnerability to illness 

✔Ability to protect and maintain health ✔Access to care

✔Quality of care received

✔Burdens of ill - health

✔Gender based violence

Gender, health & decision making ▪Poverty is strongly correlated with lower rate of contraceptive use.

▪This relationship is mitigated by gender norms which prevent women of varying socioeconomic status from autonomous decision - making and control over and/or access to financial resources and services.

▪Addressing gender as a social determinant of health appropriately can therefore make a difference to the health and well-being of both men and women.

What is being done to improve access to care and hence care - seeking 

▪ Health promotion: addressing myths and misconceptions about health & disease

▪ In sectors such as maternal health:

▪ Preparedness: prepayments especially for delivery ▪ Use of vouchers for poor women

▪ Political commitment

▪ Maternal health services in facilities: currently free **(linda mama initiative)\***

▪ Maternal deaths: towards zero campaign by the 1st lady ▪ Motivation of CHWs: token payment

Community Engagement in Health ▪Community participation as key concept in PHC

▪Community Contribution to health facilities within their locality

▪Engagement of community health resource persons

▪Redefining the role of Traditional Birth Attendants (TBAs)

▪Support to community health initiatives

Cont. ▪ Innovative disease e.g. shelters at health facilities

Innovative Ideas- Shelters at health facilities

**The “Kirap” outside Ortum mission hospital**

Innovative Ideas- Shelters at health facilities

**Boarding facilities in the “Kirap” showing two prenant women and a nurse (in green)**

****Enhancing community health ▪Understanding the causes of inequity in health status and designing programmes to reduce it.

▪It is essential to analyse social structures which inhibit access to and use of safe and effective health services.

▪Public - health programmes that endeavour to provide equitable access to services by decreasing disparities in service utilization.

▪Addressing GBV

Cont. ▪The entrenchment of the **community health strategy** to enhance: 

▪Community mobilization & engagement ▪Drawing from available community resources

▪With the new constitutional

dispensation: concerted effort to support & cushion the growing number of vulnerable groups

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REFER TO PROF’S SLIDES.

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****QUESTION 1 ▪What is the role of community participation in health care?

DEFINITIONS ▪COMMUNITY 

▪Geographical as well as cultural grouping of people with shared values & practices.

CONT. ▪HEALTH CARE 

▪The organized provision of medical care to individuals or a community.

▪Efforts made to maintain or restore physical, mental or emotional wellbeing especially by trained and licensed professionals (health care providers)

CONT. ▪COMMUNITY PARTICIPATION

▪A process by which the community mobilizes its resources, initiates and takes responsibilities for its own development activities and shares in decision making for and implementation of all other development programs for the overall improvement of its health status

▪The key to the successful organization of PHC is community participation.

▪Through this process, the people gain greater control over the social, political, economic & environmental factors determining their health.

Types of participation

**Passive (manipulation)**: • Individuals and families are mere spectators 

**Active (consultation)**: • The community may be carrying out some tasks in a program but it is not involved with the final decision making on what is to be done. The community does not, therefore, develop a sense of self - reliance 

**Involvement** 

**(community control)**:

• The community is involved in all aspects of a program. This type enables the community to participate willingly to improve its own 

health program for it to have lasting results i.e., thinking, planning,

acting & evaluating. • This empowers the community to make informed decisions in matters affecting their health and

development.

IMPORTANCE OF COMMUNITY PARTICIPATION IN HEALTH 

▪ Create awareness of disease

▪ Reduces disease prevalence

▪ Promote health seeking practices

▪ Reduces morbidity and mortality

▪ Increased economic output

▪ The community provides secondary health care services. ▪ The community aids policy implementation

▪ Preventive measures are taken up to reduce incidence of disease.

AIMS OF COMMUNITY PARTICIPATION ▪The community develops self reliance

▪The community develops critical awareness

▪The community develops problem solving skills

SOCIOECONOMIC SECTOR ▪ Positive:

▪ There are collective fundraising drives towards facilitating health care provision amongst community members e.g. harambees, paybill numbers etc.

▪ Support groups are being created to have a pool of finances from which members can access health care services. ▪ People are getting involved in income generating activities hence they are able to seek health care.

▪ Negative:

▪ Lack of confidence in the medical care provided within the society and an increase in the levels of outsourcing medical care e.g. going to India. These finances are directed away from the country resulting in a financial drain.

CULTURAL SECTOR ▪ Positive: 

▪ Certain cultural practices have a beneficial effect on health e.g. male circumcision

▪ Communities are receptive to suggested changes in their cultural practices that are promotive to health e.g. discouragement of FGM ▪ Communities have volunteers who provide health care services at a grass - root level e.g. traditional birth attendants, CHEWs

▪ Negative:

▪ Alternative health service providers skew the health – seeking behavior away from medical centers e.g. TBAs, herbalists ▪ Certain cultural practices promote ill health e.g. wife – inheritance, myths in the community (HIV is a curse 🡪 stigmatization; TBAs have more experience in assisting a circumcised woman to deliver); husband breastfeeding the other breast

AGRICULTURAL SECTOR ▪ Positive:

▪ Good nutrition is encouraged by the society esp. in women to boost maternal and child health e.g. woman in West and South Africa as well as Western Kenya are encouraged to be well built

▪ Farming and dairy production is a common economic activity in the African set up which promotes natural and healthy feeds which are cost – effective

▪ Negatives:

▪ Increased spread of infections e.g. brucellosis in dairy producing areas

▪ Increased use of pesticides has deleterious effects on health ▪ Tendency to move from food crop to cash crop

EDUCATION SECTOR ▪Positive:

▪Particular health promotion activities are being encouraged in schools, churches etc. e.g. safe sexual practices, handwashing etc.

▪Embracing basic education in the community resulting in increased health literacy levels in the community

▪Negative:

▪Spread of communicable diseases e.g. chicken pox etc.

WORK ENVIRONMENT SECTOR ▪Negative: 

▪at the work environment, individual health is not prioritized above overall productivity.

▪Positive:

▪Health insurance

PHYSICAL ENVIRONMENT SECTOR ▪People are encouraged to plant trees 

▪Negative:

▪Cutting down trees 🡪

deleterious effects on the environment.

QUESTION 2 ▪Define the cultural model of health & apply to a disease or condition of your choice.

DEFINITION ▪Culture is what defines a community ▪It is a belief system of any given community 

▪Shared knowledge based on socialization ▪Identifiable practices that are unique to a particular community

What is a cultural model ▪This is what a culture defines health in its own terms. 

▪E.g. culturally, a para 6 + 0, should be able to deliver on her own as she must have experience. Medically, such a woman is a high risk patient and requires skilled obstetric care.

Emic vs etic perspectives

EMIC (*‘insider perspective’*) • From within the social group • This evaluates how local people think, how they perceive and 

categorize the world, their rules for behavior, what has meaning for them and how they imagine & explain things.

• This approach is subjective. • Emphasizes differences between cultures

• Assumes behavior patterns are unique to a culture.

• Emic data is used to describe the perspective of a specific society, group or individual.

ETIC (*‘outsider perspective’*) • From the perspective of the observer 

• This approach is scientist – oriented and is objective.

• It realizes that members of a culture are often too involved in what they are doing to interpret their cultures impartially.

• Emphasizes similarities between cultures

• Assumes behavior patterns are universal

• Etic data can be used to compare the traits, views and patterns of diverse societies, groups or individuals.

Cultural model ▪ Illnesses and health are perceived as cultural phenomena

▪Based on cultural ideas of disease causation

▪Attribution of ill health to witchcraft, evil eyes, taboos and transgression e.g. malnutrition & HIV./ AIDs

▪ Influences health seeking behavior

▪Supernatural forces lead to fatalism and resignation

▪**EMIC perspectives**; reflects the views of an insider which seem irrational to an outsider.

Examples of cultural practices ▪FGM & circumcision 

▪Scarification among the Pokot

▪Removal of teeth

▪Foot biding among girls in ancient china ▪Widow inheritance

▪Anorexia nervosa

▪Bulimia nervosa

FGM ▪Communities that practice it view it as a good cultural practice with the following relevance:

▪Transition period to adulthood and marriage ▪Hygiene

▪Beauty

▪But there is a negative health impact such as: ▪Obstetric and gynecological problems e.g. complicated deliveries, dysmenorrhea, PPH & perinatal deaths

▪Physical and mental trauma

question 3 ▪What is the role of gender in health? 

Illustrate with examples.

What is gender? ▪ Gender is the state of being male or female with reference to social and cultural differences rather than biological ones i.e.

the socially constructed roles, behaviors, activities and attributes that a given society considers appropriate for men and women.

▪ This differs greatly from “sex” which is the biological and physiological characteristics that define women and men.

▪ As for health, it is a state of complete ***physical***, ***mental*** and ***social wellbeing***, not just the absence of disease or infirmity.

▪ Health can influence an individual’s ability to reach his or her full potential in society.

How do the 2 relate to each other? ▪This connection stems from the idea that the different genders should be treated differently and separately from one another. 

▪These ideas themselves stem from society and cultural ideologies that plague both men and women based on roles assigned to each.

▪In short, by being a woman or a man in the eyes of society, certain treatment tailored to the gender role you have been assigned comes your way be

it beneficial or detrimental. This not only affects the social aspect of health but it could also affect the other aspects of health as well such as physical, mental, emotional and even sexual.

CONT. ▪ This eventually results in health inequity or disparities based on gender roles assigned to an individual, which obviously

goes against the idea of fair opportunity to attain one’s full health potential.

▪ Based on this, one could argue that the role of gender in health is to cause disharmony and bring about a lack of fairness and injustice in the process of obtaining health. Sad to say it is indeed the crux of the issue but through this injustice, a means to fight back can be devised.

▪ So in an actual sense, the role of gender in health is to aid in reviewing and addressing the social determinants of health appropriately so as to promote social justice and health equity for all.

HOW IS GENDER USED IN MATTERS OF HEALTH? 

▪As mentioned earlier, by looking into the social injustice caused by gender roles, we health workers are able to pinpoint issues of concern and not only bring them to light but also manage them as best as we can. This is known as ***gender analysis.***

▪To start with, it is indeed women that suffer greatly due to assigned gender roles and relations. By structuring society in such a way, we make women more vulnerable to abuse and mistreatment making them more prone to illness and early death. Examples;

CONT. ▪ In some societies women are shunned from attaining tertiary education and forced to live uneducated lives which could result in poor health. ▪ Some women are mutilated as seen in FGM cases predisposing women to poor health in various aspects apart from physical.

▪ Societies functioning on a patriarchal framework predispose women and girls to physical, emotional and sexual abuse simply due to being viewed as property or seen as socially inferior to men.

▪ Healthcare systems though meant to provide and promote good health for all could be influenced by societal norms that in one way or another could be biased to women.

▪ It is important to note that men and boys could also suffer from health inequities due to assigning masculinity to aggressive and confrontational behavior

EXAMPLES OF HEALTH DISPARITIES DUE TO MALE GENDER 

▪ There is the issue of having more women based care in health systems compared to male based care centers. Due to the idea of men being hardy society does not see the need to invest in male health care.

▪ To add injury to insult most of these male healthcare clinics limit their services to urological conditions and infertility. In comparison to women healthcare clinics which receive multidisciplinary health services from gynecologic to obstetric to infertility, antenatal healthcare and breast care.

▪ There is also a noted predominance of screening and preventive procedures which are more women focused than men focused.

CONT. ▪The best way forward is through gender analysis which reveals how inequalities 

disadvantage men or women and the constraints they both face to attain health. This has been followed through by; ▪Gender mainstreaming.

▪Female empowerment.

GENDER MAINSTREAMING ▪This is the process of assessing the implications for women and men in any planned action such as in legislation, policy formation or programs. This means that any action taken is meant to consider how it will affect both men and women in the short term and in the long run. Be it in government or in the private sector.

▪This goes a long way in ensuring gender equality.

FEMALE EMPOWEREMENT ▪Since women are most affected by this inequity, their empowerment is only necessary for a move forward in the right direction.

▪This is seen in;

▪Women gaining land rights.

▪Having monetary power.

▪Participation in various forums e.g. the political field, schools, households..

▪Giving microcredit to women.

▪Providing education for them.

QUESTION 4 ▪In Kenya while over 90%of women attend ANC services just about half deliver in a health 

facility. Account for this discrepancy.

▪ Distance from the hospital and unavailability of transport and proper infrastructure.

▪ Lack of awareness, esp. amongst multiparous women who do not see the need of going to hospital to deliver.

▪ Lack of finances.

▪ 3 delays:

▪ Decision to seek health

▪ Culture

▪ Low SES

▪ Myths & misconceptions

▪ Previous mistreatment in hospital 🡪 lack of confidence in hospital

▪ Home is more comfortable

▪ Lack of support from immediate family & spouse

▪ Reaching the health facilit

CONT. ▪ 2nd delay

▪ Scarcity of health facilities in the immediate vicinity of the mothers

▪ Poor infrastructure: roads etc.

▪ 3rd delay: in receiving adequate TREATMENT ▪ Understaffing

▪ Inadequately trained and poorly motivated staff

HOW TO SOLVE THIS ▪ Create public awareness about the importance of delivering in a health facility (health education)

▪ Improving physical access of health facilities (appropriate and affordable transport)

▪ Maternal health care costs should be catered for ▪ Linda mama initiative (find out)

▪ Train TBAs

In brief, what is antenatal care? ‘Care during pregnancy’ 

Ideally, should be eight ANC visits in an uncomplicated pregnancy as recommended by WHO.

(WHO) Should include measurement of blood pressure, diabetes, anemia, urine testing for proteinuria/bacteriuria, screening for STIs, malaria etc.

It also includes administering of supplements, vaccination, treatment of infections and controlling comorbidities.

The visits are also used to educate the women and families about danger signs and symptoms and about the risks of labor and delivery.

All this is done with the aim of improving maternal health and survival during the pregnancy and after birth.

Factors that predict place of delivery.

▪ According to a study done in Kenya in 2013 by Kitui et al. , the following factors can strongly predict place of delivery: ⮚Living in urban areas, being wealthy, more educated, using ANC services optimally, lower parity, insurance cover, region, ethnicity, type of facility used, marital status, maternal age

• Women most commonly cited distance and/or lack of transport as the reasons for not delivering in a health facility, but over 60% gave other reasons including 20.5% who considered health facility delivery unnecessary (especially the multipara), 18% who cited abrupt delivery as the reason and 11% who cited high cost.

The discrepancies can be accounted for by these three points: 

▪ Factors that lead to a delay in decision of the mother to seek care.

▪ Factors that lead to a delay in reaching care.

▪ Factors that lead to a delay in receiving adequate

care.

 the mother to seek care, include: 

1. Low socio-economic status of the mother

2. Low level of education/lack of health education

3. Lack of confidence in hospitals – they perceive traditional birth attendants to be effective caregivers.

4. Comfort of home and avoiding hospital stay

5. Previous mistreatment in hospital

6. Culture/ beliefs

7. Lack of social support system

 care. 

1. Distance to health facilities/hospitals

2. Availability and cost of transportation

3. Geography: e.g. mountainous, rivers

 adequate care. 

1. Poor facilities and lack of medical supplies and equipment. 2. Inadequately trained and poorly motivated medical staff 3. Inadequate referral systems