MODULE: COMMUNITY HEALTH

UNIT: PRIMARY HEALTH CARE (PHC) & COMMUNITY BASED HEALTH CARE (CBHC)

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OUTLINE

	Topic and Subtopics	Hours
1.	Primary Health Care (PHC) – Health Services in Kenya, Historical Background and evolution of PHC; Bamako Initiative	2
2.	Primary Health Care (PHC) - Pillars, Principals and Elements	2
3.	Child Health (needs, concepts, feeding, growth and development) and Immunization – vaccines, cold chain, immunizable diseases, harmful practices)	2
4.	Maternal Health – Concepts (morbidity, mortality, safe motherhood, bonding, gender isssues) Harmful practices	2
5.	Kenya (Vision 2030), Millennium Development Goals (MDGs), Sustainable Development Goals (SDGs)	2
6.	Organization of Health Services	2
7.	Community Based Health Services	2
8.	Assignments	4
TOTAL		**20**

Topic 1: PHC – INTRODUCTION & BACKGROUND

Learning Outcomes

At the end of the lesson the learner will be able to
1) Explain the philology of PHC
2) Describes the pillars and principles of PHC

1.0. INTRODUCTION TO PHC

- Main goal of Governments and World Health Organization in embracing the PHC concept aimed at attaining a level of health that would allow all people of the world to lead a socially and economically productive life by the year 2000
- Adoption of the Alma-Ata Declaration and the strategy of "Health for all by the year 2000" set the motion for PHC to became a core policy for WHO in 1978

2.0. DEFINITION OF PHC

- *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)*
- PHC
  i) Includes health promotion, illness prevention, care of the sick, advocacy and community development
  ii) Has systems whose main areas of concern are formed by the community, is dependent upon the general social and economic development of the country
  iii) Focuses on disease prevention and health promotion
  iv) Advocates for healthcare delivery described as 'by the people, of the people and for the people'
  v) Involves the community in the whole process of healthcare delivery and encourages them to maintain their own health with the ultimate goal of better health for all

3.0. PHILOSOPHY, STRATEGIES AND SERVICES

3.1. Philosophy

- PHC represents a **philosophical approach** to health and health care characterized by a **holistic understanding** of health as wellbeing, rather than the absence of disease
- Good health is dependent upon multiple determinants e.g. health services, housing, education, public works, industry, agriculture, communication and other services
- Health status of communities is both a function of and a reflection of development in those communities
- PHC - health services should reflect local needs and involve communities and individuals at all levels of planning and provision of services and eliminate causes of ill health through health promotion and preventive care
- Services and technology should be affordable and acceptable to communities
- PHC should be based upon social, biomedical and health services research in order to provide effective health care
- PHC Philosophy includes
  i) Holistic understanding of health
  ii) Recognition of multiple determinants of health
  iii) Community control over health services
  iv) Health promotion and disease prevention
  v) Equity in health care
  vi) Research-based methods
  vii) Accessible, acceptable, affordable technology

3.2. PHC Strategy

- Involves a **set of strategies** aimed at creating health care consistent with the underlying philosophy and healty education is a key strategy
- PHC services require balance between health promotion, preventive care and illness treatment
- PHC Strategies include
  i) Needs-based planning and decentralized management
  ii) Education
  iii) Intersectoral coordination and cooperation
  iv) Balance between health promotion, prevention and treatment
  v) Multi-disciplinary health workers

3.3. PHC Services

- PHC is the first level of health care (directly accessible to individuals and communities)
- Services include health promotion, disease prevention, and illness treatment and rehabilitation services.

4.0. ALMA ATA DECLARATION

- PHC gained the world's attention after the 1978 International Conference on PHC held at Alma Ata in the USSR (now Almaty in Kazakhstan)
- Countries started the PHC approach to reach rural communities where most of the health problems exist
- PHC forms an integral part of a 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)
- WHO identified five key elements to achieving that goal including
  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)
5) Increasing stakeholder participation

- The 1978 Declaration of Alma-Ata proposed a set of **PRINCIPLES** for PHC that it should: -
  1) Reflect and evolve from the economic conditions and socio-cultural and political characteristics of the country and its communities
  2) Address main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly"
  3) Involve 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
  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"
- Three key ideas saturate the declaration of Alma Ata namely-:
  i) A preference for non-technological interventions (such as nutrition and sanitation)
  ii) Opposition to medical elitism through genuine community involvement in health care strategies
  iii) The notion that health care was inseparable from socio-economic development. Indeed,

5.0. HISTORY OF PHC

5.1. Initiation

- At the end of 60's and during 70's of the last century it was 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 had little success
- All diseases in the developing countries were diseases that could be prevented (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:
  i) Western systems are one-sided oriented, oriented to curative dimensions while neglecting prevention and aspects of social medicine.
  ii) They are too expensive,
  iii) Lack of specialists who can handle the high-technical medicine.
  iv) 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.
- 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
- The strategy was introduced in 1978 in the first conference of WHO for health in Alma Ata/Kazakhstan (in former Soviet Union).
- This concept is deeply concerned with people embracing the principles of participation, social justice, accessibility, appropriateness and acceptance of medical services with consideration of the needs of people in the communities
- 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.

5.2. "Selective" Primary Health Care (SPHC)

- The corporate sector and medical right wing proponents did not embrace the PHC concept thus proposed an alternative system at the Rockefeller Conference (1979) was held to address "disturbing signs of declining interest in population issues"
- Four basic services were to be provided with international Aid - defined as the **G.O.B.I**. approach (**G**rowth Monitoring, **O**ral rehydration, **B**reast Feeding & **I**mmunisation) rather than
  i) Implement costly interventions to eradicate world hunger growth monitoring would be implemented, to see which infants were worst affected.
  ii) Solve basic sanitation issues that resulted in many dying of dehydration from dysentery and diarrhoea, oral rehydration sachets would be distributed.
  iii) 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
  iv) Actively promote health as defined by Alma Ata, specific diseases would be 'selectively' targeted by Immunisation campaigns.

Lessons learnt from SPHC

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

5.3. Holistic Primary Health Care (HPHC)

- At the 30th anniversary of the Alma Ata Declaration (2008), 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 with the 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
- OHO's firm conviction was that PHC was never really given a trial, and that it is even more necessary today than in 1978.
- Based on unification of four of the most important international declarations which summarizes OHO's vision of
  i) The interdependence of human rights
  ii) Community health and ecological harmony
  iii) 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) – 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
     - 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) – upholds the rights and importance of the environment in relation to health
   - An ecologically informed model
   - A view towards sustainable initiatives

Origins and History of HPHC

1) The Barefoot Doctors
   - Story of HPHC begins with China's cultural revolution in 1949 when the entering government found itself facing a health care crisis where there was only one registered and qualified medical doctor for every 10 000 people
   - 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
   - System was recognized by the World Bank and WHO at the time and was considered to be a viable alternative to the western hospital based system

2) A Crumbling Health Care Model
   - After 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 to state "The scientific and technological structures of public health are crumbling".

6.0. CORE ACTIVITIES

- Declaration of Alma-Ata (1978) proposed that core activities should include:
  1) Education - prevailing health problems, 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 & social care of the elderly

7.0. WHO STRATEGIES OF PHC

1) Reduce excess mortality of poor marginalized populations:
   - 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
2) Reduce the leading risk factors to human health:
   - Address known risk factors through preventative and health promotion roles, must, which are the major determinants of health outcomes for local populations
3) Develop 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) Develop an enabling policy and institutional environment

8.0. HEALTH FOR ALL

- The philosophy of health for all was based on 3 pillars
  1) The First Pillar – The rights based approach to healthcare
     - The Universal Declaration of Human Rights (UDHR) is 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'.*
  2) The Second Pillar – The principles of Community Health
     - Creation of health, through community focused programs is a central pillar of a holistic approach to PHC
     - Provision of healthcare should be community oriented as "*people are 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"* (Ottawa Charter of Health Promotion, 1986)
     - Healthcare strategies should be positive, preventative and promotive
     - Adequate Healthcare entails a strong nutritional and lifestyle emphasis
  3) The Third Pillar – the values of ecological sustainability
     - 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 PHC
     - An ecologically informed model with 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 & self-determination).

9.0. 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 immunized against the major diseases of childhood
8) Communicable diseases in the developing countries will be of no greater public health
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

10.0. 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

11.0. THE BAMAKO INITIATIVE

Introduction

- The **Bamako Initiative** was a formal statement adopted by African health ministers in 1987 in Bamako, Mali, to implement strategies designed to increase the availability of essential drugs and other healthcare services for sub Saharan Africa
- The Bamako Initiative, sponsored by UNICEF and WHO and adopted by African ministers of health in 1987, was based on the realization that, despite accepting in principle the core tenets of comprehensive primary health care, by the late 1980s many countries – especially in sub-Saharan Africa – were burdened by a lack of resources and practical implementation strategies
- In the late 1980s many countries were burdened by lack of resources & practical implementation strategies
- Many health facilities lacked the resources and supplies to function effectively forcing the health workers to sometimes prescribe drugs to be bought from private outlets that were mainly unlicensed and unsupervised
- Many patients had lost confidence in the inefficient and under-resourced public health facilities developments that were threatening to reverse the gains of the 1980s
- The major challenges were
  i) To promote additional donor investment
  ii) Stop and reverse the decline of government expenditure on social spending in general and health in particular
  iii) Attract the money spent in the private and informal sectors back into the public system.
- Another influential international policy that impacted on healthcare delivery in sub-Saharan Africa is the Structural Adjustment Program (SAP) in the 1980's
- African countries adopted different implementation routes for BI however the cardinal objective was providing a basic package of integrated services through revitalized health centres that employ user fees and community co-management of funds.
- This was made possible through support structures facilitating "Going to scale" such as
  i) The supply of essential drugs,
  ii) Training and
  iii) Supervision
  iv) Monitoring
- 'Going to scale' moment that pace of expansion was influenced by availability of internal and external resources, local capacity, the need to work at the speed of community needs and not pressure from governments and donors.
- The main mechanism for ensuring accountability was community participation in the management and control of resources at the health-facility level

Aims of Bamako

1) To increase access to PHC by raising effectiveness, efficiency, financial viability and equity of health services
2) To Implement the Bamako health centres as 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.
3) Enhance community participation directly in the management and funding of essential drug supplies,
4) Improve community financing 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
   - Main interventions included

i) Fair prices (below rates in private) and subsidization of drugs prices through higher markup and co-payments
ii) Free supplies of immunization and oral rehydration therapy
iii) Establishment of criteria for exempting the poor (waiver)

5) 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

Pillars of The Bamako Initiative

1) Community participation,
2) Self-financing mechanisms and
3) Regular supply of drugs.

Principles of The Bamako Initiative

1) Improve PHC services for all: **equity;**
2) Decentralize management of PHC services to district level;
3) Decentralize management of locally collected patient fees to community level;
4) Ensure consistent fees are charged at all levels for health services—hospitals, clinics or health centres
5) High commitment from governments to maintain and expand PHC services;
6) National policy on essential drugs should be complementary to PHC;
7) Ensure the poorest have access to PHC (pro-poor policy)
8) Monitor clear objectives for curative health services

Bamako Initiative Results

1) Indicators of effectiveness
   a) Increase in activities and rates of immunization
   b) Increase in antenatal utilization rate
   c) Increase in geographic access to essential generic drugs, but some stock shortages
   d) No clear picture (positives and negatives) of general consultation rates
   e) Low level of cost recovery
   f) Low community participation
2) Indicators of equity
   a) Regional disparity in terms of geographic access to health centres and drugs
   b) Worst-off less likely than the others to use health services
   c) Absence or ineffectiveness of exemption schemes
   d) Worst-off perceive the quality of health care lower than the others
   e) No participation in decisions among women and the worst-off
   f) Tendency toward hoarding and no utilization of cost recovery to increase access for the worst-off
   g) Drug prices and user fees never calculated according to capacity to pay

Topic 2: PILLARS, PRINCIPLES AND ELEMENTS OF PHC

Learning Outcomes

At the end of the lesson the learner will be able to
1) Discuss the pillars and principles of PHC
2) Identify the elements of PHC in Kenya
3) Discuss the elements of PHC

1.0. INTRODUCTION

- Implementation of PHC is based on pillars and principles

2.0. PILLARS OF PHC

	Pillar	Description	Strategies
1.	Social justice	• Equal distribution of available resources	•
2.	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.	•
3.	Community participation	• Participation of the intended groups in planning and carrying out issues related to people's health • Meaningful involvement in planning, implementing and maintaining their health services • Ensures maximum utilisation of local resources, such as manpower, money and materials, can be utilised to fulfil the goals of PHC	•
4.	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	•
5.	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 use	•
6.	Sustainability of the measures	• guaranteeing curative services including services of medicines (self-reliance	•

3.0. PRINCIPLES OF PHC

	Principle	Description	Strategies
1.	**Equity**	• Means health services must be more equally accessible without discrimination, neglect of those in rural, peri-urban and urban areas (services must be equally shared by all the people of the community irrespective of their race, creed or economic status) • 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 neediest and vulnerable groups of the population live • Health services must be shared equally by all people irrespective of their ability to pay and all (rich or poor, urban or rural) must have access to health services. Currently health services are mainly in towns and inaccessibility to majority of population in the developing world	
2.	**Inter-Sectoral Collaboration**	• Need to put all key players in held or other sectors which directly or indirectly affect the delivery or health services to apply together. • PHC involves in addition to the health sector all related sectors and aspects of national and community development, in particular education, agriculture, animal husbandry, food, industry, education, housing, public works and communication. • To achieve cooperation, planning at country level is required to involve all sectors. • Sectors affecting health services directly e.g. transport/infrastructure of roads, finance and poverty levels, security, agriculture, sports, education, NGOs, local government and water department	
3.	**Community participation and involvement**	• Active involvement of the community in decision making • Done through problem identification mobilization of local resources and implementation • Lays emphasis on problem identification-prioritization-allocation of resources-implementation with active involvement of the communit • The involvement of individuals, families, and communities in promotion of their own health and welfare is an essential ingredient of primary health care. • PHC coverage cannot be achieved without the involvement of community in planning, implementation and maintenance of health services.	
4.	**Appropriate Technology**	• Technology that is scientifically sound, adaptable to the local needs, and acceptable to those who apply it and those for whom it is used and can be maintained by the people themselves with the resources of the community and country can afford. • 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	

	Principle	Description	Strategies
5.	Decentralization	• Transfer of authority for planning, decision making and management from higher to a lower level eg ministry to district level with the aim of promoting local participation and services to be more responsive to local needs	
6.	Accessibility	• Ability to utilize a service either by its physical availability, cost affordability or social acceptability • Reachable, convenient services • Geographic, economic, cultural accessibility	
7.	Affordability	• Community members should be able to afford the health services offered	
8.	Health Promotion and Disease Prevention	• Includes behaviour change in relation to many activities eg nutrition, environment and recreation	
9.	Effectivensess and Efficiency	• Methods used to achieve a certain result use the minimum resources (effectiveness) • Get outputs using the least possible resource inputs (efficiency) • Technologies and strategies used in health care work(do what they are supposed to do) – reduce risk, prevent disease or cure diseas	
10.	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	

4.0. ELEMENTS OF PHC

- The Alma Atta conference of 1978 identified elements of PHC; - **8 ELEMENTS** namely **E**ducation (Health Education), **L**ocal Disease Control (endemic disease), **E**PI (Expanded programme on Immunization), **M**CH/FP, **E**ssential Drugs supply, **N**utrition and Food Supply, **T**reatment of common conditions and **S**anitation and clean water supply
- Countries were at liberty to identify other elements based on their needs thus Kenya added two elements - Dental Oral Health and Mental health and later two more - CBR (community based rehabilitation) and HIV / AIDS/STIs

ESSENTIAL ELEMENTS

		Element	Description	Strategies
1.	**E**	Health Education	• Is a process of giving information and advice and facilitating development of knowledge and skills in order to change health behaviour • Is a combination of learning experiences designed to help individuals and communities improve their health by increasing their knowledge or influencing their attitudes (WHO)? • Addresses prevailing health problems and methods of prevention and control • Education for the promotion of health and prevention of diseases remains a critical element.	**RECAP** 1) What is health education? 2) Principles of health education 3) Theories of health education? 4) Stages and process of health education.

		Element	Description	Strategies
			• 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 behaviour	5) Teaching methods and teaching aids relevant in health education 6) Identify opportunities for health education
2.	**L**	Local Disease control	• Include malaria, typhoid fever, ascariasis, anaemia, malnutrition, schistosomiasis, filariasis, hookworm, trachoma and kala azar	
3.	**E**	Expanded programme on immunization	• Has been intensified in Kenya through DVI/KEPI and number of immunizable diseases have increased (Identify the immunizable diseases in Kenya) • Vitamin A has also been in-cooperated as part of immunization schedule	
4.	**M**	Maternal Child health and Family planning	• 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	
5.	**E**	Essential Drug Supply	• Major supplier for drugs is done by KEMSA[1] • 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. • Drug manufacturing industries, pharmacies, shops & commercial outlets for public use.	
6.	**N**	Nutrition and Food Supply	• Through co-ordination of other sectors like Ministry of Health, Agriculture, education and community Development	
7.	**T**	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.	
8.	**S**	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	

[1] Kenya Medical Supplies Agency

		Element	Description	Strategies
			• Critical in prevention of diseases such as water-related, water-based, water-washed, water-borne; Ensure proper waste disposal	
9.	**M**	Mental Health	•	
10.	**D**	Dental Health	•	
11.	**C**	Community Based Rehabilitation (CBR)	• CBR is a strategy within community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities • Implemented through the combined efforts of disabled people themselves, their families and communities, and the appropriate health, education, vocational and social services.	
12.	**H**	HIV/AIDS	•	

Components of CBR

	Component	Description
1.	Creating a positive attitude towards people with disabilities	is essential to ensure equalization of opportunities for people with disabilities within their own community. Positive attitudes among community members can be created by involving them in the process of programme design and implementation, and by transferring knowledge about disability issues to community members.
2.	Provision of functional rehabilitation services	People with disabilities require assistance to overcome or minimize the effects of their functional limitations (disabilities) CBR workers should be trained to provide primary rehabilitation therapy in – Medical, Eye care service, Hearing services, Physiotherapy, Occupational therapy, Orientation and mobility training, Speech therapy, Psychological counselling, Orthotics and prosthetics, Other devices
3.	Provision of education and training opportunities	People with disabilities must have equal access to educational opportunities and to training that will enable them to make the best use of the opportunities that occur in their lives. In communities where professional services are not accessible or available, CBR workers should be trained to provide basic levels of service in the following areas - Early childhood intervention and referral, especially to medical rehabilitation services, Education in regular schools, Non-formal education where regular schooling is not available, Special education in regular or special schools, Sign language training, Braille training Training in daily living skills
4.	Creation of micro and macro income-generation opportunities:	Access to micro and macro income-generation activities, including obtaining financial credit through existing systems, wherever possible. In slums and rural areas, income-generation activities should focus on locally appropriate vocational skills. Training in these skills is best conducted by community members who, with minimal assistance, can
5.	Provision of care facilities	

6.	Prevention of the causes of disabilities:	
7.	Management, monitoring and evaluation:	People must be trained in effective management practices.

EXTENDED ELEMENTS IN 21ST CENTURY

1. Expanded options of immunizations
2. Reproductive Health Needs
3. Provision of essential technologies for health
4. Health Promotion
5. Prevention and control of non-communicable diseases
6. Food safety and provision of selected food supplements

Topic 3: CHILD HEALTH

Learning Outcomes

At the end of lesson, the learner shall be able to
1) Explain the major concepts in child health
2) State causes of child morbidity and mortality
3) Discuss factors affecting child health in the communities

1.0. INTRODUCTION AND DEFINITIONS

1) A child
   - A person below the age of 18, unless the laws of a particular country set the legal age for adulthood younger (The Convention on Child Rights)
   - The Criminal Law Amendment Act
     - Minimum age of sexual consent to 16 years (the Penal Code – applicable to girls and 12 years for boys (presumed to be incapable of having carnal knowledge)
     - Minimum age for criminal responsibility - 8 years
   - Children's Act - defines a child" as any human being under the age of eighteen years
   - Employment Act (section 2) - an individual male or female who has not attained the age of 16 years
   - Infants – Children under the age of 12 months (Department of Health 2003)
   - Legal age – child refers to a minor who is generally understood as a person younger than the age of **majority**
2) Infant - typically applied to a child between ages of 1 – 12 months
3) Neonate - baby aged 0 – 28 days (premature, post mature and full term babies)

2.0. KEY CONCEPTS IN CHILD HEALTH

1) Basic Needs of a Child

- Almost the same for neonates, infants and toddlers but attention is given to special groups
  i) Breathing
  ii) Feeding/nutrition - Breast feeding, supplementary and complementary feeding
  iii) Warmth - kept warm from birth to avoid hypothermia because child losses heat through radiation (cold clothing, cold objects), conventional (cold air circulating carries away heat) and evaporation
  iv) Infection prevention - personal and environmental hygiene, hand washing, decontamination (process of rendering instruments free of microorganisms), sterilization (uses hot air or steam to kill microorganisms), proper storage, high level disinfection, proper waste disposal and immunization
  v) Protection against injuries - care by adults and a safe environment for play
  vi) Immunization
  vii) Company and security
  viii) Shelter – housing
  ix) Play – play ground, space, time
  x) Clean environment -

2) Child Health – Key Players

Introduction

- Child health is a state of physical, mental, intellectual, social and emotional well-being and not merely the absence of disease or infirmity
- Healthy children live in families, environments, and communities that provide them with the opportunity to reach their fullest developmental potential

The Role of Social Institutions

What is the role of the social institutions in promoting child health?

The Role of the Community in Promoting Child Health

What is the role of the community in promoting child health?

3) **Immunization**
4) **Child Nutrition**
5) **Growth and Development**

6) **Child Morbidity (Common Childhood Disorders)**

- Common childhood problems include obesity, protein energy malnutrition (kwashiorkor & marasmus), upper respiratory tract infections, gastroenteritis, diarrhoea and vomiting, worm infestation, fungal infections, ear infections, pneumonia, malaria and HIV/AIDS
- Integrated Management of Childhood Illness (IMCI)
  - An integrated approach to child health focusing on the well-being of the whole child
  - Aims to reduce death, illness and disability, and to promote improved growth and development among children under five years of age
  - Includes both preventive and curative elements that are implemented by families and communities as well as by health facilities
  - Strategy includes three main components of improving case management skills of health-care staff, overall health systems and family and community health practices.

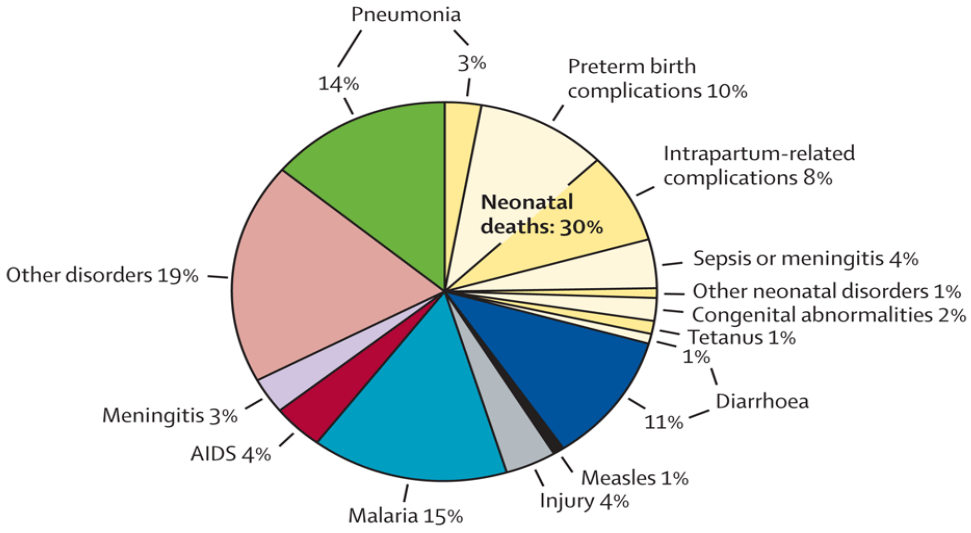
7) **Child Mortality**

Introduction

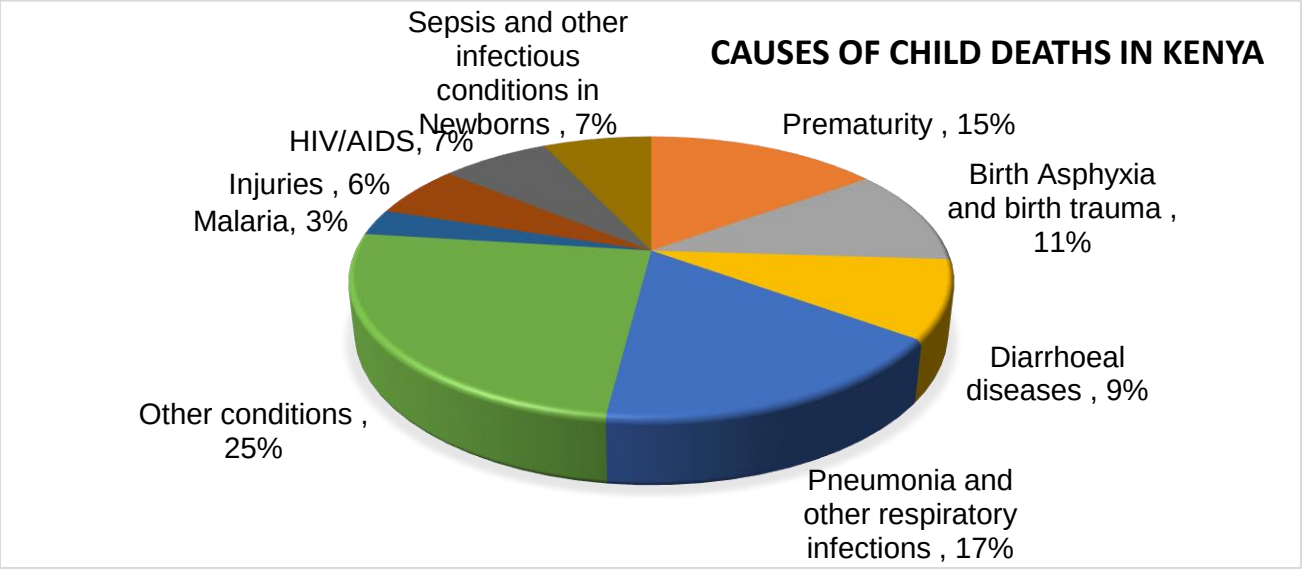
- Over 3 million new-borns and 7.6 million Children under the age of 5 died in 2010 a decline of only 600,000 in 10 years
- Kenya is one of many sub-Saharan African countries that battle various life-threatening diseases that can be prevented by the right combination of education and resources
- About one in every fourteen babies born in Kenya will die before their first birthday and about one in every nine children die before their fifth birthday

Causes of Child Mortality

Sub Saharan Africa



Kenya



8) Child Protection, Rights, Responsibilities & Obligations

Rights of the Child

Convention on Child Rights

1) Life
2) Non-discrimination
3) Protection from all forms of violence by care givers
4) Protection from economic exploitation
5) Protection from all forms of sexual exploitation and sexual violence and from abduction, sale and trafficking in children
6) Protection from torture and other cruel, inhuman or degrading treatment

Kenyan Constitution

1) Life
2) Care – parents
3) Food
4) Education - responsibility of the Government and the parents (every child shall be entitled to free basic education which shall be compulsory in accordance - article 28 of the UN Convention on the Rights of the Child)
5) Shelter
6) Water
7) Health and medical care - responsibility of the parents and the Government
8) Identify
9) Freedom
10) Privacy
11) Protection - a child shall be entitled to protection from physical and psychological abuse, neglect and any other form of exploitation including sale, trafficking or abduction by any person.
12) No child shall be subjected to discrimination on the ground of origin, sex, religion, creed, custom, language, opinion, conscience, colour, birth, social, political, economic or other status, race, disability, tribe, residence or local connection

Duties and Responsibilities

1) Work for the cohesion of the family
2) Respect parents, superiors and elders at all times and assist them in case of need;
3) Serve national community by placing his/her physical and intellectual abilities at its service
4) Preserve and strengthen social and national solidarity
5) Preserve and strengthen the positive cultural values of his/her community in his relations with other members of that community

Child Protection Laws

Identify any 5 child protection laws in Kenya excluding the Children's Act (Cap 141) of 2010

Institutions for Child Protection and Care

1) The family - The Local and International community; The Government - National – Executive, Judiciary and Legislature/County Governments; Government agencies - Child welfare society of Kenya; UN agencies – WHO, UNICEF, UNESCO, UN Habitat, UNHCR; NGOs e.g. Care International, Orphanage homes; Social Institutions; Health facilities; All institutions dealing with children

3.0. CHILD NUTRITION

3.1. Introduction

- Infant & young child feeding is a cornerstone of care for childhood development
- World-wide about 30% of children under 5 are stunted as a consequence of poor feeding and repeated infections
- The Global Strategy for Infant and Young Child Feeding aims to rejuvenate efforts to promote, protect and support appropriate infant and young child feeding
- Strategy calls for action in the following areas: -
  i) Governments - develop and implement a comprehensive policy on infant and young child feeding
  ii) All mothers - have access to skilled support to initiate and sustain exclusive breastfeeding for 6 months and ensure the timely introduction of adequate and safe complementary foods with continued breastfeeding up to two years or beyond
  iii) Health workers - be empowered to provide effective feeding counselling, and their services be extended in the community by trained lay or peer counsellors
  iv) Governments - review progress in national implementation of the International Code of Marketing of Breast Milk Substitutes, and new legislation or additional measures needed to protect families from adverse commercial influences
  v) Governments - enact imaginative legislation to protect breastfeeding rights of working women and establish means for its enforcement in accordance with international labour standards
  6

3.2. Definitions (UNICEF 2010)

1) Exclusive breastfeeding or totally breastfeeding - Infant has received only breast milk from his/her mother or a wet nurse, or expressed breast milk, and no other liquids or solids, with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines
2) Predominant breastfeeding - infant's predominant source of nourishment has been breast milk; however, the infant may also have received water and water-based drinks (sweetened flavoured water, teas, infusions etc.); fruit juice; oral re-hydration salts solution; drop and syrup vitamins, minerals and

medicines; and ritual fluids (in limited quantities). With the exception of fruit juice and sugar-water, no food-based fluid is allowed under this definition
3) Full breastfeeding - includes both exclusive and predominant breastfeeding
4) Partial breastfeeding - refers to a situation where the baby is receiving some breastfeeds but is also being given other food or food-based fluids, such as artificial milk or weaning foods
5) Bottle-feeding - infant has received liquid or semi-solid food from a bottle with a teat/nipple. The term applies irrespective of the nature of the liquid or semi-liquid
6) Artificial feeding - infant who is artificially fed receives no breast milk at all
7) Infant formula - foodstuffs intended for particular nutritional use by infants during the first months of life and by themselves satisfy the nutritional requirements of such infants, until the introduction of appropriate complementary feeding.

3.3. Feeding Practices in African Communities

- Feeding in the African communities includes food choice and preparation, storage and practices (breast feeding; bottle feeding; cup and spoon)

Food Choice and Preparation

What influences food choices for child in Kenyan communities?
How is food for children prepared among the Kenyan communities?

Food Storage

Identify and evaluate how the food for children is stored among the various Kenyan communities?

Feeding Practices

1) Breast Feeding

Introduction

- Breast feeding is an unequalled way of providing ideal food for the healthy growth and development of infants as well as an integral part of the reproductive process with important implications for the health of mothers
- Infants **should be exclusively breastfed for the first six months** of life to achieve optimal growth, development and health
- To meet their evolving nutritional requirements infants should receive nutritionally adequate and safe complementary foods while breastfeeding is continued up to 2 years of age or beyond (WHO, 2002).
- Exclusive breastfeeding is recommended up to 6 months of age, with continued breastfeeding along with appropriate complementary foods up to 2 years of age or beyond

Technique

- Although breastfeeding is the natural method of feeding a baby, it is a skill that must be learned in order to be effective and enjoyable
- Correct positioning of the baby is important because proper positioning
  i) Allows the baby to empty or "milk" the breast efficiently and in turn, efficient milking stimulates breasts to produce the amount of milk your baby needs
  ii) Can help prevent or greatly minimize sore nipples or other complications.
- Ensure appropriate attachment
- When a baby has learned to grasp the breast properly and obtain milk efficiently, that baby is said to be "latched" onto the breast.

Manual Expression of Breast Milk

- Reasons for expressed breast milk
  i) Initiate flow and assist an infant to grasp the breast properly
  ii) Encourage milk production early in lactation when an infant is premature or ill
  iii) Relieve breast congestion
  iv) Remove milk when it is not possible to nurse an infant at a given feeding
  v) Maintain lactation when an infant cannot be fed
  vi) Pump and save milk for feeding an infant at another time
  vii) Contribute to a milk bank
  viii) Pump and discard milk while temporarily in a specific medication

Breast Feeding Positions

	Position	**Indications**	**Not Preferred**
1.	Traditional or cradle hold (tummy to tummy)	1. Full term baby, all new born babies	After C/S
2.	Cross cradle hold (tummy to tummy	1. Early days of breast feeding 2. Small babies 3. Mother with big breasts 4. Mother with flat or short nipples	
3.	Football (Clutch) position	1. After C/S 2. Big breasts 3. Flat nipples 4. Twins 5. Small babies	
4.	Side lying position	1.	
5.	Chest position	1.	
2.	Under-arm	1.	


Chest position – immediately after birth


Cradle position


Cross cradle for small infants

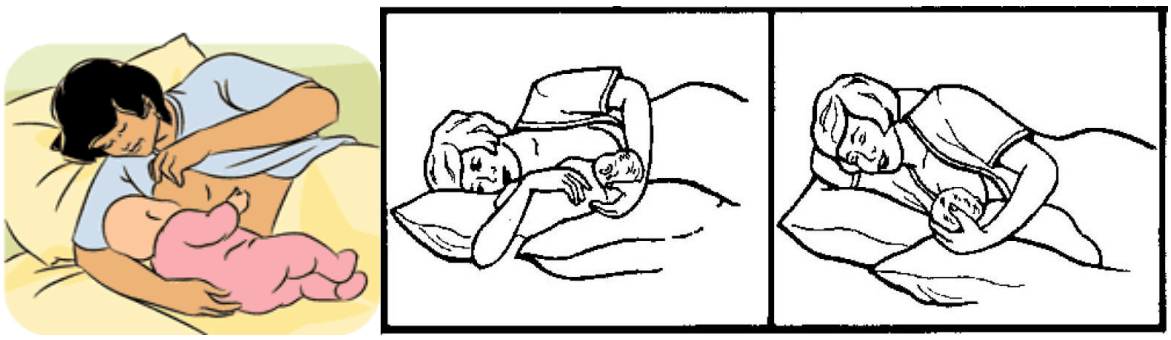

Hand expression


Lying down


Under arm position


Under arm position for twins


Cross position for twins



Advantages of Breast Feeding and Breast Milk

Breast Milk (For the Baby)

i) Best natural food for babies - easy digestion and assimilation
ii) Has protein in a more soluble form hence easily digested and absorbed
iii) Fat and calcium in human milk is easily absorbable
iv) Milk sugar (lactose) provides ready energy
v) Always clean
vi) Protects the baby from diseases (antibodies) and allergies
vii) Available 24 hours a day and requires no special preparation
viii) Does not need to be purchased
ix) Constantly changes in its composition to meet the changing needs of the baby
x) Reduces the risk of sudden infant death syndrome (SIDS)

The Mother

i) Special bond and relationship between mother and baby
ii) Family planning (lactational amenorrhoea)
iii) Helps the mother to shed extra weight gained during pregnancy
iv) Causes the uterine to contract lessening the risk of post-partum haemorrhage
v) Quick involution of the uterus
vi) Reduces the risk of diabetes, postpartum depression, breast cancer,

Society Benefits

i) Reduced medical care costs
ii) Employer medical costs are low
iii) Contributes to a more productive workforce
iv) Reduced financial burden of the family

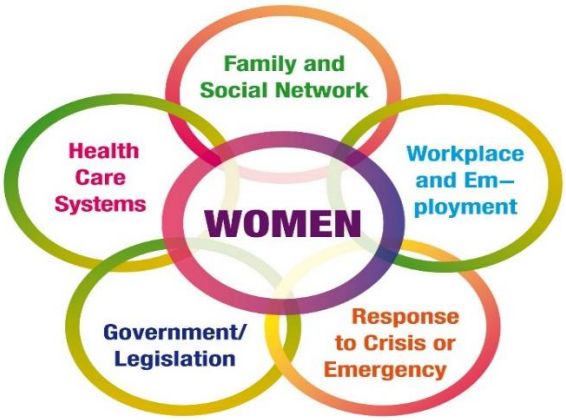
Breast Milk Vs Cow's Milk and Formula Milk

State the similarities and differences between breast milk and cow's milk; breast milk and formula milk

The Circles of Support

- Include the family and social network, healthcare, workplace and employment, government/ legislation and response to crisis or emergency, all surrounding women in the centre circle.
    1) Women in the Centre Circle
        - Active participants in the support dynamic, being both providers and recipients of information and support

2) Family and Social Network
   - Husbands/partners/fathers, family and friends compose the mother's immediate and continuous support network
   - Social support includes community support - at the market place, within a religious context, at a neighbourhood park, etc.
   - Support during pregnancy reduces stress
   - Support during labour and birth empowers the mother
   - Societal support increases the mother's confidence in her ability to breastfeed beyond the early weeks and months



3) Health Care Systems
   - Has a multitude of opportunities to support breast feeding e.g. mother friendly prenatal care and supportive labour and delivery services to postpartum and postnatal care that facilitates bonding and optimal infant feeding.
   - Health workers trained in counselling skills support mothers before & after birth

4) Workplace and Employment
   - Need support at the workplace to succeed at working and breastfeeding.
   - Opportunities for mother support are as varied as the work women do, but usually involve facilitating mother-baby contact or expression and storage of breast milk.

5) Government/Legislation
   - Support of international documents, protections for optimal infant feeding, plus active and well-funded national commissions.
   - Legislation that combats aggressive marketing of breast milk substitutes and enacts paid maternity leave also benefits breastfeeding women.

6) Response to Crisis or Emergency
   - Represents the need for support if a woman finds herself in an unexpected and/or serious situation, with little control
   - Situations that require special planning and support include natural disasters, refugee camps, and divorce proceedings, critical illness of mother or baby, or living in an area of high HIV/AIDS prevalence with no support for breastfeeding.

Challenges Facing Breast Feeding

1) Sore nipples
2) Low milk supply
3) Oversupply of milk
4) Engorgement

5) Plugged ducts
6) Breast infection/inflammation (mastitis)
7) Infections
8) Poverty
9) Nursing strike

- Occurs when a baby who has been breastfeeding well for months suddenly begins to refuse the breast
- Baby is trying to let you know that something is wrong (not that baby is ready for weaning)
- Major causes include:
  i) Pain - teething, a fungal infection (thrush, cold sore, ear infection), injury, certain breastfeeding position, or from soreness from an immunization
  ii) Being upset about a long separation from the mother or a major change in routine
  iii) Being distracted while breastfeeding — becoming interested in other things
  iv) A cold or stuffy nose that makes breathing while breastfeeding difficult
  v) Reduced milk supply from supplementing with bottles or overuse of a pacifier
  vi) Responding to the mother's strong reaction if the baby has bitten her
  vii) Being upset about hearing arguing or people talking in a harsh voice while breastfeeding
  viii) Reacting to stress, overstimulation, or having been repeatedly put off when wanting to breastfeed

10) Employment
11) Inverted, flat or very large nipples
12) Health problems – cleft lip/cleft palate, malformations
13) Special situations– twins/triplets/quadruplets, pregnancy, adoption, after surgery

2) Bottle Feeding

- What are the indications for bottle feeding?
- What are the requirements for bottle feeding?
- What are the dangers associated with bottle feeding?

3) Cup and Spoon Feeding

- What are the indications for cup and spoon feeding?
- What are the requirements for cup and spoon feeding?
- What are the dangers associated with cup and spoon feeding?

4) Complementary and Supplementary Feeding

Supplementary Feeding

- Supplementary feeding is the feeding **provided in place** of breastfeeding
- Include expressed or banked breast milk
- Any foods given prior to 6 months, the recommended duration of exclusive feeding, are thus defined as supplementary
- Possible indications for supplementation in term, healthy infants
  1) Infant indications
     - Hypoglycaemia (infant has had adequate opportunity to breastfeed)
     - Clinical evidence of significant dehydration
     - Weight loss of 8% to 10% accompanied by delayed lactogenesis (day 5 ±)
     - Delayed bowel movements or continued meconium stools on day 5
     - Insufficient intake despite an adequate milk supply
     - Hyperbilirubinemia
     - Breastfeeding jaundice where intake is poor despite appropriate intervention

- Breast milk jaundice when levels reach >20–25 mg/dL in an otherwise thriving infant and where a diagnostic interruption of breastfeeding may be helpful
- Low birth weight
- When sufficient milk is not available
- When nutrient supplementation is indicated

2) Maternal indications
- Delayed lactogenesis (day 5 or later) and inadequate intake by infant
- Intolerable pain during feedings unrelieved by interventions
- Unavailability of mother due to severe illness or geographic separation
- Breast pathology or prior breast surgery resulting in poor milk production
- Delayed lactogenesis
- Retained placenta (lactogenesis probably will occur after placental fragments are removed)
- Sheehan syndrome (postpartum haemorrhage followed by absence of lactogenesis)

Complementary Feeding
- Feeding provided in addition to breastfeeding
- Term is used to describe foods given in addition to breastfeeding after 6 months, a "complement" to breastfeeding needed for adequate nutrition
- Supplementation can prevent the establishment of maternal milk supply, have adverse effects on breastfeeding (e.g., delayed lactogenesis, maternal engorgement), alter infant bowel flora, sensitize the infant to allergens (depending on the content of the feeding and method used), and interfere with maternal-infant bonding
- Before supplementary feedings are begun, it is important that a formal evaluation of each mother-baby dyad, including a direct observation of breastfeeding, is completed

5) Harmful Traditional Feeding Practices

- Based on tradition, culture, custom and practice, religion and/or superstition
- Committed and actively condoned by the child's parents or significant adults within the child's/young person's community
- Many involve physical abuse and pain leading, in some cases intentionally, to death or serious injury. Others involve mental abuse.
- Force-feeding is also a harmful traditional practice. Others include food taboos and belief; food preparation and storage methods.

6) School Feeding Programs (SFPs)

- Have been implemented in Kenya since 1980's
- Is a partnership between the Ministry of Education and the World Food Programme to promote universal basic education among disadvantaged children
- Target group are pre-primary and primary school pupils in ASAL districts and urban slums
- Achievements of SFPs
  i) Increase children's educational achievement so as to improve their potential future productivity and earnings
  ii) Alleviate short term hunger which improves children's cognitive functioning and attention span
  iii) Improves nutritional status of children by providing them calories and nutrients in addition to their regular diet
  iv) Enhance enrolment in school and better educational outcome

v) Better health and better resistance to infectious diseases and illnesses that would keep children from attending school

3.4. Challenges Child Feeding

- Congenital malformations; poverty; illness; cultural beliefs and taboos; maternal illnesses; ignorance; large families; food insecurity; maternal death; adoption and occupation/employment

> Explain how these challenges arise and how they can be mitigated or surmounted

4.0. CHILD GROWTH AND DEVELOPMENT

4.1. Introduction

- Growth and development go together but at different rates
- Growth is the progressive increase in the size of a child or parts of a child. It refers to specific body changes and increases in the child's size (height, weight, head circumference, BMI)
- Development is an increase in complexity (a change from simple to more complex) and progressive acquisition of various skills (abilities) such as head support, speaking, learning, expressing the feelings and relating with other people
- Development involves a progression along a continuing pathway on which the child acquires more refined knowledge, behavior, and skills
- Importance of assessing growth and development
  i) Indicate the state of health and nutrition of a child
  ii) Monitor continuous normal growth
  iii) Determine abnormal growth or growth failure

Differences between Growth and Development

	Growth	**Development**
1.	Is indicative i.e. increase in body, size, weight, height etc.	Not indicative
2.	Quantitative progress	Qualitative progress
3.	Physical change	Psychological change
4.	External in nature	Internal in nature
5.	Stops at a certain stage	Continuous process
6.	Physical progress	Cognitive progress

4.2. Factors Influencing Growth

i) Genetic - short parents are more likely to have short children
ii) Environmental - general health and maternal age, parity, socio-economic status and substances such as smoking affect birth weight and growth
iii) Nutritional - breastfed infants have different growth in the first year of life compared to non-breastfed babies.
iv) Biological causes - children who are large for gestational age at birth following exposure to an intrauterine environment of either maternal diabetes or maternal obesity are at increased risk of developing later obesity and metabolic syndrome.

4.3. Child Development

Principles of Child Development

- Principles of child development state that
  - i) Developmental sequence is similar for all
  - ii) Development proceeds from general to specific
  - iii) Development is continuous
  - iv) Development proceeds at different rates

Domains of Development

1) Physical Development - refers to typical growth patterns, changes in weight and height, general health and safety, visual perception, hearing and understanding the roles of health care professionals
2) Motor Development - child's ability to move about and control various body parts e.g. performances like grasping, rolling over, sitting up, hopping on one foot, writing their names and using tools for tasks
3) Social & Emotional Development
   - Broad area focusing on how children feel about themselves and their relationships with others
   - Refers to children's individual behaviors and responses to play and work activities, attachments to parents and caregivers, relationships with siblings and friends and pro-social behaviors
4) Cognitive Development - involves intellectual development
5) Personality Development
   - v) All areas of development are interrelated

Stages of Development

Stage	Period	Features
Infancy	From birth to 2 years	• Develop bonds with others; Communicate non-verbally; Rapid physical growth; Begins to explore the world; Develop skills of learning about the world; Very dependent; Establish behavioural tools
Early childhood	2 – 6 years	• Ability to communicate will increase greatly; Language skills are very active; Extremely predominant creativity and imagination; Physical changes; Marked emotional development marked by affection, trust, and occasional selfishness; child is very interactive
Middle childhood	6 – 10 years	• Social bonds dominate and friendship is very important; Learn a lot through social interaction and peers; Focus more on reality than imagination, and responsibilities become introduced; Physically - more athletically active
Early adolescence	10 – 14 years	• Puberty occurs with many physical changes and emotional developments; Strongly impacted by the opinions of peers; Thinking abilities increase heavily; Cognitive ability (think, reason creatively, and for many hours on end occurs during this stage; Development occurs through perception of the world and their peers
Late adolescence	14-18	• Opinions of peers and relationships with peers are still held highly; Decisions are another important focus of children during this stage of development

Child Development Theories

1) Maslow and the Hierarchy of Needs
   - Developed a hierarchy of human needs (5 – 8 levels)
   - One set of things is dependent on the next, both of which are dependent on the next

2) Sigmund Freud (Psychosexual Theory)

- Psychological development in childhood takes place in a series of fixed stages
- As a person grows physically certain areas of their body become important as sources of potential frustration (erogenous zones), pleasure or both.
- **5 STAGES** – Oral (0 – 1), anal (1 – 3), phallic (3 – 6), latent (6 – puberty) and genital (puberty – adult)

3) Erik Erikson - Developmental psychologist (Psychosocial Theory)
   - Determined 8 psychosocial stages through which humans develop throughout their entire lifetime
   - Individuals must go through each of these stages, called —**conflicts**
   - Moving successfully through these develops a strong social and emotional life
   - **8 STAGES** - trust versus mistrust; autonomy versus shame & doubt; initiative versus guilt; industry versus inferiority; identity versus identity confusion; intimacy versus isolation; generativity versus stagnation; and integrity versus despair.

4) Jean Piaget (Cognitive Development Theory)
   - Interested in psychology of intelligence (intellectual understanding of the world)
   - Based on the concept of cognitive structures (patterns of physical or mental action that underlie acts of intelligence and correspond to stages of child development)
   - Children develop the ability to learn in four basic stages with each stage focusing around acquiring a different set of related characteristics and abilities
   - **4 STAGES** - sensorimotor, preoperational, concrete operational, and formal operational

5) Urie Bronfenbrenner (Ecological Development Theory)
   - Believed that a person's development was affected by everything in their surrounding environment.
   - **5 LEVELS**
     i) Microsystem (system closest to the person and have direct contact e.g. home, school, day-care, peers, caregivers or work)
     ii) Mesosystem (interactions between different parts of a person's microsystem)
     iii) Exosystem (a setting that does not involve the person as an active participant, but still affects them but decisions made have bearing on the person e.g. a parent receiving a promotion at work or losing their job)
     iv) Macrosystem (cultural environment in which the person lives and all other systems that affect them e.g. the economy, cultural values, & political systems)
     v) Chronosystem (encompasses the dimension of time as it relates to a child's environments. Elements within this system can be either external, such as the timing of a parent's death, or internal, such as the physiological changes that occur with the aging of a child)

6) Lawrence Kohlberg (Moral Development Theory)
   - Described three stages of moral development (process through which people learn to discriminate right from wrong and develop sophisticated appreciations of morality)
   - Stages are cumulative with each built off understanding & abilities gained in prior stages
   - Moral development is a lifelong task, and many people fail to develop the more advanced stages of moral understanding
   - **3 STAGES**
     i) Pre-conventional level (morality is essentially only driven by consequences only)
     ii) Conventional (believe that following the rules is the best way to promote good personal relationships and a healthy community)
     iii) Post-conventional (people determine what is moral based on a set of values or beliefs they think are right all the time)

7) Lev Vygotsky (Social Development Theory)
   - Children acquire knowledge through culture and learn through problem-solving experiences shared with a knowledgeable adult or peer
   - Initially, the person interacting with the child assumes more responsibility for guiding the learning as the child learns, the responsibility is gradually transferred to him (an instructional technique called **scaffolding**)
   - Social interaction plays a fundamental role in the development of cognition.
   - Involves **three major themes**
     i) On the social level between people (inter-psychological) and then inside the child (intra-psychological)
     ii) More Knowledgeable Other (MKO) – anyone who has a better understanding or ability with respect to a particular task, process or concept is thought of being a teacher, coach or older adult
     iii) Zone of proximal development (ZPD) attained when children engage in social behaviour. Full development of the ZPD depends upon full social interaction

4.4. Physical Development

- Factors that affect physical development:
  i) Genetic and hereditary - physical growth is governed by hereditary factors
  ii) Hormones
  iii) Environmental factors e. g. food, education, family income and infections
  iv) Gross and fine motor skills
  v) Play
     - Healthy physical development
     - Contributes to children's fine (e.g. writing) and gross motor (e.g. hopping, skipping, football) skill development & body awareness as they actively use their bodies
     - Enables them to feel physically confident, secure, and self-assured
     - Valuable for children with joint or muscular illnesses, e.g. juvenile rheumatoid arthritis, multiple sclerosis
     - Help build or maintain energy, joint flexibility, and muscular strength
     - Development of social skills and an increasing ability to endure stressful situations

4.5. Emotional Development

- Is the emergence of a child's experience, expression, understanding, and regulation of emotions from birth through late adolescence?
- Comprises how growth and changes in these processes concerning emotions occur.
- Factors driving emotional development include
  i) Hereditary factors
  ii) Maturation level of the child
  iii) Training
  iv) Soundly healthy children have better control their emotions

v) Intelligent children are emotionally stable
vi) Family relation - relation of family members with each other and how they express their emotions affects the emotional behaviour of the child
vii) Social environment - neighbourhood, school, society members
viii) Control over emotions - to maintain physical and mental health, have control over emotions. At the time of emotional state, body undergoes many changes like change in blood circulation, pulse rate, breathing, effect on digestive system, stretching of eyes, closing of fists
ix) Play

4.6. Social Development (Socialization Process)

- Involves learning the values, knowledge and skills that enable children to relate to others effectively and to contribute in positive ways to family, school and the community
- Factors influencing social development
  1) Home Environment
     - Home is the first socialising agency thus a friendly home environment has a positive and socialising effect on the child. Family influence plays a vital role in the process of social development
  2) Socio-Economic Status of the Family
     - Family members of high socio-economic status have the opportunity of moving about in a higher and wider circle of society mixing with a large number of and different sorts of people and this helps them in their socialisation
  3) Love and Affection
     - Love and affection are the basic psychological needs of children
     - If the child is treated with love and affection, he feels secure, and thus, develops self-confidence giving him/her the necessary courage to enter into social relationships outside the family
  4) Participation in Social Organisations
     - Participation in various types of social organisations widens the sphere of child's social contacts and increases his social understanding
     - He/she learns the qualities of leadership, cooperation, and toleration
     - Self-centeredness is replaced by social consciousness which is increasingly broadened bringing about social development of the child
  5) Play
     - During play, children also increase their social competence and emotional maturity
     - Vital to children's social development as it enables children to
       i) Practice both verbal and nonverbal communication skills by negotiating roles, trying to gain access to ongoing play, and appreciating the feelings of others
       ii) Respond to their peers' feelings while waiting for their turn and sharing materials and experiences
       iii) Experiment with roles of the people in their home, school, and community by coming into contact with the needs and wishes of others
       iv) Experience others' points of view by working through conflicts about space, materials, or rules positively
     - Provides a way to express and cope with feelings
     - Pretend play helps children express feelings in the following four ways (Piaget, 1962):
       i) Simplifying events by creating an imaginary character, plot, or setting to match their emotional state. A child afraid of the dark, for example, might eliminate darkness or night from the play episode.

ii) Compensating for situations by adding forbidden acts to pretend play. A child may, for example, eat cookies and ice cream for breakfast in play, whereas in reality this would not be permitted
iii) Controlling emotional expression by repeatedly re-enacting unpleasant or frightening experiences. For example, a child might pretend to have an accident after seeing a real traffic accident on the highway.
iv) Avoiding adverse consequences by pretending that another character, real or imaginary, commits inappropriate acts and suffers the consequences
v) Allows them to think out loud about experiences charged with both pleasant and unpleasant feelings
vi) Learn to cope with their feelings as they act out being angry, sad, or worried in a situation they control (Erikson, 1963)

- Older children learn valuable emotional skills, such as increasingly realistic self-perceptions, the ability to manage their emotions, and self-control that improves over time through games and inventions.

6) School Programmes
   - Child gets an opportunity of mixing with the large number of students, and thus, getting varied types of social experiences
   - School experiences in the form of various types of school programmes and activities, opportunities for healthy social communication, guidance from teachers, determine to a large extent the social skills and attitudes as well as the habits that the child learns
   - Schools teach basic social attitudes and principles of good conduct tremendously helping social development

4.7. Personality Development

- Development of organized pattern of behaviours and attitudes that makes a person distinctive (unique)
- Occurs by the ongoing interaction of temperament, **character**, and **environment**
  i) Temperament
     - Set of genetically determined traits that determine the child's approach to the world and how the child learns about the world
     - Genes control development of the nervous system, which in turn controls behaviour
     - Temperament is dependent on genetic factors (referred to as "**nature)**
  ii) Environment - personality developed comes from adaptive patterns related to a child's specific environment (environmental factors are called "**nurture**")
  iii) Character
     - Set of emotional, cognitive, and behavioural patterns learned from experience that determines how a person thinks, feels, and behaves
     - Evolves throughout life, but much depends on inborn traits and early experiences
     - Is dependent on a person's moral development

Factors Influencing Personality Development

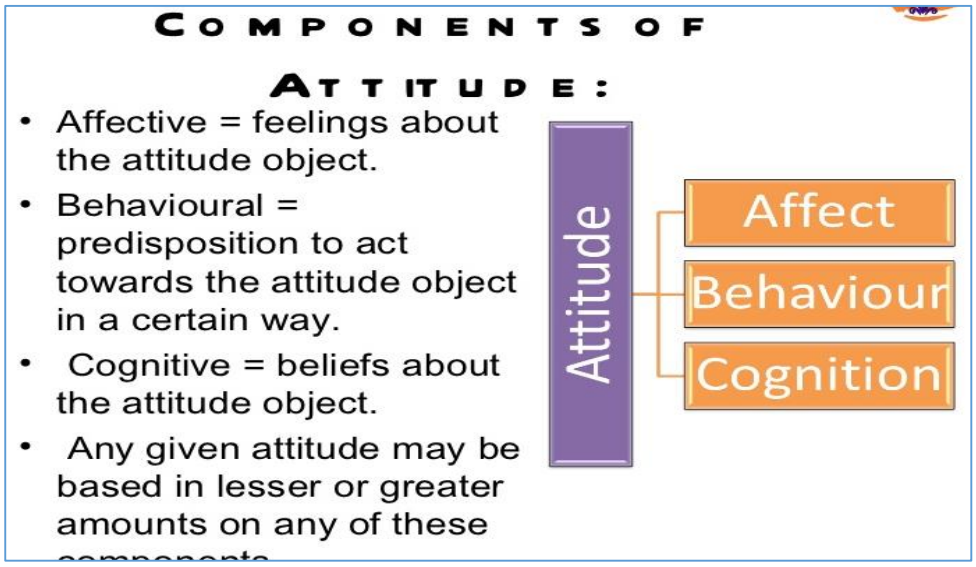
1) Heredity
   - Is an effective factor in determining the type of his personality
   - Three bodily types of personality - short & stout; tall & thin; muscular & well proportioned

2) Biological Factors
   - The working of the nervous system, glands and blood chemistry determines our characteristics and habitual modes of behaviour
   - Factors form the biological basis of our personality.

- Development of personality is influenced by the nature of nervous system, adrenal, thyroid and pituitary endocrine glands
- Personality defects lead to the development of inferiority complex and the mental mechanism of compensation

3) Intelligence - intelligent persons can make better adjustment in home, school and society

4) Attitude
   - A mental and neural state of readiness, organised through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related
   - An attitude is a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour
   - It expresses an individual's positive and negative feeling about some objects. It describes an individual's feelings, thoughts and predisposition to act toward some object in the environment.



5) Sex Differences
   - Play a vital role in the development of personality of individual
   - Boys are generally more assertive and vigorous thus prefer adventures while girls are quieter and more injured by personal, emotional and social problems.

6) Environment
   i) Physical Environment - includes the influence of climatic conditions of a particular area or country on man and his living
   ii) Social Environment - environment in the society where the child lives has an important say in the personality development of the child.
   iii) Family Environment (Home)
      - Family is the cradle of all social virtues and first environment which the child moves in
      - Child comes in contact with his parents and other family member his likes, dislikes, stereotypes about people, expectancies of security and emotional responses all are shaped in early childhood
      - Economic factors i.e., economic condition of the family and the type of relations between the parents also influence the personality of the child.
   iv) Cultural Environment
      - Cultural traditions, ideals, and values etc., which are accepted in a particular society
      - All these factors leave a permanent impression on the child's personality

v) School Environment
- Schools take a significant part of a child's life is spent in school where the teacher substitutes the parents
- School poses new problems to be solved, new taboos to be accepted into the superego and new models for imitation and identification, all of which contribute their share in moulding personality

7) Other Social Factors
   i) Language
   - An important vehicle by which the society is structured and culture of the race transmitted from generation to generation
   - The child's personality is shaped by the process of interaction through language with other members of his environment

   ii) Social Role
   - Child has to play several roles like son, brother student, officer, husband, father, etc., throughout his life at rent stages of his development.
   - Social roles may be described as process by which the co-operative behaviour and communications among the society members are facilitated

   iii) Self-Concept
   - Influences our personality development in two ways - if other people hold high positive ergative enhances our self and others hold may us otherwise, it creates feelings of worthlessness and to self-defence or withdrawal from social situation.

   iv) Identification
   - An important mechanism by which we try to imitate the physical, social and mental characteristics of our model. It is a very important relationship with others

   v) Inter-personal Relations
   - Inter-personal relations among the members of a society are important means which help in the development of certain social personality characteristics like attraction towards others, concept of friendship, love, sympathy, hostility and also isolation which is a negative orientation.

8) Psychological Factors
- Include our motives, acquired interests, our attitudes, our will and character, our intellectual capacities such as intelligence
- Determine our reactions in various situations and thus affect our personality, growth and direction
- An individual with a considerable amount of will power is able to make decisions more quickly

4.8. Intellectual and Cognitive Development

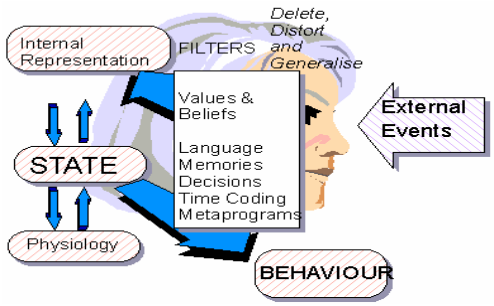
- Process of acquiring intelligence and increasingly advanced thought and problem-solving ability from infancy to adulthood
- Relates to conscious intellectual activity (as thinking, reasoning, remembering, imagining, or learning)
- Concerned with the development of a person's thought processes through learning
- Culture is the prime determinant of cognitive development

Theories of Cognitive Development

1) Jean Piaget – 4 stages

2) Lev Vygotsky

- Believed that individual development could not be understood without reference to the social and cultural context within which such development is embedded
- Mind evolution is continuous
- Focused on the mechanism of the development, excluding distinguishable developmental stages

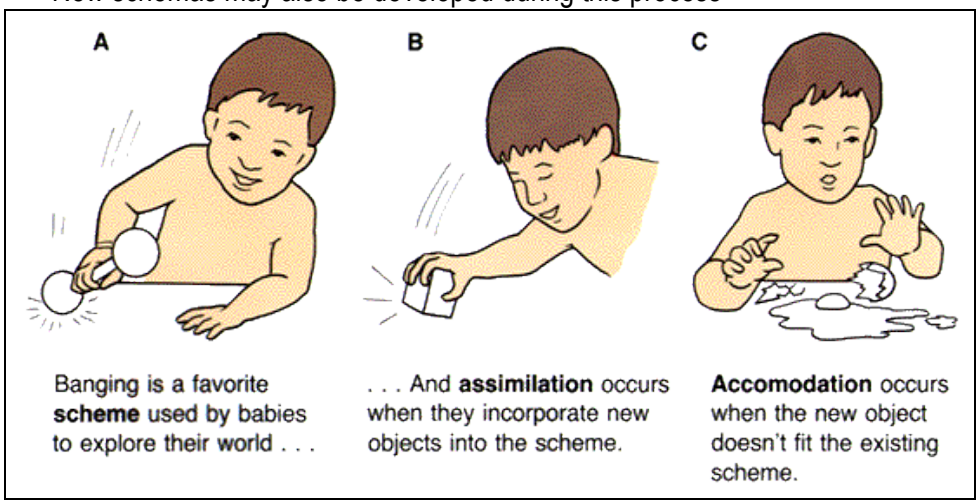


Key Concepts of Cognitive Development

a) Schemas
- Describe both the mental and physical actions involved in understanding and knowing
- Are categories of knowledge that help us to interpret and understand the world
- In Piaget's view, a schema includes both a category of knowledge and the process of obtaining that knowledge
- As experiences happen, this new information is used to modify, add to, or change previously existing schemas
- For example, a child may have a schema about a type of animal, such as a dog. If the child's sole experience has been with small dogs, a child might believe that all dogs are small, furry, and have four legs. Suppose then that the child encounters a very large dog. The child will take in this new information, modifying the previously existing schema to include this new information

b) Assimilation
- Process of taking in new information into our previously existing schemas
- Is subjective, because we tend to modify experience or information to fit in with our pre-existing beliefs. In the example above, seeing a dog and labelling it "dog" is an example of assimilating the animal into the child's dog schema

c) Accommodation
- Part of adaptation that involves changing or altering our existing schemas in light of new information
- Involves altering existing schemas, or ideas, as a result of new information or new experiences
- New schemas may also be developed during this process



d) Equilibration
   - Piaget believed that all children try to strike a balance between assimilation and accommodation through a mechanism called equilibration
   - As children progress through the stages of cognitive development, it is important to maintain a balance between applying previous knowledge (assimilation) and changing behaviour to account for new knowledge (accommodation)
   - Equilibration helps explain how children are able to move from one stage of thought into the next

Factors Influencing Cognitive development

1) Biological factors - sense organs, intelligence, heredity and maturation
2) Environment factors - learning opportunities, economic status, play, various types of stimuli, family and society

5.0. PRACTICES ADVERSELY AFFECTING CHILD HEALTH

5.1. Introduction

- Several factors that affect child health negatively and thus their overall development
- These include, child abuse and neglect, child labour and

5.2. Harmful Cultural Practices and Believes

1) Harmful cultural and traditional practices including female genital mutilation/cutting, virginity-testing; male circumcision; binding, breast ironing, scarring, burning, branding, coin-rubbing, tattooing, piercing; harmful initiation ceremonies, early and forced marriage; crimes committed in relation to bride-price and dowry, beliefs in witchcraft, denouncing of children as witches or possessed by evil spirits
2) Violence against children - domestic violence, sexual and gender based violence) and violent and/or humiliating forms of punishment, corporal punishment, isolation etc.
3) Polygamy
4) HIV/AIDS “cleansing”
5) “Honour” crimes; acid attacks,
6) Deliberate discriminatory treatment of children,
7) Extreme restriction of liberty for certain groups of disabled children – autism; albinos
8) “Bogus” forms of treatment/medication/diets not based on medical evidence; discrimination against children born on certain days; food taboos

5.3. Child Abuse and Neglect

Introduction

- Child abuse is non-accidental physical and psychological injuries to a child as a result of acts perpetuated by a parent or care taker
- Child abuse can also be defined as any omission or commission that endangers a child’s physical or emotional health and development
- Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power

Causes

- Poverty; ignorance; culture; greed of parents; stress from parents; lack of education especially for girls; being orphaned; lack of employment; economic conditions; personal characteristics of the abuser; characteristics of the child; lack of social support

Forms of Child Abuse

1) Physical abuse
    - Involves physical trauma or non-accidental injuries
    - Results in actual or potential physical harm from an interaction or lack of an interaction, which is reasonably within the control of a parent or person in a position of responsibility, power or trust

2) Emotional abuse
    - Includes the failure to provide a developmentally appropriate, supportive environment, including the availability of a primary attachment figure, so that the child can develop a stable and full range of emotional and social competencies commensurate with her or his personal potentials and in the context of the society in which the child dwells.
    - Acts towards the child that cause or have a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development
    - Acts include restriction of movement, patterns of belittling, and scape-goating, threatening, scaring, discriminating, ridiculing or other non-physical forms of hostile or rejecting treatment.

3) Neglect/negligence or lack of adequate care
    - Neglect is the failure to provide for the development of the child in all spheres: health, education, emotional development, nutrition, shelter, and safe living conditions, in the context of resources reasonably available to the family or caretakers and causes or has a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development. Includes the failure to properly supervise and protect children from harm as much as is feasible.

4) Sexual abuse
    - Any form of sexual contact between an adult and a child
    - Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society
    - Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person.
    - Include but is not limited to inducement or coercion of a child to engage in unlawful sexual activity and exploitative use of child in prostitution or other unlawful sexual practices, and in pornographic performances and materials, exposing children to pornographic materials, obscene talk, having a child deliberately witness sexual organs or having a child touch an adult sexually
    - Forms - using children to gain profit, incest, FGM, sodomy, rape and defilement
5) Exploitation - commercial or other exploitation of a child refers to use of the child in work or other activities for the benefit of others. Includes, but is not limited to, child labour and child prostitution
6) Deliberate starvation
7) Failure of stimulation – no play
8) Psychological abuse involves harm to a child's emotional and cognitive functioning (demeaning language, insults, cursing, non-recognition, verbal abuse, humiliation, bullying and ridicule, undue high expectation and pressure)
9) Abandonment
10) Child trafficking and exploitation
    - Is the recruitment, transportation, transfer, harbouring or receipt of children for the purpose of exploitation

- Forms - forced labour, bonded labour, debt bondage among migrant labourers, involuntary domestic servitude, forced child labour, child soldiers, sex trafficking (child sex trafficking and related abuses - commercial sexual exploitation of children (CSEC) and child sex tourism (CST) is one form of "demand" for victims of child sex trafficking.

11) Child labour
    - Is the participation of school aged children in the labour force on a regular basis
    - Several ILO conventions prohibit employment of children
    - Forms of Child Labour in Kenya - children are involved in tea or coffee picking, house helps, shamba boys, prostitution, child care, hawking, begging, herding animals, loaders, begging, turn boys, bar attendants, construction sites, farms, crime
    - Effects include fail to attend school, emergence of young families, street children, diseases, crime, insecurity, illiteracy and dependency; Physical injuries; disabilities and mental anguish; psychological problems; running away from home (leads to malnutrition, health problems, assault, criminal activities); may carry on the practice to their children; difficult relationships and poor educational achievement
    - Eradication of Child labour
        i) Cultural re-orientation
        ii) Legislation and policy
        iii) Law enforcement - Education Act, Children's Act, Employment Act and Employment of women, children and young person's Act
        iv) Education
    - Challenges in Eradication of child labour include poverty , mplementation of the Education Act , increasing number of orphans, shortcomings of law enforcement and cultural re-orientation

Prevention

- Parents take responsibility; Report cases to relevant authorities; Skills for parenting; Legislation; Abusers should face criminal justice; Improve livelihoods; Offers services for the abused – shelter, education, therapy; Stress management; Prepare young parents for parenting; Enforce the laws

5.4. Violence against Children

- Domestic Violence - see Maternal Health
- Gender Based Violence - see Maternal Health

5.5. Alcohol and Substance Abuse

Using relevant examples explain how alcohol and substance abuse in communities affects child health?

5.6. Poor Environment Management

Using relevant examples explain how poor environmental management in communities affects child health?

Religious Believes

Using relevant examples explain how religious beliefs of communities affects child health?

Topic 4: IMMUNIZATION

Learning Objective

At the end of the session the learners should be able to: -
1) Explain basic concepts in immunity and immunization
2) Identify immunizable diseases
3) Describe all the aspects of the various vaccine and immunization schedules

1.0. BACKGROUND

1.1. Introduction

- Immunization is a proven tool for controlling and eliminating life-threatening infectious diseases and is estimated to avert between 2 and 3 million deaths each year
- It is one of the most cost-effective health investments, with proven strategies that make it accessible to even the most hard-to-reach and vulnerable populations
- Has clearly defined target groups and can be delivered effectively through outreach activities; and vaccination does not require any major lifestyle change
- Immunization triggers an immune system response by which the vaccine develops long-term protection(immunity) that would normally follow recovery from many naturally occurring infections

1.2. History of Immunization

- From variolation, inoculation of smallpox into skin (18th century) to vaccination (Edward Jenner developed the modern practice of vaccination when he inoculated people with cowpox virus to protect them against smallpox)
- Chinese noticed children who recovered from smallpox did not contract the disease again. They infected children with material from a smallpox scab to induce immunity (this process known as *variolation)*
- Variolation spread to England & America but was stopped because of risk of death
- 1796 – Edward Jenner discovered process of vaccination
- 1879 – Louis Pasteur developed a vaccine against *Pasteurella multocida*
- Antibody transfer developed when it was discovered vaccines protected through the action of antibodies

1.3. Definitions

	Key word	Definition/description
1.	Immunity	• A state in which a host is not susceptible to infection or disease • Non-susceptibility to the invasive or pathogenic effects of microorganisms or helminthic parasites or to the toxic effect of antigenic substances • The capacity to distinguish foreign material from *self*, and to neutralize, eliminate or metabolize that which is foreign (*non-self*) by the physiological mechanisms of the immune response
2.	Acquired immunity	•
3.	Natural immunity	•
4.	Innate Immunity	•
5.	Adaptive immunity	•

	Key word	Definition/description
6.	Herd immunity	•
7.	Immunization	• Process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine which stimulate the body's own immune system to protect the person against subsequent infection or disease
8.	Vaccine	• a biological preparation that improves immunity to a particular disease
9.	Vaccination	• Administration of antigenic material (a vaccine)) to stimulate an individual's immune system to develop adaptive immunity to a pathogen by producing antibodies
10.	Antigen	• a substance (usually proteins) on the surface of cells, viruses, fungi, or bacteria. Non-living substances such as toxins, chemicals, drugs, and foreign particles (such as a splinter) can also be antigens
11.	Antibody	• a blood protein produced in response to and counteracting a specific antigen

2.0. IMMUNE SYSTEM AND IMMUNITY

- Immune system protects the body from possibly harmful substances by recognizing and responding to antigens
- The system recognizes and destroys substances that contain antigens.
- Forms of immunity
  1) Innate (Non-specific) Immunity - first line of defence against non-specific invasion. Includes - cough reflex, enzymes in tears and skin oils, mucus, bacteria and small particles, skin and stomach acid, chemicals, inflammation
  2) Specific (Adaptive) - protects against specific invasion and makes use of antibodies and T cells
  3) Natural Immunity - immunity resulting from the genetic makeup of the host, before exposure to an antigen
  4) Acquired Immunity - immunity that develops with exposure to various antigens and the system builds a defence against that specific antigen.
  5) Active Immunity - develops after the body develops antibodies after introduction of an antigen
  6) Passive Immunity
     - Due to antibodies that are produced in a body other than your own
     - Infants have passive immunity because they are born with antibodies that are transferred through the placenta from their mother
     - May also be due to injection of antiserum, which contains antibodies that are formed by another person or animal
     - Provides immediate protection against an antigen, but does not provide long-lasting protection

3.0. IMMUNIZATION SYSTEM COMPONENTS

1) Service Delivery
   - Programme to sustain and improve on the gains made over the years by providing quality immunization services
   - Re-energize the outreach strategy within the RED[2] strategy framework and sustain
   - SIAs[3] to be implemented periodically
2) Vaccine Supply, Quality and Logistics
   - Ensure that adequate vaccines bundled with injection materials are

[2] Reaching Every District
[3] Supplemental Immunization Activities

- Procured through WHO/UNICEF approved mechanisms
- Advocate for the adequate and timely release of funds, procurement of vaccines and other logistics to be prioritized to avoid disruption of services
- Expand storage capacities for both vaccines and dry store materials at central & regional vaccine stores
- Improve surveillance through production of guidelines, adequate tools and specific training.
- Introduction of a computerized stock management system
- Provide resources for maintenance and other operational costs of the vehicles.
- Procure cold-chain equipment and expand our total cold-chain capacity
- Advocate for adequate resources
- Strengthen injection safety and waste management

3) Disease Surveillance
   - Vaccine preventable disease surveillance data (Polio, measles, PBM and MNT[4]) will be monitored so as to address gaps in immunization coverage in a timely manner as appropriate.
   - Maintain or improve the tempo of detection and notification of
   - AFP[5], measles, and NNT[6] at current levels efficiently.

4) Advocacy, social Mobilization and Communication
   - Advocacy, social mobilization and communication are very crucial in EPI services
   - Lobby for resources through the Child Health ICC[7] and the health SWAp,
   - Health workers will be trained on the new guidelines
   - Advocacy meetings will be conducted with District Health Management Teams (DHMTs) and District Health Stakeholders for more EPI specific resource mobilization
   - EPI messages developed and disseminated through print media and electronic media both nationally and at local levels where this capacity is available.
   - Other channels such as drama and community meetings will be encouraged and strengthened, spearheaded by the CORPs in conjunction with their respective CHEWs.

4.0. DVI/KEPI

- Immunization programme in Kenya is managed by the division of vaccines and immunization (DVI)
- Been in existence since 1980 when it was established as Kenya Expanded Programme on Immunization (KEPI) under the department of the Department of Preventive and Promotive Health Services of the MoH
- Renamed as the Division of Vaccine and Immunisation (DVI) in 2008
- Goal of the DVI is to reduce morbidity, mortality and disability due to life threatening infections due to vaccine preventable diseases

Components of EPI

- There are three components of the EPI system are
  i) Routine immunization - delivered through the RED[8] approach in all districts
  ii) Accelerated disease control (ACD) which comprises the campaigns, also known as Supplemental Immunization Activities (SIAs) and child health days (CHDs)
  iii) Vaccine preventable disease (VPD) surveillance, targeting polio, measles, neonatal tetanus, yellow fever.

[4] Maternal Neonatal Tetanus
[5] Acute Flaccid Paralysis
[6] Neonatal Tetanus
[7] Child Health Inter-Agency Coordinating Committee
[8] Reaching Every District

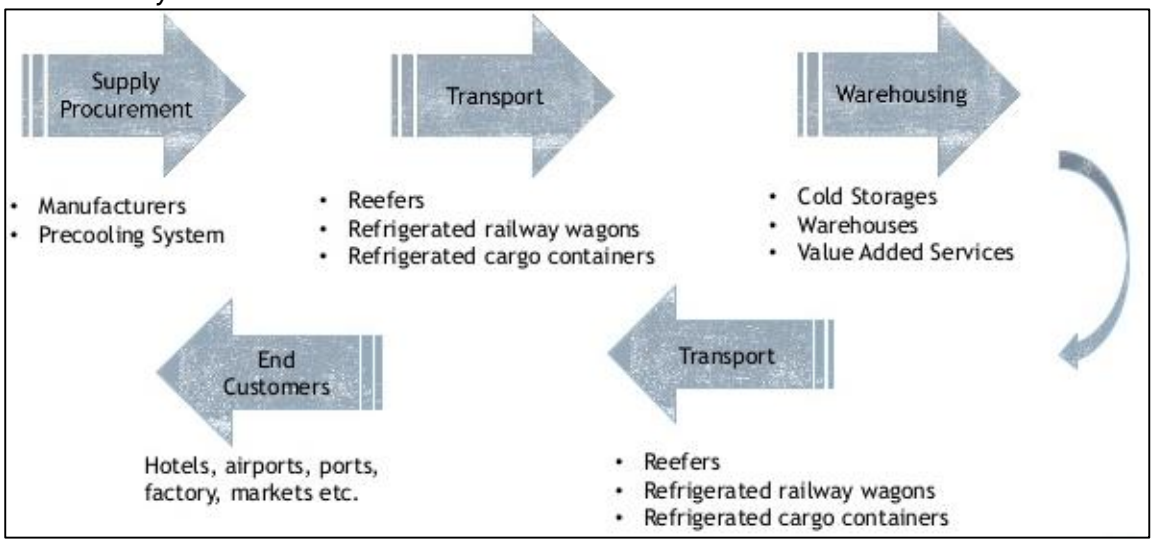
- Main EPI delivery strategies
  i) Static - routine immunization services daily at health facilities/hospitals
  ii) Outreach – services are to remote communities
  iii) Mini-mass (mop up) – occasional activities in selected districts to capture defaulters and also reach out to children missed in routine services
  iv) Campaigns –national activities conducted to reach large population target group at a given period as a supplementary activity to increase immunization
  v) Persons mostly involved

5.0. COLD CHAIN

5.1. Introduction

- Cold chain is a system of transporting and storing vaccines within a recommended temperature range of +2 to +8 degrees Celsius (°C)
- Process used to maintain optimal conditions during the transport, storage, and handling of vaccines (from the manufacturer to the administration of the vaccine to the client)
- Optimum temperature for refrigerated vaccines is between +2°C(35°F) - +8°C (45°F) and -15°C or lower for frozen vaccines the optimum temperature is

Cold Chain System



5.2. Cold Chain Management

- Cold chain and logistics (CCL) system includes:
  i) An information management system capable of collecting and reporting data
  ii) A stock inventory control system (ensure proper management of all supplies)
  iii) Storage and warehousing of adequate capacity & quality
  iv) A distribution/maintenance system for efficient transport
  v) Sufficient number of trained personnel at every level

5.3. Cold chain breach

- Vaccines are delicate biological substances that can become less effective or destroyed if they are frozen, allowed to get too hot and/or exposed to direct sunlight or fluorescent light.
- Vaccines are exposed to temperatures outside the recommended +2° to +8°C temperature range ISPs are required to contact the RIC for advice on vaccine efficacy
  i) Freezing - most common reason for vaccine damage and loss
  ii) Heat

- Vaccines exposed to temperature ranges over +8°C will, in some instances, still be able to be administered but may have a shortened shelf life as a result of the heat exposure
- Vaccines exposed to repeated episodes of heat, the loss of vaccine potency is cumulative and cannot be reversed

iii) Accuracy of temperature measurement
- Accurate reading of temperature is essential in determining vaccine efficacy
- A standard min/max thermometer (with a single digit display) usually has an error margin of ± 1°C. In contrast, data loggers can have an error margin of ±0.5°C or less.

6.0. IMMUNIZABLE DISEASES

- Immunizable diseases include - tuberculosis, poliomyelitis, diphtheria, pertussis, measles, pneumonia, yellow fever, cholera, rabies, rota virus, hepatitis B, meningococcal, rubella, tetanus, pneumococcal and Haemophilus influenza, typhoid fever, anti-snake venom.

7.0. VACCINATION AND VACCINES

7.1. Introduction
- Vaccination (Latin: *vacca—cow)* is named because the first vaccine was derived from a virus affecting cows, the relatively benign cowpox virus, which provides a degree of immunity to smallpox, a contagious and deadly disease
- Word "vaccination" was originally used specifically to describe the injection of the smallpox vaccine
- Vaccines can prevent or ameliorate morbidity and infection

7.2. Vaccine
- A vaccine is an antigenic material that stimulate adaptive immunity to a disease
- Considered to be the most effective method of preventing infectious diseases
- Typically contains an agent that resembles a disease-causing microorganism. The agent stimulates the body's immune system to recognize the agent as foreign, destroy it, and "remember" it, so that the immune system can more easily recognize and destroy any of these microorganisms that it later encounters.
- Material administered can be
  i) Live but weakened forms (live attenuated)
  ii) Killed or inactivated form
  iii) Purified material such as proteins
  iv) Toxoids - produced for immunization against toxin-based diseases, such as the modification of tetanospasmin toxin of tetanus to remove its toxic effect but retain its immunogenic effect

7.3. Classification of Vaccines

Primary Vaccines (Primary immunization)
- Vaccines given as early in life as possible (from birth to 5 years to build immunity to a particular disease.
- Require all doses to be completed
- Examples; -

Secondary Vaccines

i) Identify all the secondary vaccines in Kenya
ii) State the indications and when administered.
iii) State what type of vaccines they are

7.4. Vaccine Types

	Type of Vaccine	Description	Examples
1.	Attenuated (live) vaccines	• Use pathogens with reduced virulence and can result in mild infections • Active microbes stimulate a strong immune response • Can provide contact immunity • Modified microbes may retain enough residual virulence to cause disease • Do reproduce and continue to present antigen beyond the initial vaccination, boosters are required less often • Cannot be used by immune-compromised individuals	Tuberculosis (BCG), polio Sabin (OPV), measles, influenza, Rota virus, rubella. Yellow fever, varicella, mumps
2.	Inactivated (killed) vaccines	• Consists of virus particles which are grown in culture and then killed • Virus particles are destroyed and cannot replicate, but the virus proteins are intact enough to be recognized and remembered by the immune system and evoke a response • Vaccine is not infectious, but improper inactivation can result in intact and infectious particles • Booster shots are required periodically to reinforce the immune response	Hepatitis A, pertussis (whole cell), polio salk (IPV), rabies, influenza
3.	Subunit vaccines (purified antigens)	• A subunit vaccine presents an antigen to the immune system without introducing viral particles, whole or otherwise • Involves isolation of a specific protein from a virus or bacteria and administering this by itself. • Often elicit weaker antibody responses than the other classes of vaccines • Safer than live vaccines	Pertussis (acellular), hepatitis B, pneumococcal, typhoid, meningococcal, HiB (Haemophilus influenza)
4.	Toxoid (inactivated toxins) vaccines	• Chemically or thermally modified toxins used to stimulate immunity • Useful for some bacterial diseases • Stimulate antibody-mediated immunity • Require multiple doses because they possess few antigenic determinants • Examples –	Diphtheria, Tetanus
5.	Combination vaccines	• Consist of two or more antigens in the same preparation • Advantages include cost reduction, improve timeliness of vaccination and facilitate addition of new vaccines into the immunization schedule	Pentavalent

8.0. INVALID CONTRAINDICATIONS

- Mild illness; Antimicrobial therapy; Disease exposure or convalescence; Pregnant or immunosuppressed person in the household; Breastfeeding; Preterm birth; Allergy to products not present in vaccine or allergy that is not anaphylactic; Family history of adverse events; Tuberculin skin testing; Multiple vaccines

9.0 IMMUNIZATION SCHEDULE – KENYA

Vaccines in the Immunization Schedule (Primary Vaccines)

	Vaccine	Ages of Routine immunization	Dose and Route	Description	Side Effects	Contraindications
1.	BCG	At birth	Infants < 12 months **0.05 ml** Children > 12 months 0.10 **ml** ID	Live attenuated	Injection abscess, regional or wide-spread lymphadenitis, osteomyelitis; Disseminated BCG infection (treat with anti-tuberculosis drugs)	
2.	OPV	At birth, 6wk, 10wk and 14wk	2 drops	Live attenuated	Adverse reactions rarely occur	
3.	IPV	14wk	05 mls IM			
4.	DPT-HepBHib (pentavalent)	6wk, 10wk and 14wk	0.5 mls IM		• Most adverse reactions attributed to the pertussis component • Minor reactions include - Pain at the site of injection and fever • Major reactions are persistent crying, high pitched cry, excessive somnolescence, convulsions, encephalopathy and coma	
5.	Pneumococcal vaccine (PCV[9] 10)	6wk, 10wk and 14wk	0.5 mls IM			
6.	Measles-Rubella	9 months, (6 months in ISS), 15 – 18 months	0.5 mls S/C, IM (deltoid)		Fever; Mild rash; Rarely convulsions, encephalitis and sub-acute schlerosing pan-encephalitis (SSPE	
7.	Rota Virus	6wk, 10wk and 14wk	1 – 2 mls Oral		Vomiting, diarrhea, irritability, fever	• Severe allergic reaction following previous dose • Allergy to latex
8.	Yellow Fever	9 – 12 months	0.5 mls IM			
9.	Vitamin A .	First dose at 9 months then every 6 months (twice per year) up to the age of 60 months	<6 months - 50,000 IU 6-12 months-			

[9] Pneumococcal conjugate vaccine

	Vaccine	Ages of Routine immunization	Dose and Route	Description	Side Effects	Contraindications
			100,000 IU >12 months-200,000 IU; Oral			
10.	TT	Pregnant women, WCBA[10] and School aged children 7 to 14 years	0.5 mls IM (Deltoid)	Toxoid		
		Pregnancy: 1st Dose - pregnancy/subsequent pregnancy; 2nd dose - 4 weeks after first dose 3rd dose - 6 months after 2nd dose; 4th dose - at least 1 year after the third dose 5th dose - at least 1 year after the fourth dose	0.5 mls IM (Deltoid)			
		Trauma:				

Table: Secondary Vaccines

	Vaccine	Ages of Routine immunization	Dose and Route	Description	Side Effects	Contraindications
1.	Typhoid					
2.	Pneumococcal					
3.	Rota Virus					
4.	Anti-rabies					
5.	Meningococcal				Adverse reactions: local reaction, fever, systemic (headache, malaise, fatigue)	• Severe allergic reaction, • Moderate or severe acute illness
6.	HPV				Adverse reactions: local (pain, swelling), fever, system reactions (nausea, dizziness, myalgia, malaise)	severe allergic reaction

[10] Women of child bearing age

Topic 5: MATERNAL HEALTH

Learning Outcomes

At the end of the lesson the learner will be able to
1) Explain the major concepts in maternal health
2) State causes of maternal morbidity and mortality
3) Discuss factors affecting maternal health in the communities

1.0. INTRODUCTION

- Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period
- Concept encompasses family planning, preconception, prenatal & post-natal care as well as child care
- An enabling environment for safe motherhood and childbirth depends on the care and attention provided to pregnant women and new-borns by communities and families, the acumen of skilled health personnel and the availability of adequate health-care facilities, equipment, and medicines and emergency care when needed.
- Many women in developing world and most women in the world's least developed countries – give birth at home without skilled attendants, yet their new-borns are usually healthy and survive past their first few weeks of life until their fifth birthday and beyond

2.0. FACTORS CONTRIBUTING TO HEALTH OF MOTHER IN THE COMMUNITY

1) Support – social-economic and emotional support
2) Medical care – facilities, infrastructure, human resource
3) Good nutrition
4) Infection Prevention
5) Awareness of risk factors and early detection through assessment
   a) Danger signs in pregnancy e.g. per vaginal bleeding; drainage of liquor; severe abdominal pain; severe headache; reduced foetal movements; convulsions
   b) Danger signs in labour e.g. labour pains lasting > 12 hours unless if a primi gravida, excessive bleeding, ruptured membranes without labour for > 12 hours, convulsions and mal presentation of the foetus
   c) Danger signs in postpartum period e.g. excessive bleeding; retained products of conception (POCs); poor uterine contraction; haemorrhagic diatheses; fever; foul smelling discharge (lochia); painful breasts, cracked nipples; abdominal pain and cramps; extreme fatigue; oedema (facial, leg); severe headache; convulsions; painful cuff muscles (deep venous thrombosis - DVT)
6) Diseases e.g. pregnancy induced hypertension (PIH), anaemia, puerperal sepsis, ante partum haemorrhage (APH), post-partum haemorrhage (PPH) and any Infection/disease

3.0. FACTORS INFLUENCING THE HEALTH OF MOTHER IN THE COMMUNITY

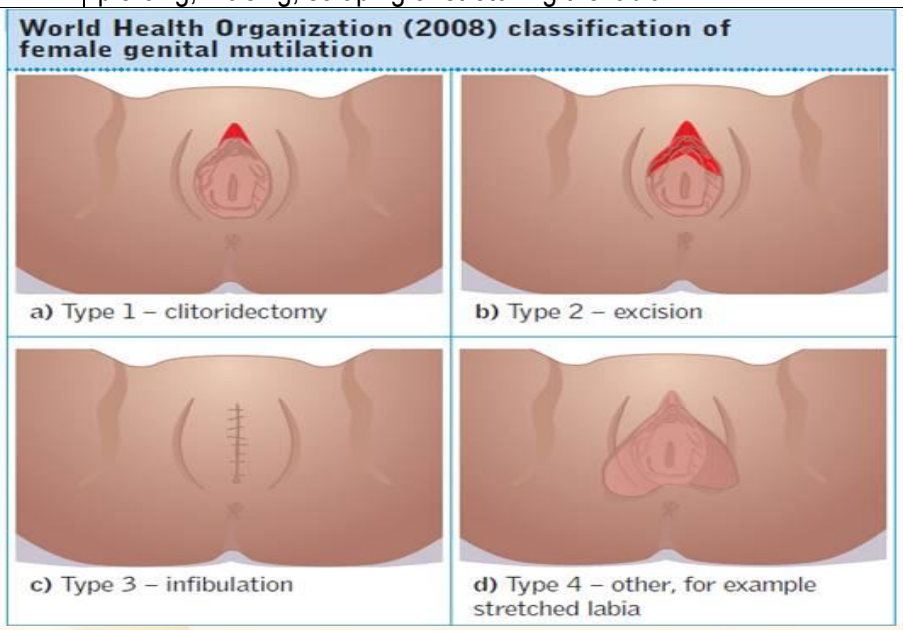
POSITIVE
1) Cultural Practices (Which cultural practices positively influence maternal health?)
2) Health Services
   - Should be accessible, affordable, acceptable, available, appropriate, friendly
   - Trained health workers
3) Social Institutions - family, community, education, government, religion, science, mass media

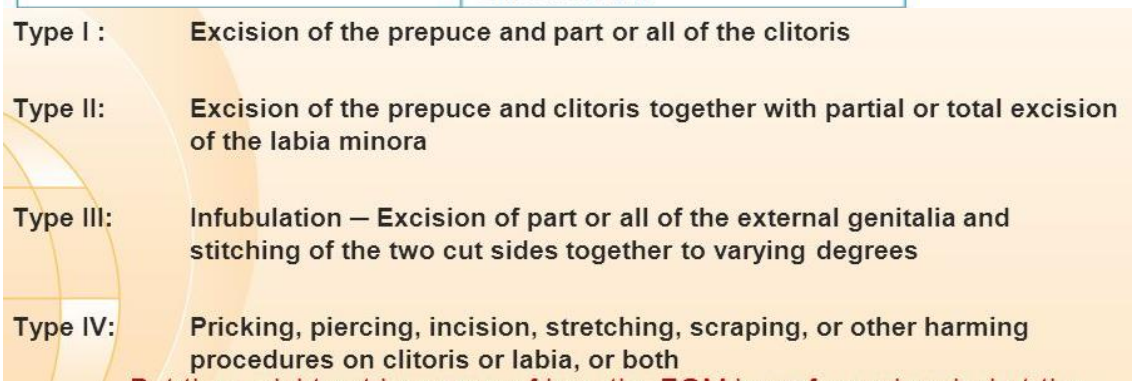
NEGATIVE

1) Traditional Practices
   a) Early and forced marriages

b) Female Genital Mutilation (FGM)
- Generally performed on young girls below 10 years
- Practice has grave consequences during childbirth, especially for women who have undergone extreme forms of the procedure
- Linked to increased complications in childbirth and maternal deaths.
- Other side effects are severe pain, heavy bleeding, infection, infertility, urinary incontinence, and psychological and sexual problems.
- FGM also puts babies in substantial danger during childbirth
- Grading of FGM

Type	Description
1	Clitoridectomy (partial or total removal of the clitoris)
2	Excision (partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora)
3	Infibulation (narrowing of the vaginal opening through the creation of a covering seal). The seal is formed by cutting and repositioning the inner, and sometimes outer, labia, with or without removal of the clitoris)
4	All other procedures to the female genitalia for non-medical purposes, for example pricking, piercing, incising, scraping or stretching the labia





c) Infanticide and/or neglect - killing, withholding food from, and/or neglecting female children because they are considered to be of less value in a society than male children
d) Denial of education for girls or women - removing girls from school, prohibiting or obstructing access of girls and women to basic, technical, professional or scientific knowledge
e) Serorate and levirate marriages, widowhood rites
f) Honour killing and maiming

g) Other practices include massage of the clitoris, lip plates, breast ironing, kidnapping/abduction

2) Drug and Substance Abuse

- Explain how alcohol, drug and substance abuse affect maternal health
- Identify drugs and s substances commonly abused by mothers in Kenya

3) Violence against Women

- Encompass, but not be limited to, the following:
  i) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
  ii) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
  iii) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs."

- What are the causes of sexual abuse?
- Forms of sexual abuse
- How do they affect reproductive health of women?
- How can communities prevent such acts?

4) Domestic Violence
   - Is the intentional or control of behaviour in the context of an intimate relationship
   - Forms of Domestic violence
     i) Physical violence - involves doing something that causes pain and physical bodily damage e.g. assault, physical aggression, torture, rape, spouse battering, death
     ii) Economic violence - involves harming a person's legitimate economic rights e.g. husband's spending family income on themselves, underpayment by employers
     iii) Religious violence - harming others due to their creed they profess
     iv) Psychological violence - inflicting psychological, mental, emotional, moral or social harm
     v) Sexual abuse - having sex with unwilling person, often accompanied by physical and emotional abuse
     vi) Verbal violence - use of abusive language
   - Factors Enhancing Domestic Violence
     i) Culture
     ii) Social organization of the family - people spend more time in their families; increased interaction – lengthy interactions, disagreements, irritations
     iii) Power and family inequality - power and resource control
     iv) Family privacy

5) Spousal Violence
   - Is the deliberate aggressive behaviour against the spouse with the intent of producing harm
   - Forms of spousal violence
     i) Beating/battering involves – biting, beating with hands, kicking, slapping, hitting or attacking with weapons, burning, chopping off genitals, pouring hot water or liquids, chemicals
     ii) Denial of conjugal rights, food/refusal to eat
     iii) Death

- Causes **-** inadequacy of husbands – sexual, economic, frustration from work; economic conditions; verbal aggression; alcohol abuse; changing gender roles; family history of abuse; barrenness; parenting and control of children; infidelity
- Reasons why Spouses remain in abusive relationships include
  - Children, fear of the worst, history of shared love, expectations from society, age, projects, economic factors, learned helplessness, self-blame, they are convinced that things will change for the better
- Consequences - physical injuries, economic (reduced output), psychological, suicide and death

6) Gender based violence (GBV)
   - Violence that targets individuals or groups on the basis of their gender
   - Include physical violence (physical assault, trafficking, slavery) and emotional and psychological violence (abuse/humiliation and confinement)
7) Socio-Economic Violence
   a) Discrimination and/or denial of opportunities, services
   b) Social exclusion/ostracism based on sexual orientation
   c) Obstructive legislative practice
      - Prevention of the exercise and enjoyment of civil, social, economic, cultural and political rights by women.

- How does violence against women affect maternal health?
- How can the communities reduce such actions and promote reproductive health?

4.0. THE ROLE OF COMMUNITIES IN MATERNAL HEALTH

- Includes community participation, mobilization and empowerment; social mobilization and advocacy; social institutions

5.0. CONCEPTS OF MATERNAL HEALTH

- The main concepts in maternal health include:
  1) Maternal morbidity
  2) Maternal mortality
  3) Safe motherhood
  4) Maternal Bond
  5) Gender issues

5.1. Maternal Morbidity

- Maternal morbidity is “any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the woman’s wellbeing
- Maternal deaths have been described as the tip of the iceberg with maternal morbidity as the base
- It is estimated that for every woman who dies of pregnancy-related causes, 20 or 30 others experience acute or chronic morbidity which may affect the women’s physical, mental or sexual health, their ability to function in certain domains (e.g. cognition, mobility, participation in society), their body image and their social and economic status.

Find out 10 common causes of maternal morbidity

5.2. Maternal Mortality

- This is maternal death which occurs to pregnant women after delivery or within 42 days of termination of pregnancy irrespective of duration (gestation) but not from accidental or incidental causes (WHO)
- A reduction in maternal mortality is a critical measure of progress in improving maternal health (MDG 5 targeted a 75% reduction in maternal mortality between 1990 and 2015)

Definitions

i) Maternal death - is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes
ii) Maternal mortality rate - the number of registered maternal deaths due to birth or pregnancy -related complications per 100,000 registered live births
iii) The maternal mortality ratio (MMR) - is the ratio of the number of maternal deaths during a given time period per 100,000 live births during the same time-period (usually one year)
iv) Lifetime risk of maternal death – the probability of becoming pregnant and the probability of dying from a maternal cause during a women's reproductive lifespan
v) Proportion of deaths among women of reproductive age that are due to maternal causes (PM) - number of maternal deaths in a given time period divided by the total deaths among women aged 15–49 years

Statistics and Statistical Measures

- Maternal Mortality Rate –
  - Global – 380 deaths/100, 000 live births (1990), 216 deaths/100, 000 live births (2015);
  - Kenya –
    - 400 deaths/100, 00 live births (1990);
    - 590 deaths/100,000 live births (1998)
    - 414 deaths/100,000 live births (2003)
    - 360 deaths/100,000 live births (2010)
    - 362 deaths/100, 000 live births (2014) – Mandera - 3795, Wajir - 1683, Turkana – 1594, Marsabit – 1127, Isiolo - 790

Factors Contributing to Maternal Mortality

1) Difficulty of predicting and/or preventing obstetric complications
2) Lack of access to good quality maternal health services
3) Poor health before and during pregnancy
4) Women's low social and economic status
5) Biological factors e.g. age, parity
6) Families and community involvement can make motherhood safer through
   a. Proper nutrition before and during pregnancy
   b. Reduced workload during pregnancy and after delivery
   c. Knowledge of the signs of life-threatening complications before, during, and after delivery and where/when to seek appropriate care
   d. Planned delivery with a skilled birth attendant

Causes of Maternal Deaths

Global

- Major direct causes of maternal morbidity and mortality include haemorrhage, infection, high blood pressure (eclampsia), unsafe abortion, prolonged and obstructed labour and other indirect causes including HIV/AIDS, malaria and TB, heart disease, anaemia

Diagram 6.1: Regional Distribution of Maternal Deaths (WHO, 2005)

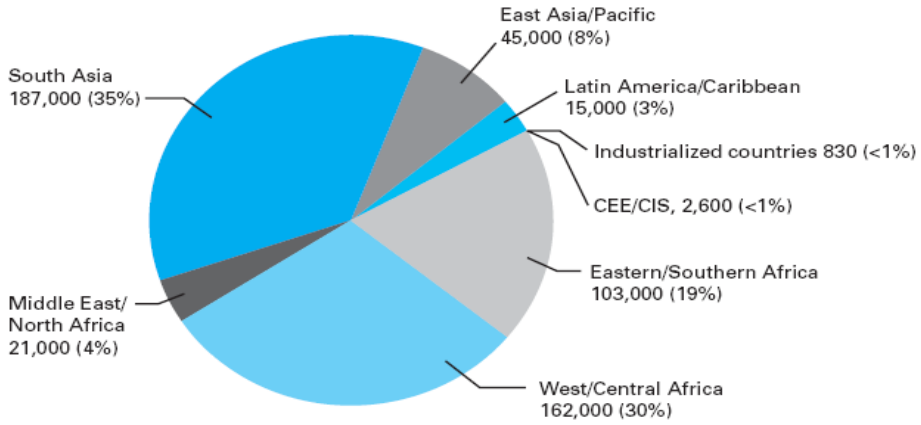
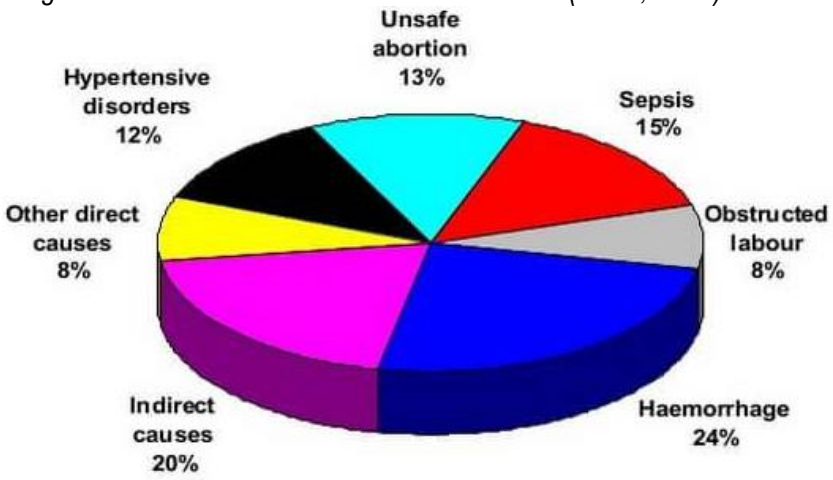
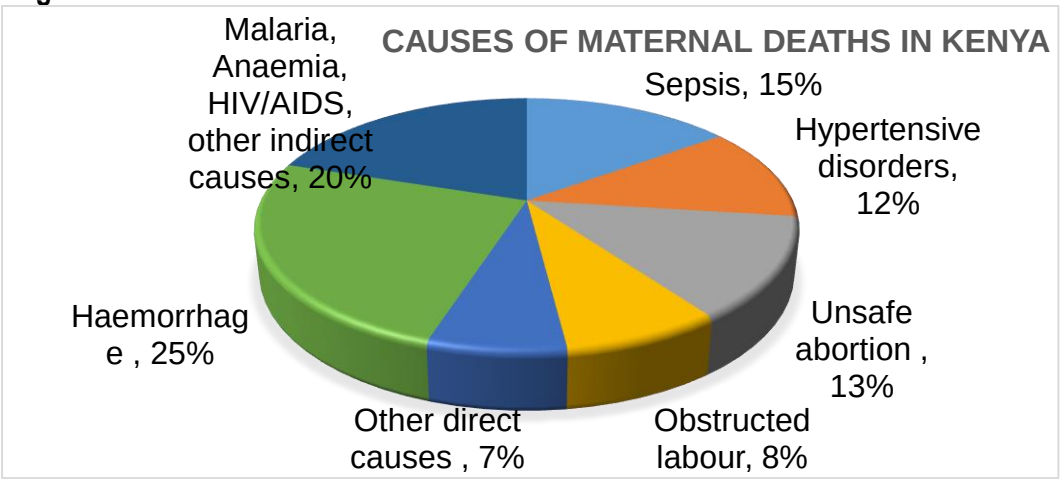


Diagram 6.2: Global Causes of Maternal Deaths (WHO, 2005)



Regional and National Causes and Distribution



5.3. Safe Motherhood

Introduction

- Safe motherhood is a woman's ability to have a safe and healthy pregnancy and delivery
- It begins with the assurance of basic safe living as a girl and a woman in society
- **It** means
  - Ensuring that all women receive the care they need to be safe and healthy throughout pregnancy and childbirth.
  - That no woman, foetus or baby should die or be harmed by pregnancy or birth.

- It is founded on freedom
  - To choose when and whether to have children, and encourages active participation during health care.
  - From discrimination of any form.

Foundations

1) Equality for All/Reproductive Health Rights
2) Community Action, Partnerships and Male Involvement
3) Support and Effective Health Systems
4) Skilled Attendants and Enabling Environment to Provide Quality Health

Pillars of Safe Motherhood

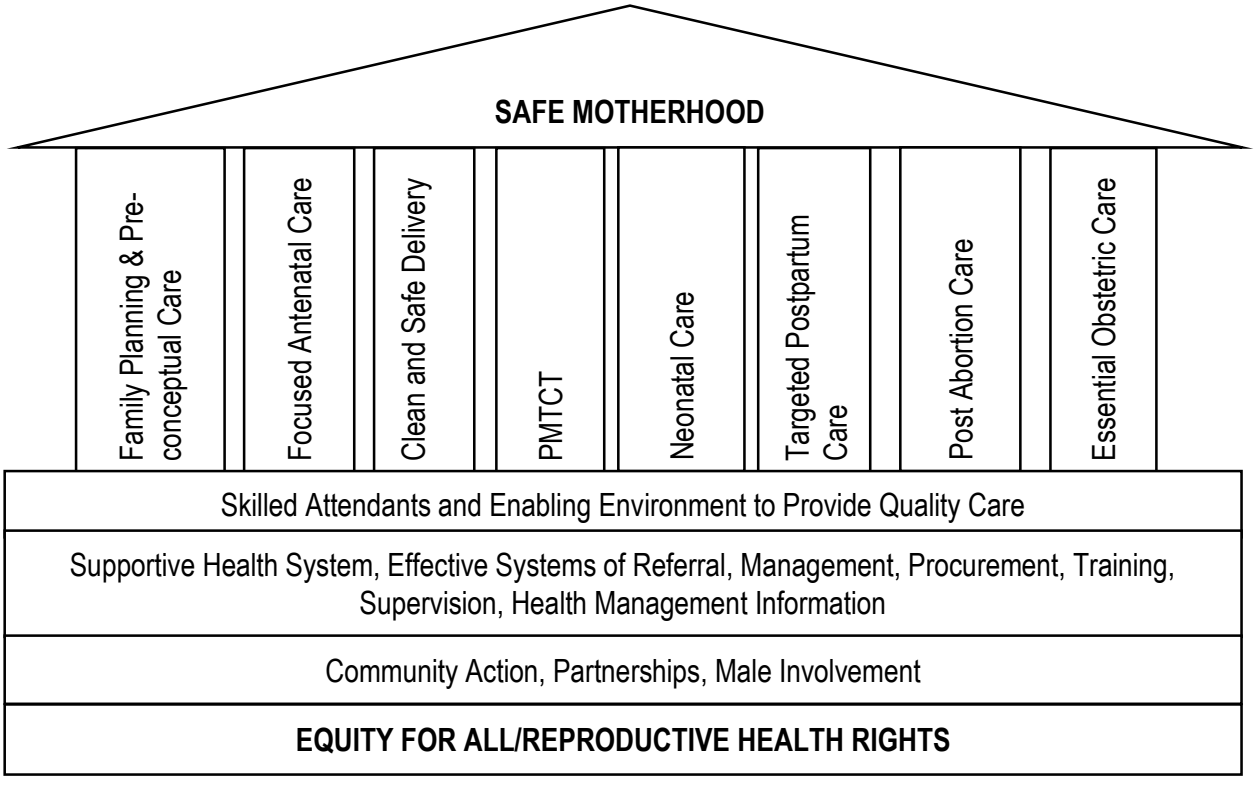
i) Family Planning (FP) and Pre-conceptual care

Family Planning

- FP is one of the means of maintenance and promotion of maternal & child health
- It's the means by which individuals/couples space the process of conception, pregnancy and child birth at intervals mutually determined by both husband and wife in order to have the desired number of children that they can conveniently maintain
- Reasons for family planning include health reasons, survival, development of the family, socioeconomic reasons, family welfare, individual welfare, marital adjustment, community and national welfare

Family Planning Methods

1) Natural methods - abstinence; cultural enforcement virginity; traditional abstinence after childbirth; cervical-mucous methods; basal-body-temperature (BBT) method; symptom-thermal method (combines BBT and cervical mucous method); rhythm (safe period) method; withdrawal (coitus interuptus) method and lactational amenorrhea method (LAM)
2) Mechanical methods - IUCD – intra-uterine contraceptive device
3) Barrier Methods - condoms (male and female), diaphragm and cervical cup
4) Chemical (hormonal) - COC (combined oral contraceptive), POP (progesterone only pill), Injectable – depo provera, Implants – Jadelle, Norplant, Implanon, Emergency contraception – E-pill; Spermicides
5) Surgical - female (tubal ligation (bilateral tubal ligation – BTL) and male (vasectomy)



Pre-Conceptual Care

Definitions

- Preconception care is any intervention provided to women of childbearing age, regardless of pregnancy status or desire, before pregnancy, to improve health outcomes for women, new-borns and children
- Peri-conception care is any intervention provided to women of childbearing age preceding, including and immediately following conception to improve health outcomes for women, new-borns and children.
- Inter-conception care is any intervention provided to women of childbearing age between pregnancies, to improve health outcomes for women, new-borns and children.

Components of Preconception Care

1) Genetic
   - Folic acid supplement (400 mcg routine, 4 mg previous neural tube defect)
   - Carrier screening (racial/ethnic background/family history):
   - Sickle cell anaemia, cystic fibrosis, thalassemia
2) Screen for Infectious Diseases, Treat, Immunize, Counsel
3) Environmental Toxins
4) Medical Assessment
5) Lifestyle
6) Assess any complications from previous pregnancies

ii) Focused Ante-Natal Care (FANC)

Introduction

-
- ANC was developed in the 1900s
- ANC is the care that a woman receives during pregnancy and helps ensure healthy outcomes for the woman and new-borns (WHO/UNICEF, 2003)
- Links the **woman and her family** with the formal health system, increases the chance of using a skilled attendant at birth and contributes to good health through the life cycle
- ANC is
  i) A key entry point for pregnant women to receive a broad range of health promotion and preventive health services – nutritional support, prevention and treatment of anaemia, prevention, detection and treatment of malaria, TB, STIs, HIV/AIDS; tetanus toxoid and immunization
  ii) An opportunity to promote benefits of skilled attendance at birth and encourage women to seek postpartum care
  iii) An avenue to counsel women about the benefits of child spacing
  iv) An essential link in the household-to-hospital care continuum (can be provided at the household and health facility)
- ANC package is to prepare for birth and parenthood; prevent, detect, alleviate, or manage health problems during pregnancy that affect mothers & babies
- ANC provides women and their families with appropriate information and advice for a healthy pregnancy, safe childbirth, and postnatal recovery, including care of the new-born, promotion of early, exclusive breastfeeding, and assistance with deciding on future pregnancies in order to improve pregnancy outcomes

Focused ANC (FANC)

- Traditional ANC used a **risk approach to classify women more likely to experience complications** and assumed that **more visits to the clinic meant better outcomes** for the mother and baby

- But many women who have risk factors will develop complications while women without risk factors can develop complications
- There was a risk of misuse of scare resources and a burden to the pregnant mothers hence the need to have an approach that emphasis **quality** over **quantity** of visits
- *FANC means that providers focus on assessment and actions needed to make decisions and provide care for each woman's individual situation*
- FANC
  - Is a goal-oriented antenatal care approach that aims to give holistic individualised care to each woman to help maintain the normal progress of her pregnancy (WHO, 2002)
  - Emphasizes on client's rights, birth preparedness and management of complications
  - Recognizes three key issues
    i) Visits are a unique opportunity for early diagnosis and treatment of problems in the mother and prevent problems in the new-born
    ii) Majority of pregnancies progress without complications
    iii) All women are considered at risk of complications because most complications cannot be predicted
- Has the following three stages:
  i) Evaluation (history taking, physical examination and basic investigations)
  ii) Intervention (prevention/prophylaxis and treatment)
  iii) Promotion (health education/counselling and health service dissemination).

Goals of FANC

- Major goal of FANC is to help women maintain normal pregnancies through: -
  i) **Targeted assessment** - ensure normal progress of the pregnancy and postpartum/new-born period and to facilitate early detection of and special care for complications, chronic conditions and other potential problems
  ii) **Individualized care** - help maintain normal progress, including preventive measures, supportive care, health messages and counselling, empowerment of women and families for appropriate and effective self-care, birth preparedness and complication readiness planning

Principles of FANC

1) Woman-friendly
2) Inclusive of a woman's partner or other family member
3) Culturally appropriate
4) Individualized
5) Part of the household-to-hospital continuum of care
6) Integrated

Essential Elements

1) Identification and surveillance of the pregnant woman and her expected child
2) Recognition & management of pregnancy-related complications, particularly pre-eclampsia
3) Recognition and treatment of underlying or concurrent illness
4) Screening for conditions & diseases such as anaemia, STIs (e.g. syphilis), HIV infection, mental health problems, and/or symptoms of stress, domestic violence
5) Preventive measures, including tetanus toxoid immunization, de-worming, iron and folic acid, intermittent preventive treatment of malaria in pregnancy (IPTp), insecticide treated bed nets (ITN)
6) Advice and support to the woman and her family for developing healthy home behaviours and a birth and emergency preparedness plan

Minimum Package

- WHO recommends **a minimum of 4 visits** (16, 24-26 weeks, 32 weeks and 36 weeks

- Each visit should include care that is appropriate to the overall condition and stage of pregnancy and should include four main categories of care
  1) Identification of pre-existing health conditions (examples)
  2) Early detection of complications (e.g., check for pre-eclampsia, gestational diabetes)
  3) Health promotion and disease prevention (e.g., tetanus vaccine, prevention and treatment of malaria, nutrition counselling, micronutrient supplements, family planning counselling)
  4) Birth preparedness and complication planning (e.g., birth and emergency plan, breastfeeding counselling, antiretroviral for HIV positive women and reducing mother-to- child transmission [PMTCT]

Preventive Interventions in FANC

- Include immunization against tetanus, reduction of iron deficiency anaemia, protection against malaria, prevention of STIs/HIV/AIDS, presumptive treatment for hookworm and protection against vitamin A and/or iodine

Antenatal Profile

- Complete blood count (full haemogram); Blood Group; Blood Sugar; Hepatitis B; HIV 1& 2; VDRL (venereal disease research laboratory); Urinalysis; TSH (thyroid stimulating hormone)

Challenges

1) Supply factors
   a) Competition for staff and money with other programmes or components
   b) Lack of enough funding
   c) Low managerial capacity
   d) Lack of up-to-date standards and protocols, poorly defined roles among programmes or staff, weak monitoring systems contribute to low quality ANC
   e) Poor regulatory mechanisms or insufficient capacity to enforce regulations
   f) Human resources are a major challenge.
   g) Staff lacking the required skills to provide all components of ANC
   h) Increased work load
   i) Weak health referral systems to support case management of complications of pregnancy inevitably reduces the overall impact of ANC.

2) Social, economic, and cultural barriers
   a) Inability to pay for ANC or the treatment prescribed in ANC
   b) Conflict or poor communication among formal health care providers, traditional birth attendants (TBA) and other CHWs
   c) Pregnancy is perceived as a natural process of life, women, families and communities may underestimate the importance of ANC.
   d) Lack knowledge about danger signs in pregnancy
   e) Lack of awareness exists about extent and impact of traditional household and community beliefs and customs, e.g. maternal nutrition, infant feeding practices
   f) The attitudes and behaviours of health care providers in ANC clinics

Four-Visit FANC Model (WHO) - GOALS

First visit (8-16 weeks)	Second visit (24-26 weeks)	Third visit (28- 32 weeks)	Fourth visit (34 weeks)
1) Confirm pregnancy and EDD 2) Classify women for basic ANC 3) Screen, treat and give preventive measures. 4) Develop a birth & emergency plan. 5) Advice and counsel.	1) Assess maternal and foetal well-being 2) Exclude PIH and anaemia 3) Give preventive measures. 4) Review and modify birth and emergency plan. 5) Advice and counsel.	1) Assess maternal and foetal well-being 2) Exclude PIH, anaemia, multiple pregnancies 3) Give preventive measures. 4) Review and modify birth and emergency plan 5) Advice and counsel	1) Assess maternal and foetal well-being 2) Exclude PIH, anaemia, multiple pregnancy, malpresentation. 3) Give preventive measures. 4) Review and modify birth and emergency plan. 5) Advice and counsel.

ACTIVITIES

Activity	First visit (8-16 weeks)	Second visit (24-26 weeks)	Third visit (28 - 32 weeks)	Fourth visit (34 weeks)
History	Assess significant symptoms Take psychosocial, medical & obstetric history; Confirm pregnancy & calculate EDD. Classify all women	Assess significant symptoms. Check record for previous complications & treatments during the pregnancy; Re-classification if needed	Significant symptoms. Check record for previous complications and treatments during the pregnancy.	Assess significant symptoms. Check record for previous complications and; Treatments during the pregnancy; Re-classification if needed
Examination	Complete general, and obstetrical examination, BP	Anaemia, BP, foetal growth, and movements	Re-classification if needed Anaemia, BP, foetal growth, multiple pregnancy	Anaemia, BP, foetal growth and movements, multiple pregnancy, malpresentation
Screening and Tests	HB, Syphilis, HIV, Urinalysis Proteinuria, Blood/ Rh group;	Urinalysis	Urinalysis	Urinalysis
Treatments	Syphilis; ARV if eligible Treat UTI if indicated	Antihelminthic, ARV if eligible; Treat UTI	ARV if eligible Treat UTI if indicated	ARV if eligible; If breech, ECV or referral for ECV; Treat UTI
Preventive measures	Tetanus toxoid Iron and folate+	Tetanus toxoid, Iron and folate, IPTp, ARV	Iron and folate IPTp, ARV	Iron and folate ARV
Health Education, advice, and counselling	Self-care, alcohol and tobacco use, nutrition, safe sex, rest, sleeping under ITN, birth and emergency plan	Birth and emergency plan, reinforcement of previous advice	Birth & emergency plan, infant feeding, postpartum & postnatal care, pregnancy spacing, reinforce previous advice	Birth and emergency plan, infant feeding, postpartum/postnatal care, pregnancy spacing, reinforcement of previous advice

Strengthening Antenatal Care

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1) Establish or strengthen national policies
2) Strengthen the quality of ANC services
   - Training to incorporate FANC protocols and new competences, attitude and motivation of health care providers is crucial.
   - Time for service delivery - 4 visits would allow for longer, high quality content at each visit
   - Supplies and logistics
   - Quality improvement approaches and tools help identify and overcome local constraints to providing client-orientated, effective ANC and ensure that women return after their first ANC visit.
3) Improve integration with other programmes
4) Harmonise activities by multiple partners through effective partnership
5) Reduce barriers to accessing care and reach out to women without access - user fees, limited opening hours, long travel distances and waiting times, and dehumanization of care.
6) Use data effectively to monitor and improve ANC coverage and quality

Features of ANC and FANC

Characteristics	Traditional antenatal care	Focused antenatal care
Number of visits	16–18 regardless of risk status (at least every month)	4 for women categorised in the *basic component* (as described later in this study session)
Approach	*Vertical*: only pregnancy issues are addressed by health providers	*Integrated* with PMTCT of HIV, counselling on danger symptoms, risk of substance use, HIV testing, malaria prevention, nutrition, vaccination, etc.
Assumption	*More frequent* visits for all and categorizing into high/low risk helps to detect problems. Assumes that the more the number of visits, the better the outcomes	Assumes all pregnancies are potentially 'at risk'. *Targeted and individualized* visits help to detect problems
Use of risk indicators	Relies on routine risk indicators, such as maternal height <150 cm, weight <50 kg, leg oedema, malpresentations before 36 weeks, etc.	Does not rely on routine risk indicators. Assumes that risks to the mother and fetus will be identified in due course
Prepares the family	To be solely dependent on health service providers	Shared responsibility for complication readiness and birth preparedness
Communication	*One-way communication* (health education) with pregnant women only	*Two-way communication* (counselling) with pregnant women and their husbands
Cost and time	Incurs much cost and time to the pregnant women and health service providers, because this approach is not selective	Less costly and more time efficient. Since majority of pregnancies progress smoothly, very few need frequent visits and referral
Implication	Opens room for ignorance by the health service provider and by the family in those not labelled 'at risk', and makes the family unaware and reluctant when complications occur	Alerts health service providers and family in all pregnancies for potential complications which may occur at any time

WHO recommendations on antenatal care for a positive pregnancy experience

- The World Health Organization (WHO) visualizes a world where every pregnant woman and newborn receives quality care throughout the pregnancy, childbirth and the postnatal period
- A positive pregnancy experience is defined as maintaining physical and sociocultural normality, maintaining a healthy pregnancy for mother and baby (including preventing or treating risks, illness and death), having an effective transition to positive labour and birth, and achieving positive motherhood (including maternal self-esteem, competence and autonomy).
- Entails
  i) Nutritional interventions – dietary interventions, supplementation for Fe, folic acid, calcium, vitamins A, B6, E, D and C zinc, macronutrients, and restrict caffeine
  ii) Maternal and foetal assessment
  iii) Preventive measures
  iv) Interventions for common physiological systems
  v) Health systems intervention to improve the utilization and quality of antenatal care
- The guidelines recommend a minimum of eight contacts to reduce perinatal mortality and improve women's experience of care.

iii) Post Abortion Care (PAC)

Introduction

- The WHO defines unsafe abortion as a procedure for terminating a pregnancy that is performed by an individual lacking the necessary skills, or in an environment that does not adhere to minimal medical standards, or both
- WHO estimates 21.6 million women experience an unsafe abortion worldwide each year, nearly half of all abortions worldwide are unsafe, and nearly all-unsafe abortions (98%) occur in developing countries

PAC approach

- PAC is an approach for reducing morbidity and mortality from incomplete and unsafe abortion and resulting complications and for improving women's sexual and reproductive health and lives.
- Five essential elements of PAC are: -
  1) Community and service provider partnerships
     - For prevention (of unwanted pregnancies and unsafe abortion), mobilization of resources (to help women receive appropriate and timely care for complications from abortion), and ensuring that health services reflect and meet community expectations and needs
     - To achieve high quality PAC and other health services, community members, lay health workers and traditional healers and formally trained service providers must work in partnership.
     - This partnership includes:
       a) Education to increase family planning and contraceptive use
       b) Education about the risks and consequences of unsafe abortion;
       c) Participation by community members in decisions on sexual and reproductive health services
       d) Education about and promotion of client-cantered, human rights-based sexual and reproductive health services, including PAC, that meet communities' expectations, priorities and needs;
       e) Education about the signs and symptoms of obstetric emergencies such as post abortion complications to promote appropriate care-seeking behaviours;
       f) Mobilization of community resources
       g) Access for special populations of women, including adolescents, women with HIV/AIDS, women who have experienced violence, women with female genital cutting (FGC), women who partner with women, refugees, commercial sex workers and cognitively and physically disabled women to PAC and other sexual and reproductive health services; and
       h) Planning for the sustainability of PAC and other sexual and reproductive health services.

  2) Counselling

- To identify and respond to women's emotional and physical health needs and other concerns;
- The aims of counselling:
  a) Solicit and affirm women's feelings and provide emotional support throughout the entire post abortion care visit;
  b) Ensure that women receive appropriate answers to their questions or are otherwise provided with information about medical conditions, test results, treatment and pain management options and follow-up care, and that they understand how to prevent post procedure complications and when and where to seek care for complications if they arise;
  c) Help women clarify their thoughts about their pregnancy, incomplete abortion, treatment, resumption of ovulation and reproductive health future;
  d) Listen and ask questions to help the provider better understand and respond to other needs and concerns that could potentially impact their care; for example, if women are infected with HIV, have STIs or are at risk of STI/HIV, or if women are survivors of sexual or gender-based violence; and,
  e) Address other concerns women may have.

3) Treatment of incomplete and unsafe abortion and complications that are potentially life-threatening;

4) Contraceptive and family planning services
   - To help women prevent an unwanted pregnancy or practice birth spacing
   - Access to a wide range of contraceptive methods, including emergency contraception, to prevent unwanted pregnancy and help women to practice birth spacing, including emergency contraception where authorized, are effective strategies for preventing future unwanted pregnancies and unsafe abortion

5) Reproductive and other health services
   - Are preferably provided on-site or via referrals to other accessible facilities in providers' networks.
   - Reproductive and other health services might include, for example:
     a) STI/HIV prevention education, screening, diagnosis and treatment;
     b) Screening for sexual and/or domestic violence, immediate treatment as needed, and referral for medical/social/economic services and support;
     c) Screening for anaemia, and treatment and/or nutrition education;
     d) Infertility diagnosis, counselling and treatment;
     e) Nutrition education;
     f) Hygiene education; and,
     g) Cancer screening and referral, as needed.

iv) Obstetric Care

- Can be essential obstetric care or emergency obstetrics care

Essential Obstetric Care (EOC)

- Provides the means to manage emergency complications when they happen and procedures for early detection and treatment to prevent the progression of problem pregnancies to the level of an emergency
- Includes early detection and treatment or referral of such problems as anaemia, preeclampsia, and prolonged labour, as well as surgery, anaesthesia, and blood replacement
- EOC is defined for two different levels of the health care system – **basic essential obstetric care** (BEOC) and **comprehensive essential obstetric care** (CEOC)

i) Basic Obstetric Care

- Includes all EOC elements with the exception of surgery, anaesthesia and blood replacement.

- Services include preventive elements that can be provided at the first referral level (health centre, maternity, or basic hospital) through non-physician providers, such as medically trained midwives.
- Approach does not demand highly trained obstetrics/gynaecology specialists or fully equipped operating theatres and, therefore, has the potential to bring services closer to women
- Basic essential obstetric care services at the health centre level should include at least the following:
  - parenteral antibiotics
  - parenteral oxytocic drugs
  - parenteral sedatives for eclampsia
  - manual removal of placenta
  - manual removal of retained products

ii) Comprehensive essential obstetric

- CEOC care services at the district hospital level (first referral level) should include all the above plus surgery, anaesthesia, and blood transfusion
- For the services at a facility to be considered functional, the elements of care must have been provided during the 6 months previous to data collection

Emergency Obstetric and Neonatal Care (EmONC)

- EmONC is a subset of EOC and responds to unexpected complications such as haemorrhage and obstructed labour with blood transfusion, anaesthesia and surgery
- It does not include management of problem pregnancies, monitoring of labour, or neonatal special care

Neonatal Care

Introduction

- Normal new-born care includes
  i) Clean childbirth and cord care to prevent new-born infection
  ii) Thermal protection - prevent and manage new-born hypo/hyperthermia
  iii) Early and exclusive breastfeeding - started within 1 hour after childbirth
  iv) Initiation of breathing and resuscitation - early asphyxia identification and management
  v) Eye care - prevent and manage ophthalmia neonatorum
  vi) Immunization
  vii) Identification and management of sick new-born
  viii) Care of preterm and/or low birth weight new-born

Essential New-born Care (ENC)

- ENC comprises:
  i) Basic preventive new-born care such as care before and during pregnancy, clean delivery practices, temperature maintenance, eye and cord care, and early and exclusive breastfeeding on demand day and night;
  ii) Early detection of problems or danger signs (with priority for sepsis and birth asphyxia) and appropriate referral and care seeking
  iii) Treatment of key problems such as sepsis and birth asphyxia.

- **Four levels of care**
  1) **Intensive care** - provided for babies who have serious problems, who are very premature
  2) **High dependency care** - provided for babies with less serious problems but who still need a great deal of observation and support and for those who are recovering from critical illness
  3) **Low dependency** - provided for babies who do not require continuous observation and/or who are stable and growing
  4) **Transitional care** - provided for babies who need some medical treatment but who are well enough to be cared for at their mother's bedside

- Is located within the maternity area of the hospital

DISCUSSION

1) Identify how local communities take care of the new-borns
2) What challenges do communities encounter in new born care?
3) What are the challenges facing health institutions with regard to new born care?

v) PMTCT

- How would you prevent transmission of HIV from the mother to the unborn child?
- What drugs will be used?

vi) Clean and Safe Delivery

- How would you ensure that mothers have clean and safe deliveries?
- What role will the community play?

vii) Post Natal Care (PNC)

Introduction

- Postpartum period is defined as one hour following the delivery of the placenta through the first six weeks of an infant's life
- Is critical to the health and survival of a mother and her new-born
- Most vulnerable time for both is during the hours and days after birth
- Lack of care in this time period may result in death or disability as well as missed opportunities to promote healthy behaviours, affecting women, new-borns, and children:

Routine PNC

- Preventive care practices and routine assessments to identify and manage or refer complications for both mother and baby including:
  1) Essential routine PNC for all mothers
     - Assess and check for bleeding, check temperature
     - Support breastfeeding, checking the breasts to prevent mastitis
     - Manage anaemia, promote nutrition, prevent malaria, vitamin A supplementation
     - Complete tetanus toxoid immunisation, if required
     - Provide counselling and a range of options for family planning
     - Refer for complications such as bleeding, infections, or postnatal depression
     - Counsel on danger signs and home care

  2) Essential routine PNC for all new-borns
     - Assess for danger signs, measure and record weight, check temperature; feeding
     - Support optimal feeding practices, particularly exclusive breastfeeding
     - Promote hygiene and good skin, eye, and cord care
     - Prophylactic eye care
     - Promote clean, dry cord care
     - Identify superficial skin infections, e.g. pus draining from umbilicus, redness extending from umbilicus to skin, swelling, redness, and hardness of skin, and treat or refer if the baby also has danger signs
     - Ensure warmth (delay the baby's first bath to after the first 24 hours, practice skin-to-skin care, and putting a hat on the baby)

- Encourage and facilitate birth registration
- Refer for routine immunizations
- Counsel on danger signs and home care

3) Extra care
   - For low birth weight (LBW), preterm or small babies and other vulnerable babies, such as those born to HIV- infected mothers (2 or 3 extra visits)
   - Intensive care is not needed to save the majority of these babies. Around one third could be saved with simple care, including:
     - Identify the small baby
     - Assess for danger signs and manage or refer as appropriate
     - Provide extra support for breastfeeding, including expressing milk & cup feeding, if needed
     - Pay extra attention to warmth promotion, such as skin-to-skin care or Kangaroo Mother Care
     - Ensure early identification and rapid referral of babies who are unable to breastfeed or accept expressed breast milk
     - Provide extra care for babies whose mothers are HIV-positive, particularly for feeding support

4) Early identification & referral /management of emergencies for mother & baby
   - Appropriate detection, management, or referrals are necessary to save mothers and babies in the event of life-threatening complications
     a. Danger signs for the mother (what are they?)
     b. Danger signs for the baby (what are they?)

Targeted PNC

- Identify specific risk factors in women and in new-borns (LBW, preterm birth, feeding problems, illness and history of prolonged and difficult labour, mother with HIV) and follow up by CHWs
- Extra care is specifically needed for LBW babies and preterm babies

Responsibility

1) Facility level – Service providers/health care workers
2) Outreach - Home visits by a skilled attendant
3) Family and community level
4) Through linking facility care with outreach and community care

Effects of PNC

1) On women
   a. Reduced postnatal maternal deaths, sepsis and infection
   b. Reduce mortality in HIV-positive mothers
   c. Access to family planning
   d. Emotional and psychosocial support to reduce the risk of depression.
2) On new-borns
   a. Reduce neonatal deaths from asphyxia (during the first day, and the majority of deaths due to preterm birth occur during the first week), infections, mainly after the first week of life and low birth weight (LBW) and preterm babies
   b. Reduce long term disability and poor development that often originate from childbirth and the early postnatal period.
3) On children
   a. Reduced child death
   b. Support breastfeeding
   c. Immunization
   d. PMTCT follow up

5.4. Gender

Introduction

- Sometimes it is hard to understand exactly what is meant by the term "gender", and how it differs from the closely related term "sex"
- "Sex" refers to the biological and physiological characteristics that define men and women while "gender" refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women.

Definitions

- Gender
  - i) Refers to the roles, norms, customs and practices by which biological differences between males and females are tabulated into socially constructed differences between men and women, boys girls based on the norms and customs of society people are assigned roles depending on their sex (Kabeer Nailt)
  - ii) Is a social construct, defining differential roles, rights, responsibilities and obligations of men and women. The social differences have been superimposed on innate/inborn biological differences between males and females to create a set of social expectations and define behaviour that are appropriate for men and women. (Ministry of Gender /UNDP)
  - iii) Refers to socially constructed and socially learnt behaviours and expectations associated that being females and males. Women and men are different biologically but all cultures interpreters and elaborate thus innate biological differences into asset of social expectations about what behaviour or activities are approach and what rights reserves and power they should possess (World Bank)
- All the definitions given point to the fact gender is a social phenomenon and not biological
- It refers to socially and culturally constructed roles
- It is a reflection of the cultural up bring and of the perceptions people have on who can do what (who does what), when and how.

Difference between Sex and Gender

- Sex refers to biological differences the basis of chromosomes, hormonal profiles, internal and external sex organs.
- Gender describes the characteristics that a society or culture considers as masculine or feminine.
- Therefore, while sex has male or female, is a biological fact that is the same in among culture, what that sex means in terms of the gender roles in society can be quite different cross cultural
- In sociological terms gender role refers to the characteristics and behaviours that different cultures attribute to the sexes. what it means to be a real man in any culture requires one to be of the male sex plus what the culture defines as masculine characteristics
- A real woman work has the female sex and the feminine social role

Gender Related Concepts

i) **Culture** - distinctive patterns of ideas, beliefs, and norms which characterise the way of life and relations of a society or group within a society

ii) **Gender analysis** - systematic gathering and examination of information on gender differences and social relations in order to identify, understand and redress inequities based on gender

iii) **Gender discrimination** - systematic, unfavourable treatment of individuals on the basis of their gender, which denies them rights, opportunities or resources

iv) **Gender division of labour** - socially determined ideas and practices which define what roles and activities are deemed appropriate for women and men

v) Gender equality and gender equity

- Gender equality denotes women having the same opportunities in life as men, including the ability to participate in the public sphere

- Gender equity denotes the equivalence in life outcomes for women and men, recognising their different needs and interests, and requiring a redistribution of power and resources

vi) **Gender mainstreaming** - an organisational strategy to bring a gender perspective to all aspects of an institution's policy and activities, through building gender capacity and accountability

vii) **Gender needs** - shared and prioritised needs identified by women that arise from their common experiences as a gender

viii) **Gender planning** - technical and political processes and procedures necessary to implement gender-sensitive policy

ix) **Gender relations** - hierarchical relations of power between women and men that tend to disadvantage women

x) **Gender training** – a facilitated process of developing awareness and capacity on gender issues, to bring about personal or organisational change for gender equality

xi) **Gender violence** - any act or threat by men or male-dominated institutions, that inflicts physical, sexual, or psychological harm on a woman or girl because of their gender

xii) **Intra-household resource distribution** - the dynamics of how different resources that are generated within or which come into the household, are accessed and controlled by its members

xiii) WIG/GAD

- WID (Women in Development) approach calls for greater attention to women in development policy and practice, and emphasises the need to integrate them into the development process
- GAD (Gender and Development) approach focuses on the socially constructed basis of differences between men and women and emphasises the need to challenge existing gender roles and relations

xiv) **Women empowerment** - a 'bottom-up' process of transforming gender power relations, through individuals or groups developing awareness of women's subordination and building their capacity to challenge it

xv) **Women's human rights** - the recognition that women's rights are human rights and that women experience injustices solely because of their gender

5.5. Maternal Bond

6.0. PROMOTION OF MATERNAL HEALTH

1) Community Support

- What structures can communities use to promote maternal health?
- What challenges do communities encounter/?
- What is the role of the CHEWs and CHWs?

2) Health services

- Policies, Personnel, Infrastructure, Supplies, Maternal Health Clinics, Mobile Clinics, PMTCT, Screening services, Family Planning Immunization campaigns, Health education, promotion and advocacy

DISCUSSION

1) What maternal health clinics are available? What services do they offer?
2) What screening services are available?

3) Cultural orientation

Explain how cultural issues would promote maternal health and reduce maternal mortality (deaths)

4) Gender issues - gender equality, gender equity, gender main streamlining, affirmative action, gender based roles,

5) Conflict resolution
6) Community development

Explain how community development would promote maternal health and reduce maternal mortality (deaths)

7) Women Empowerment and participation

Explain how empowerment of women would promote maternal health and reduce maternal mortality (deaths). Give specific examples

8) Political goodwill

Explain how political goodwill would promote maternal health and reduce maternal mortality (deaths). Give specific examples

9) Good governance

Explain how good governance would promote maternal health and reduce maternal mortality (deaths). Give specific examples

10) Constitution and legislation

- Identify sections of the constitution that promote maternal health
- Identify laws(legislation) that promote maternal health

7.0. SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KENYA

- "Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant United Nations consensus documents
- These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents
- The sexual and reproductive health rights include the right to: -
  1) Highest attainable standard of health;
  2) Life and survival
  3) Liberty and security of the person
  4) Freedom from torture, cruel, inhuman or degrading treatment
  5) Decide freely and responsibly the number and spacing of one's children and to have the information and means to do so
  6) Have control over and decide freely and responsibly on matters related to sexuality,
  7) The same right of men and women to marry with free and full consent
  8) Enjoy benefits of scientific progress and its application & consent to experimentation
  9) Privacy
  10) Participation
  11) Freedom from discrimination (on the basis of sex, gender, marital status, age, race and ethnicity, health status, disability)
  12) Access information
  13) Education
  14) Freedom from violence against women

8.0. INTERNATIONAL TREATIES

1) Covenant on Economic, Social and Cultural Rights (1966)
2) Covenant on Civil and Political Rights (1966)
3) Convention on the Elimination of all forms of Racial Discrimination (1966)
4) Convention on the Elimination of all forms of Discrimination against Women (1979)
5) The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984)

6) Convention on the Rights of the Child (1989)
7) Convention on the Rights of Persons with Disabilities (2006)

9.0. REGIONAL TREATIES

1) The African Charter on Human and Peoples' Rights (1981)
2) African Charter on the Rights and Welfare of the Child (1990)
3) The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa or the "Maputo protocol (2003)

10.0. OTHER INSTRUMENTS/COMMITMENTS

1) United Nations World Conference on Human Rights (Vienna 1993)
2) Beijing Declaration and Platform for Action adopted at the Fourth World Conference on Women (1995)
3) United Nations Millennium Development Goals (2000)
4) Abuja Declaration (2001) on HIV and AIDS, Tuberculosis (TB) and other related Infectious diseases
5) The Solemn Declaration on Gender Equality in Africa (SDGEA) (2004)
6) The Maputo Plan of Action on Sexual and Reproductive Health and Rights of operationalization of the Continental Policy framework on Sexual and Reproductive Health and Rights (2006)
7) The African Health Strategy (2007-2015)
8) Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) (2009)
9) The African Union Summit on Maternal, Infant and Child Health and Development (2010)

11.0. POLICIES ON SEXUAL AND REPRODUCTIVE HEALTH IN KENYA

1) The 2003 Adolescent Reproductive Health and Development Policy
2) The National Condom Policy and Strategy (2009-20140
3) The Contraceptive Policy and Strategy (2002-2006)
4) The Contraceptive Commodities Procurement Plan (2003-2006)
5) The Contraceptive Commodities Security Strategy (2007-2012)
6) The School Health Policy
7) Female Genital Mutilation/Cutting Policy
8) The HIV and AIDS Strategic Plan (2009/10-2012/13)
9) The National Reproductive Health and HIV and AIDS integration Strategy-August 2009
10) National Reproductive Health Policy Enhancing Reproductive Health Status for all Kenyans, October 2007
11) National Road Map for Accelerating the Attainment of the MDGs Related to Maternal and New-born Health in Kenya, August 2010.

12.0. OBLIGATIONS OF THE GOVERNMENT

1) The right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
2) Provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs
3) Ensure equitable distribution of all health facilities, goods and services
4) Adopt and implement a national public health strategy and plan of action
5) Ensure reproductive, maternal (pre- and post-natal) and child healthcare
6) Take measures to prevent, treat and control epidemic and endemic diseases
7) Provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them
8) Provide appropriate training for health personnel, including education on health and human rights

Topic 6: MILLENNIUM DEVELOPMENT GOALS (MDGs), SUSTAINABLE DEVELOPMENT GOALS (SDGs) and KENYA – VISION 2030

Learning Outcomes

At the end of the lesson the learner will be able to
1) Explain the history of MDGs
2) Identify the MDGs
3) Discuss the individual SDGs
4) Discuss the Vision 2030 for Kenya with reference to health

1.0. DEVELOPMENT

- Defined variously from different value print
- It is not a value free phenomenon since it has to do with people's lives
- Different people emphasize different aspects of development e.g. economist emphasizes quantitative aspects e.g. increase in EDP; sociologist emphasizes qualitative aspects such as people participation/empowerment.

Development, definition
- Selective attack on the worst forms of poverty
- It means that development goals must be defined in terms of progressive reduction and eventual elimination of malnutrition, diseases, illiteracy, unemployment and in-equality
- Is a process whereby the real per-capital income (per head income) of a country increases over a long period of time provided that the number of people living below the poverty line does not rise and that distribution of income does not become more unequal.

$$\text{Per capita income} = \text{GDP}$$

$$\text{Or} \quad \frac{\text{GNP of National income}}{\text{Total population of a country}}$$

2.0. INDICATORS OF DEVELOPMENT (MEASURES OF DEVELOPMENT)

- Variety of social and economic indicators used
- Make it possible to classify counties into 2 categories – developed and developing
- Indicators include gross domestic product per capita (GDP per capita), health statistics (indicators), distribution of income and wealth, literacy level, employment rates, population growth rates and dependency burdens and export trade

3.0. SUSTAINABLE DEVELOPMENT

- Sustainability pertains to a balanced interaction between a population and the carrying capacity of an environment such that the population develops to express its full potential without adversely and irreversibly affecting the carrying capacity of the environment upon which it depends.
- Sustainable development is
  - development which meets the needs of the present without comprising the ability of future generations to meet their own needs'. In other words, creating a society in which we make prudent use of, conserve and invest in our most important resources- people and our natural environment
  - using resources efficiently, living within the Earths limits and using our resources in a manner that ensures a decent quality of life for us and our children
- Domains of sustainability include
  1) The Material Domain - constitutes the basis for regulating the flow of materials and energy
  2) The Economic Domain - provides a guiding framework for husbanding and managing wealth
  3) The Domain of Life - provides the basis for appropriate behaviour in the biosphere

4) The Social Domain - provides the basis for social interactions
5) The Spiritual Domain - identifies the necessary attitudinal orientation and provides the basis for a universal code of ethics

4.0. INTRODUCTION TO MDGs

- The Millennium Development Goals (MDGs) are a set of eight goals set by 191 United Nations member countries that have the goal of halving world poverty by the year 2015
- Are the world's biggest promise – a global agreement to reduce poverty and human deprivation at historically unprecedented rates through collaborative action
- MDGs are the world's time-bound and quantified targets for addressing extreme poverty in its many dimensions-income poverty, hunger, disease, lack of adequate shelter, and exclusion-while promoting gender equality, education, and environmental sustainability
- They are also basic human rights-the rights of each person on the planet to health, education, shelter, and security.

5.0. HISTORY OF MDGs

- 1941 - President Franklin D. Roosevelt's 'Four Freedoms's speech of January 1941 and to the *Declaration of Human Rights* of 1948 and its stipulation that '*Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family including food, clothing, housing and medical care…'* (UN Declaration of Human Rights, Article 25)
- 1950 - 1980 - witnessed economic growth at a respectable pace across the developing world, which was a radical departure from the stagnation in the colonial era, but this growth did not translate into well-being for ordinary people
- 1980 – 2000 - era of markets and globalization (1980 to 2000), opposed the expectations and promises of the ideologues
- During 1980's poverty reduction was largely equated with higher economic growth, the assumption being that such growth would, sooner or later, benefit the poor through trickle-down effects as in many Africa and Latin America poverty had even worsened under SAPs
- Imbalance of development in the 1980s also led to the calling, in the early 1990s, of a number of international conferences in the UN framework that dealt with various aspects of social and ecological development leading to *'the decade of world conferences' e.g.* the 1995 Copenhagen World Summit for Social Development.
- In September 2000, the Millennium Declaration was adopted at the Millennium Summit, held in the framework of the 55th General Assembly of the United Nations (UN) at the summit was attended by the heads of state or government of nearly all UN member states
- In September 2001, the MDGs were approved by the 56th UN General Assembly
- The international community was thus in possession of a common goal system that has been agreed upon by all relevant actors and that is both measurable and set to be implemented by a fixed date.

6.0. THE MDGs

6.1. Individual MDGs

- The eight (8) MDGs and targets come from the Millennium Declaration, signed by 189 countries, including 147 heads of State and Government, in September 2000.
    1) Goal 1: Eradicate Extreme Poverty and Hunger
    2) Goal 2: Achieve Universal Primary Education
    3) Goal 3: Promote Gender Equality and Empower Women
    4) Goal 4: Reduce Child Mortality
    5) Goal 5: Improve Maternal Health
    6) Goal 6: Combat HIV/AIDS, Malaria and TB
    7) Goal 7: Ensure Environmental Sustainability

8) Goal 8: Develop Global Partnership for Development

6.2. MDG Targets and Indicators

- To measure progress towards the MDGs, a framework of 21 quantifiable targets and 60 indicators was set up by a consensus of experts from the United Nations Secretariat, the International Monetary Fund (IMF), the Organization of Economic Cooperation and Development (OECD) and the World Bank in 2003.
- Eighteen (18) targets were set as quantitative benchmarks for attaining the goals

1) Poverty and Hunger (Goal 1: Eradicate Extreme Poverty and Hunger)

Poverty

- Worldwide, approximately one billion people live on less than US$1 a day, about 2.6 billion live on < US$2 a day (40% of the world's population). In Sub-Saharan Africa, 41% of the population lives on < US$1 a day
- Term has different meanings in different situations or countries
- Complex term with various dimensions
- Scholars emphasize the following perceptions of poverty
  - i. Absolute poverty
    - a. Situation in which a population or a section of the population is able to meet only its bare subsistence essentials of food, clothing and shelter in order to maintain minimum levels of living.
    - b. Condition of life characterized by malnutrition, illiteracy, diseases, high infant mortality, low-life expectancy and poor surrounding as to be beneath any reasonable definition of human decency.
  - ii. Relative poverty
    - Situations of need that could be perceived after comparison with the living and working conditions of other members of the same society at the same true, i.e. individuals are considered poor if their incomes and other resources are below the average level of the society in which they live.
- A person is considered poor if his or her income level falls below some minimum level necessary to meet basic needs. This minimum level is usually called the "poverty line". What is necessary to satisfy basic needs varies across time and societies. Therefore, poverty lines vary in time and place, and each country uses lines which are appropriate to its level of development, societal norms and values.
- People live in poverty when they are denied an income sufficient for their material needs and when these circumstances exclude them from taking part in activities which are an accepted part of daily life in that society
- Poverty is the lack of, or the inability to achieve, a socially acceptable standard of living
  - i) Lack
    - The base case situation for the definition of poverty is that where individuals lack command over economic resources

- For example, an individual may be considered poor if he/she lacks basic food or shelter or, equivalently, if he/she lacks income to buy these basic needs

ii) Inability
- Best associated with the capability failure to participate in a society,
- Person is actually able to do (realized functioning) or the set of alternatives he/she has (real functionings)
- This space may be very basic (food, shelter) or complex (freedom, self-respect, social inclusion, etc.).
- Inability to achieve these functions makes the individual poor. E.g. disability not only reduces ability to earn income (which means lack of command over resources) but also makes it harder to convert income into functions (even though, in terms of income, that achievement is potentially feasible)
- According to this view, poverty is a state characterised by levels of capabilities that are, in the view of society, unacceptably low

iii) Standard of living
- Poverty depends on:
  - What is deemed to constitute a socially acceptable standard of living by a given society at a given time e.g. in a society where most people own cars, the use of public transport may be a signal of poverty. Not having a TV in a technologically advanced society might again be an indicator of poverty, while in other countries it may be a luxury good
  - How this standard is measured, i.e., what is the variable or the set of variables used to "capture" the standard of living.

- Human Poverty
  - The UN's Economic and Social Council has described human poverty as: "… a denial of choices and opportunities, a violation of human dignity. It means lack of basic capacity to participate effectively in society
  - It means
    - Not having enough to feed and clothe a family, not having a school or clinic to go to
    - Not having the land on which to grow one's food or a job to earn one's living, not having access to credit
    - Insecurity, powerlessness and exclusion of individuals, households and communities
    - Susceptibility to violence, and it often implies living on marginal or fragile environments, without access to clean water or sanitation

- Income Poverty
  - Is an understanding of poverty that is solely based on levels of monetary income (World Bank and the UN)
  - According to the World Bank, people living on less than US$1 per day are living in extreme poverty, and people who earn less than US$2 a day are in moderate poverty.
  - Is also used to determine a poverty threshold or poverty line (boundary between poverty and non-poverty as determined by governments)
  - It is based on the cost of subsistence needs in a given country so, while US$1 a day is the international poverty line, for countries where the cost of living is higher, the poverty line is higher. In the United States, for example, the poverty line is at about US$28 a day

Indicators of Poverty
- Are organized into five domains:
  i) Economic – unemployment, underemployment, financial stress, financial exclusion, labour force participation
  ii) Health
  iii) Education
  iv) Housing
  v) Family and community

Causes of Poverty

What are the causes of poverty in Kenya?

Hunger

- A total of 842 million people in 2011–13, or around one in eight people in the world, were estimated to be suffering from chronic hunger, regularly not getting enough food to conduct an active life. This figure is lower than the 868 million reported with reference to 2010–12. The total number of undernourished has fallen by 17 percent since 1990–92.
- Hunger describes the feeling of discomfort that is the body's signal that it is in need of more food.
- All people experience this feeling at times but, for most people, particularly in the developed world, this phenomenon is a fleeting event that is alleviated once the next meal is taken, causing no deep or permanent damage.
- When hunger or lack of food persists, however, the consequences can be devastating

Current State

What is the current state of poverty and hunger in Kenya?

Strategies	Indicators
	• Proportion of population below $1 (PPP) per day • Poverty gap ratio • Share of poorest quintile in national consumption
	• Growth rate of GDP per person employed • Employment-to-population ratio • Proportion of employed people living below $1 (PPP) per day • Proportion of own-account and contributing family workers in total employment
	• Prevalence of underweight children under-five years of age • Proportion of population below minimum level of dietary energy consumption

2) UNIVERSAL PRIMARY EDUCATION (ACHIEVE UNIVERSAL PRIMARY EDUCATION)

- The target is for all children, boys and girls, to complete a full course of primary schooling.

Strategies	Indicators
	• Net enrolment ratio in primary education • Proportion of pupils starting grade 1 who reach last grade of primary • Literacy rate of 15-24-year-olds, women and men

3) Promote Gender Equality and Empower Women

Aim	Strategies	Indicators
To eliminate gender disparity in primary and secondary education	•	• Ratios of girls to boys in primary, secondary and tertiary education • Share of women in wage employment in the non-agricultural sector • Proportion of seats held by women in national parliament

Gender

1) The state of being male or female (typically used with reference to social and cultural differences rather than biological ones). "traditional concepts of gender"
2) Gender is defined as 'the relations between men and women, both perceptual and material.

- Gender is not determined biologically (sexual characteristics of either women or men), but is constructed socially
- It is a central organizing principle of societies, and often governs the processes of production and reproduction, consumption and distribution' (FAO, 1997).
- Gender is often misunderstood as being the promotion of women only but this definition focuses on the relationship between men and women, their roles, access to and control over resources, division of labour, interests and needs. Gender relations affect household security, family well-being, planning, production and many other aspects of life (Bravo-Baumann, 2000)

3) Kabeer Nailt
   - Gender refers to the roles, norms, customs and practices by which biological differences between males and females are tabulated into socially constructed differences between men and women, boys and girls.
   - Based on the norms and customs of society people are assigned roles depending on their sex.

4) Ministry of Gender /UNDP
   - Gender is a social construct, defining differential roles, rights, responsibilities and obligations of men and women. These social differences have been superimposed on innate/inborn biological differences between males and females to create a set of social expectations and define behaviour that are appropriate for men and women.

5) World Bank
   - Gender refers to socially constructed and socially learnt behaviours and expectations associated that being females and males
   - Women and men are different biologically but all cultures interpreter and elaborate the innate biological differences into asset of social expectations about what behaviour or activities are approach and what rights reserves and power they should possess.
   - Gender is a social phenomenon and not biological as it refers to socially and culturally constructed roles
   - It is a reflection of the cultural up bring and of the perceptions people have on who can do what (who does what), when and how.

Concepts in Gender

- **Gender relations** are the ways in which a culture or society defines rights, responsibilities, and the identities of men and women in relation to one another (Bravo-Baumann, 2000)

1) Gender mainstreaming
   - Is a process that ensures that gender inequalities between women, men, boys and girls are addressed in the design, planning, implementation, monitoring and evaluation of programs and ensures that the beneficial outcomes are shared equitably by all women, men, boys and girls

2) Gender roles
   - Are the 'social definition' of women and men and vary among different societies and cultures, classes, ages and during different periods in history. Gender-specific roles and responsibilities are often conditioned by household structure, access to resources, specific impacts of the global economy, and other locally relevant factors such as ecological conditions (FAO, 1997).
   - Everything a person says or does, consciously or unconsciously, to express their maleness or femaleness—different, in different cultures

Difference between Sex and Gender

- Sex refers to biological differences the basis of chromosomes, hormonal profiles, internal and external sex organs.
- Gender describes the characteristics that a society or culture considers as masculine or feminine
- There are 3 major characteristics that distinguish sex roles from gender roles

i) Sex roles are biological deferred while gender roles are socially constructed or learnt
ii) Sex roles are universal while gender roles are multifaceted (vary that's different cultures
iii) Sex roles are pregnant or unchanging while gender roles are dynamic (they change ovals

Examples of Sex Roles

Men	**Women**
Don't give birth	Give birth to children
Do not breast fed	Breast fed
Strong physique (do heavy jobs)	Smaller bodies
Do not get pregnant	Get pregnant
Do not menstruate	Menstruate
Break their voices	Do not break their voices

3) Gender Sensitivity - ability to recognise gender issues
4) Gender Responsive - a higher level of gender sensitivity where one is not only able to recognise but is also empowered to address the gender issues and hence take action to solve a gender problem.
5) Gender discrimination - it is the unequal or unfair treatment of men or women based solely on their sex rather than on their individual skills, talents and capabilities
6) Stereotype
   - Is a standardized idea or character. *A* generalization that says all people who belong to a certain group gender, age, tribe, or race have certain characteristics and act in similar ways.
   - Gender stereotypes categorizes men and women according to rigid constructs and promote the belief that these differences are biological.
7) Gender division of labour.
8) Practical Gender Needs
   - Needs of women and men related to the responsibilities and tasks associated with traditional gender roles or to immediate necessity.
   - Responding to practical needs can improve quality of life, but it does not challenge gender divisions or men's and women's positions in society
   - Generally, involve issues of access or conditions (material in the environment in which men & women live)
9) Gender Inequality and Inequity.
   - Gender inequality-unequal access to resources by men and women e.g. unequal power relations in the household, coupled with reduced or lack of access to RH care, and reduced power in decision making over reproductive functions
   - Equity implies fairness in access to and control of opportunities and resources

4) Reduce Child Mortality

- Reduce the 1990 under-five mortality rate by two-thirds as over 9 million children under the age of five die each year, mostly from preventable diseases

Strategies	**Indicators**
	• Under-five mortality rate; Infant mortality rate • Proportion of 1-year-old children immunized against measles

5) Improve Maternal Health

- Reduce by three-quarters the maternal mortality ratio.

Strategies	**Indicators**
	• Maternal mortality ratio • Proportion of births attended by skilled health personnel

	• Contraceptive prevalence rate; Adolescent birth rate • ANC coverage (at least 1 visit and at least 4 visits) • Unmet need for family planning

6) Combat HIV/AIDS, Malaria and Other Diseases

- The aim is to halt and then begin to reverse the incidence of HIV and AIDS, malaria and other major diseases by 2015

Disease	Strategies	Indicators
HIV/AIDS	•	• HIV prevalence among population aged 15-24 years • Condom use at last high-risk sex • Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS • Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years • Proportion of population with advanced HIV infection with access to antiretroviral drugs
Malaria	•	• Incidence/death rates from with malaria • Proportion of children under 5 sleeping under insecticide-treated bed nets • Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs
TB	•	• Incidence, prevalence and death rates associated with tuberculosis • Proportion of tuberculosis cases detected and cured under directly observed treatment short course

7) Ensure Environmental Sustainability

- This goal embraces the general aim of sustainable development, while specifically seeking to halve the number of people without access to safe drinking water and sanitation, and to significantly improve the lives of the estimated 100 million slum dwellers.
- Over 2.4 billion people lack access to proper sanitation facilities and 1 billion people lack access to drinkable water

Strategies	Indicators
	• Proportion of land area covered by forest • CO2 emissions, total, per capita and per $1 GDP (PPP) • Consumption of ozone-depleting substances, • Proportion of fish stocks within safe biological limits, total water resources used, terrestrial and marine areas protected, species threatened with extinction, population using an improved drinking water source, population using an improved sanitation facility. Proportion of urban population living in slums

DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

- Establishing a fair and transparent world trade rules, debt relief and more and better quality aid
- Developed countries to work in partnership with developing countries to provide the resources and structures needed to meet the MDGs targets including Overseas Development Assistance (ODA) of 0.7%

7.0. SUSTAINABLE DEVELOPMENT GOALS (SDGs)

7.1. Introduction

- Poverty eradication is the greatest global challenge facing the world today and an indispensable requirement for sustainable development
- Poverty eradication, changing unsustainable and promoting sustainable patterns of consumption and production and protecting and managing the natural resource base of economic and social development are the overarching objectives of and essential requirements for sustainable development.

7.2. Pillars of SDGS

- The 4 pillars of SDGs include economic prosperity/sustainability, social equity/sustainability, environmental sustainability and cultural vitality

Relate this to the pillars of Vision 2030

7.3. Principles of SDGS

1) Universal
2) Equality – within countries, between countries and intergenerational
3) Gains should be irreversible
4) Sustainable development
5) Global issue must be taken into account
6) Participation
7) Accountability
8) No-discrimination
9) Holistic – must capitalize on synergy across different sectors, and understand and respond to the complex interrelations between global development challenges
10) Inclusiveness - transparent, open and participatory, recognizing access to information and decision-making as the foundation of good environmental governance, through engagement with people affected by poverty, particularly those who experience marginalization, such as women, disabled people, and indigenous people
11) Equitable - ensuring that the targets achieve reductions in inequality both within and between nations, and that fair allocation of resources is given to both people and countries which face the greatest challenges of sustainable development and poverty to allow a just transition to a world in which social, economic and environmental dimensions are equitably and sustainably managed
12) Universally applicable - contextualized national targets are needed for developed and developing countries (inspired by the principle of common but differentiated responsibility) to measure and track progress towards sustainable development and ensure accountability.

7.4. Individual SDGs

Table 6.1: Individual SDGs, Targets and Indicators

No	Description	Strategies	Indicators
1.	End poverty in all its forms everywhere		Proportion of population below $1.25 per day, Poverty Index, secure rights to land, property, and natural resources Population living below national poverty line, Poverty gap ratio (MDG Indicator) Total fertility rate Population covered by national social protection programs, Losses from natural disasters Evidence of secured rights to land, property, and natural resources Annual report by Banks, International Monetary Fund (IMF), World bank, World Trade, Domestic revenues allocated
2.	End hunger, achieve food security and improved nutrition and promote sustainable agriculture		Minimum level of dietary energy consumption; Prevalence of stunting and wasting in children, infants under 6 months who are exclusively breast fed; shortfalls of: iron, zinc, iodine, vitamin A, folate, vitamin B12/D; anaemia, Percentage children born with low birth weight Prevalence of anaemia; stunting and wasting in children under 5 years of age; percentage of infants under 6 months who are exclusively breast fed; Percentage of women, men, indigenous peoples, and local communities with secure rights to land, property, and natural resources, Losses from natural disasters; Crop yield gap; agricultural extension workers Losses from natural disasters, Crop yield gap; forest area and land under cultivation Cereal yield growth rate; Livestock yield gap; Irrigation access gap; crop insurance; Public & private R&D expenditure on agriculture & RD Technology sharing and diffusion; Genetic diversity in agriculture; agricultural extension workers Agricultural extension workers; Domestic revenues allocated; Public and private R&D expenditure on agriculture Annual reports, Average tariffs Food price volatility
3.	Ensure healthy lives and promote well-being for all at all ages		Maternal mortality ratio and rate; Percentage of births attended by skilled health personnel; ANC coverage; Post-natal care coverage (one visit) (MDG Indicator); Coverage of iron-folic acid supplements for pregnant women (%); % of health facilities meeting service specific readiness requirements infants under 6 months exclusively breast fed; Neonatal, infant, and under-5 mortality rates (modified MDG Indicator); full immunization; births attended by skilled health personnel; ANC coverage (MDG Indicator); Post-natal care coverage (one visit) (MDG Indicator); Incidence rate of diarrheal disease in children under 5 years; Percentage of children under 5 with fever who are treated with appropriate anti-malarial drugs (MDG Indicator).

No	Description	Strategies	Indicators
			Current use of any tobacco product; Harmful use of alcohol Road traffic deaths per 100,000 population Total fertility rate; Contraceptive prevalence rate (MDG Indicator); Met demand for family planning (MDG Indicator); Adolescent birth rate (MDG Indicator); % of young people receiving comprehensive sexuality education Full immunization; Healthy life expectancy at birth; Waiting time for services; Health facilities meeting service specific readiness requirements; access to affordable essential drugs and commodities on a sustainable basis; new health care facilities built in compliance with building codes and standards; Ratio of health professionals to population Mean urban air pollution of particulate matter; Mortality from indoor air pollution; Indicator on chemical pollution Current use of any tobacco product (age-standardized rate)
			Percentage of population with access to affordable essential drugs and commodities on a sustainable basis; Public and private R&D expenditure on health (% GNP); Technology sharing and diffusion
			Official development assistance and net private grants as percent of GNI; Domestic revenues allocated to sustainable development; Public & private R&D expenditure on health; Ratio of health professionals to population
			Official development assistance and net private grants as percent of GNI; Domestic revenues allocated to sustainable development as percent of GNI, by sector; Public and private R&D expenditure on health (% GNP)
4.	Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all		Primary completion rates for girls and boys; mastery of a broad range of foundational skills, Secondary completion rates for girls and boys; Percentage of girls and boys who achieve proficiency across a broad range of learning outcomes, including in reading and in mathematics by end of lower secondary schooling cycle; Number of children out of school % of children (36-59 months) receiving at least one year of a quality pre-primary education program; Early Child Development Index (ECDI); % of children under 5 experiencing responsive, stimulating parenting in safe environments Tertiary enrollment rates for women and men; % of adolescents (15-19 years) with access to school-to-work programs; % of young adults (18-24 years) with access to a learning program Secondary completion rates for girls and boys; Tertiary enrollment rates for women and men; Literacy rate of 15-24-year-old, women and men (MDG indicator); Pupil to computer ratio in primary and secondary education Percentage of children a quality pre-primary education program; Primary completion rates for girls and boys; Secondary completion rates for girls and boys; Tertiary enrollment rates for women and men

No	Description	Strategies	Indicators
			Primary completion rates for girls and boys; Percentage of girls and boys who master a broad range of foundational skills; Secondary completion rates for girls and boys; Literacy rate of 15-24 years old, women and men (MDG indicator) Percentage of girls and boys who acquire skills and values needed for global citizenship and sustainable development Share of education facilities that provide an effective learning environment; % of pupils enrolled in primary schools and secondary schools providing basic drinking water, adequate sanitation, adequate hygiene services Scholarships for students from developing countries Supply of qualified teachers
5.	Achieve gender equality and empower all women and girls		Percentage of women, men, indigenous peoples, and local communities with secure rights to land, property, and natural resources, effective financial protection or health care, per year; primary and secondary completion rates (girls & boys); representation for women and minorities; equal access to inheritance; gender gap in wages, violent injuries and deaths; physical or sexual violence Referred cases of sexual & gender-based violence against women/children that are investigated and sentenced; Violent injuries & deaths; security Percentage of women aged 20-24 married or in a union before age 18; % of girls and women aged 15-49 years who have undergone FGM/C Cover by national social protection programs; Average number of hours spent on paid and unpaid work combined (total work burden) Representation of women and minorities; Gender gap; Share of women on corporate boards of national / multi-national corporations Contraceptive prevalence rate (MDG Indicator); Undergone FGM/C; Met demand for FP (MDG Indicator); Comprehensive sexuality education Percentage of women, men, indigenous peoples, and local communities with secure rights to land, property, and natural resources, banking services (including mobile banking); Equal access to inheritance Mobile broadband subscriptions per 100 inhabitants, by urban/rural Representation of women & minorities (modified MDG Indicator); Gender gap in wages, women on corporate boards of national/multi-national corporations

No	Description	Strategies	Indicators
6.	Ensure availability and sustainable management of water and sanitation for all		Safely managed water services, by urban/rural (MDG Indicator); Wastewater treatment; Total water resources used (MDG Indicator); Basic hand washing facilities with soap and water at home; schools providing basic drinking water, adequate sanitation, and adequate hygiene services Percentage of wastewater flows treated to national standards; Indicator on water resource management Crop water productivity (tons of harvested product per unit irrigation water); Proportion of total water resources used (MDG Indicator); Proportion of the flows of treated municipal wastewater that are directly and safely reused Water resource management; Total water resources used (MDG Indicator) Indicator on international cooperation and capacity building in water and sanitation-related activities Indicator on participation of local communities for improving water and sanitation management
7.	Ensure access to affordable, reliable, sustainable and modern energy for all		Modern cooking solutions, reliable electricity, Primary energy by type Incentives for low-carbon energy in the electricity sector; renewable energy Rate of primary energy intensity improvement Official development assistance; Domestic revenues allocated to sustainable development; Fossil fuel subsidies Using reliable electricity, by urban/rural; Implicit incentives for low-carbon energy in the electricity sector
8.	Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all		
9.	Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation		
10.	Reduce inequality within and among countries		
11.	Make cities and human settlements inclusive, safe, resilient and sustainable		
12.	Ensure sustainable consumption and production patterns		
13.	Take urgent action to combat climate change and its impacts		
14.	Conserve and sustainably use the oceans, seas and marine resources for sustainable development		
15.	Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, reverse land degradation & biodiversity loss		
16.	Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable & inclusive institutions at all levels		
17.	Strengthen the means of implementation and revitalize the global partnership for sustainable development		

8.0. VISION 2030 – KENYA

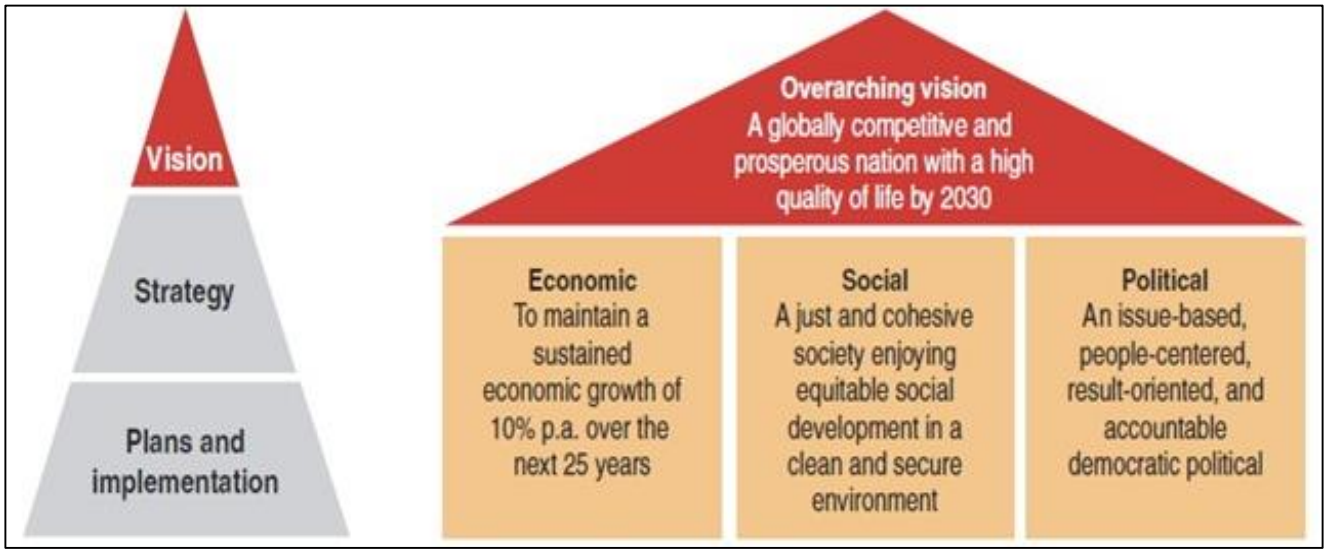
Learning Outcomes

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

8.1. Introduction

- Kenya Vision 2030 is the new long-term national planning strategy blueprint covering the period 2008 to 2030
- Aims at making Kenya a newly industrializing, "middle income country providing high quality life for all its citizens by the year 2030".
- Developed through an all-inclusive stakeholder consultative process – participation
- Based on three "pillars" namely; the economic, social and political pillars.

8.2. Pillars



8.2.1. The Economic Pillar

- Increase annual GDP growth rates to 10% and to maintain that average
- Six key sectors given priority in acting as key growth drivers
  1) Tourism
  2) Increasing value in agriculture
     - Raise incomes in agriculture, livestock and fisheries by processing and thereby adding value to her products before they reach the markets, unable producers to compete with the best in the world through an innovative, commercially oriented & modern agriculture, livestock & fisheries sector
     - Generate more money through better yields in key crops, increased smallholder specialisation utilising a million hectares of currently idle land, and new cultivation of newly opened lands
     - Introduce new land use policies
     - Improve market access to small holders through better marketing
  3) A better and more inclusive wholesale and retail trade sector
  4) Manufacturing for the Regional Market
  5) Business Process off Shoring (BPO)
     - Provide business services via the internet to companies and organizations in the developed world
     - Business process outsourcing
  6) Financial Services
     - Have a vibrant and globally competitive financial sector driving high-levels of savings and financing Kenya's investment needs
     - Raise savings and investment rates

- Reforms in the banking sector
- Credit referencing will be introduced
- Streamline informal finance and Savings and Credit Co-operative Organisations, and micro-finance institutions
- Raise institutional capital through pension fund reforms and expanding bond and equity markets, as well as tapping international sources of capital.

8.2.2. The Social Pillar

1) Education and Training

- Provide a globally competitive quality education, training and research for development
- Overall goal is to reduce illiteracy by increasing access to education, improving the transition rate from primary to secondary schools, and raising the quality and relevance of education
- Integrate all special needs education into learning and training institutions
- Achieve an 80% adult literacy rate, increase the net enrolment rate to 95%, increase the transition rates to technical institutions and universities from 3% to 8%
- Expand access to university education emphasizing on science & technology courses
- Develop key programs for learners with special needs, rejuvenate ongoing adult training programmes, and revise the curriculum for university and technical institutes.

2) The Health Sector

- Improve the overall livelihoods of Kenyans
- Provide an efficient and high quality health care system with the best standards
- Reduce health inequalities and improve key areas e.g. in reduce infant and maternal mortality
- **Specific strategies**
  i) Provision of a robust health infrastructure network
  ii) Improve the quality of health service delivery to the highest standards and promotion of partnerships with the private sector
  iii) Provide access to those excluded from health care by financial reasons.
- Flagship projects
  i) Revitalise Community Health Centres to promote preventive health care (as opposed to curative intervention) and by promoting health of individual lifestyles;
  ii) Delink the Ministry of Health from service delivery in order to improve management of the country's health institutions (primarily by encouraging independent operations at district, provincial and national hospitals);
  iii) Create a National Health Insurance Scheme in order to promote equity in Kenya's health care financing;
  iv) Channel funds directly to hospitals and Community Health Centres (as opposed to district headquarters)
  v) Scale up the output-based approach system to enable disadvantaged groups (e.g. the poor, orphans) to access health care from preferred institutions.

3) Water and Sanitation

- Conserve water sources and start new ways of harvesting and using rain and underground water.

4) The Environment

- Goal – to be a nation living in a clean, secure and sustainable environment
- Increase forest cover from less than 3% at present to 4% by 2012
- Lessen by half all environment related diseases
- **Specific strategies**
  i) Promote environmental conservation for better support to the economic pillar projects

ii) Improve pollution and waste management through the design and application of economic incentives; and the commissioning of public-private partnerships (PPPs) for improved efficiency in water and sanitation delivery.
iii) Enhance disaster preparedness in all disaster-prone areas and improve the capacity for adaptation to global climatic change
iv) Harmonize environment-related laws for better environmental planning & governance

- Flagship Projects for the Environment
  - The Water Catchment Management Initiative – rehabilitating the 5 water towers (Mau Escarpment, Mt. Kenya, Aberdares Range, Cherangany Hills and Mt. Elgon)
  - Wildlife Corridors and Migratory Routes Initiative (reclaim all wildlife corridors and migratory routes)
  - The Solid Waste Management System Initiative
  - The Plastic Bags Initiative – tightening the regulations to limit production and usage of environmentally-detrimental plastic bags, and;
  - Land Cover and Land Use Mapping Initiative – comprehensively mapping all land use patterns in Kenya.

5) Housing and Urbanisation

- An adequately and decently housed nation in sustainable all-inclusive environment.

6) Gender, Youth and Vulnerable Groups

- Improve livelihoods for vulnerable groups, and a responsible, globally competitive and prosperous youth

7) Equity and Poverty Elimination

- Reduce the number of people living in poverty
- Guarantee equality of opportunity in accessing public services and providing income generating activities as widely as possible.
- Expand access across different social and political dimensions, including increasing school enrolment for girls and children from poor, rural and slum communities; widening coverage of 'essential healthcare'; equitable distribution of water, sewerage and sanitation services; improvements in public transport and attaining gender parity and fairness in delivery of justice
- Reduce social inequalities in short, cuts across all the economic and social initiatives proposed by Vision 2030.

8) Science, Technology and Innovation (STI)

- Creation of international competitiveness through more efficient productivity at the firm and household level, with government support.
- A new incentive structure will be developed to support the use of STI in specialised research centres, universities as well as in business firms and in agriculture.

8.2.3. Political Pillar

1) Introduction

- Envisions a country with a democratic system reflecting the aspirations and expectations of its people
- Vision for 2030 is *'a democratic political system that is issue-based, people-centred, result-oriented and accountable to the public'*.
- An issue-based system is one that meets the widest public interest.
- State in which equality is entrenched, irrespective of one's race, ethnicity, religion, gender or socio-economic status; a nation that not only respects but also harnesses the diversity of its peoples' values, traditions and aspirations for the benefit of all.

2) Guiding principles

- Nine governance principles shall be adhered to:

a) Constitutional supremacy
b) Sovereignty of the people - this shall be guaranteed by an acknowledgement that government derives its power from the people.
c) Equality of citizens - Kenya shall be a nation that treats its women and men equally.
d) National values, goals and ideology
e) The Bill of Rights
f) A viable political party system - a strong and viable political party system that will be guided by policy and ideological orientation
g) Public participation in governance
h) Separation of powers - enhancement of the capacity of the three arms of government (Legislature, the Executive and the Judiciary) to discharge their Constitutional mandates in an efficient and expeditious manner and to the satisfaction of the public
i) Decentralization - democratic decentralization of decision-making and resources which calls for a devolved structure reflective of national and local structures.

3) Strategies

i) Rule of Law
- Adherence to the rule of law applicable to a modern, market-based economy in a human rights-respecting state' through enactment and operationalization of the policy, legal and institutional framework vital for promoting and sustaining fair, affordable and equitable access to justice

ii) Electoral and Political Processes
- Genuinely competitive and issue-based politics
- Enact and operationalization of necessary policy, legal and institutional framework to support issue-based political processes

iii) Democracy and Public Service Delivery
- Vision is 'a people-centred and politically-engaged open society'.

iv) Transparency and Accountability
- Envisages 'transparent, accountable, ethical & results-oriented government institutions

v) Public Administration and Service Delivery
- Vision is *'policy-driven and service-focused government institutions*
- Enact and operationalize necessary policy, legal and institutional framework to strengthen public administration and service delivery
- Specific strategies
  - Strengthen rules and processes around the policy cycle
  - Deepen use of citizen and service charters as accountability tools
  - Strengthen economic governance for better macroeconomic management; and
  - Inculcate a performance culture in the public service

vi) Security, Peace-Building and Conflict Management
- Ensure security of all persons and property throughout the Republic' through enactment and operationalize necessary policy, legal and institutional framework around security, peace building and conflict management

TOPIC 7: HEALTH SERVICES IN KENYA

Learning outcomes

At the end of the lesson the learner shall be able to
1) Identify objectives and elements of the community strategy
2) Describe the approaches and services in community health strategy
3) Describe community health services
4) Identify community based workers
5) Describe approaches to community health services

1.0. HISTORY OF HEALTH SERVICES IN KENYA

Colonial Era

- 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
- 1895 - the medical staff of the company was taken over by the British Government
- 1901 - medical department was 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 led to initiation of rat and malaria control programme
- 1915 - The first attempt to introduce a public health act
- 1924 - African Native Council was given the responsibility of administering Health Centres
- 1927 - The first formal Training of Paramedical staff – clinical officers
- 1948 - First census for Kenya was held, 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 - Family Planning Association of Kenya (FPAK) was established
- 1960 - Formation of a Ministry of Health (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.
- At independence Kenya inherited a three-tier health system –
- The central government at district, provincial and national level
- Missionaries at sub district levels
- Local government in the urban areas
- 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.
- 1965 – NHIF was introduced
- 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
- 1970 – GoK established a comprehensive rural health service system in which the health centres become the crucial points for preventive, promotive and limited curative services
- 1971-72, a joint GOK/WHO mission formulated the "*Proposal for the improvement of Rural Health Services in Kenya and establishment of 6 Rural Health Training Centres*" - Chulaimbo (Nyanza), Mbale(Western), Mosoriot (Rift Valley); Maragua (Central); Karurumo (Eastern); Tiwi (Coast)
- 1974 - The MCH/FP programme was launched

- 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."*
- 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
- 1982 - The Integrated Rural Health and Family Planning Project was launched.
- 1984 - A Community Based Health care unit was set up
- 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. Harambee movement that has existed and has greatly contributed to the development in health care delivery & education
- 1989 – user fees introduced (cost sharing or facility improvement fund – FIF)
- 2004 – 10/20 rule in dispensaries and health centres

Present Day Era

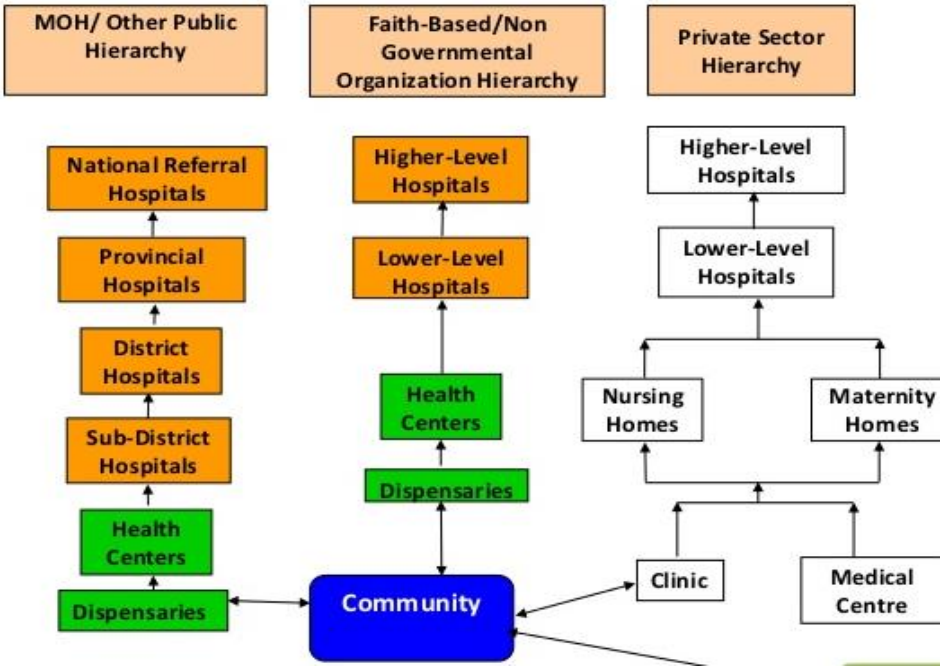
- All political parties have elaborate manifestos on health care provision thus the need to prioritize increased funding and expansion of health services in the country.
- This has been borne out of the provisions of the constitution in chapter 4 (The Bill of Rights)

2.0. THE HEALTH SECTOR

Health care service providers

- The health care providers include the government, non-governmental organizations (NGOs), faith-based organizations (FBOs) and the private sector.
- MOH and external donors support the health services offered by NGOs and the private sector
- Depending on their comparative advantage, NGOs, FBOs, and community-based organisations (CBOs) undertake specific health services
- The MOH provides support to mission health facilities by training their staff as well as seconding staff to these facilities and offering drugs and vaccines

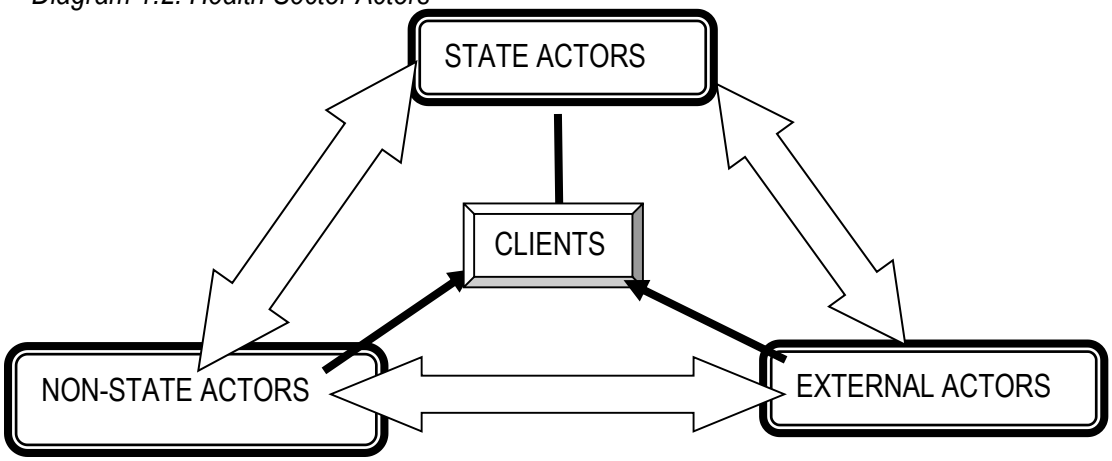
Diagram 1.1; Health Care System Hierarchy



Health Sector Actors

- The key health sector actors include
  i) Public health sector – Ministry of Health and other government institutions e.g. KMTC, NHIF, KEMSA, KEMRI, KNH, MTRH
  ii) Private sector – profit making e.g. Nairobi Hospital, Aga Khan, Karen Hospital etc. and non-profit making institutions e.g. FBOs (Catholic church, Anglican church, Methodist, Seventh Day Adventists), Charitable organisations e.g. Red Cross, Lions Club,
  iii) Alternative medicine practitioners -
  iv) Individuals, households, families and communities
  v) Development partners – USAID, UKAID, UN (WHO, UNICEF, WFP, UNESCO, UN-HABBIT, UNEP)

Diagram 1.2: Health Sector Actors



3.0. ORGANIZATION OF HEALTH SERVICES IN KENYA

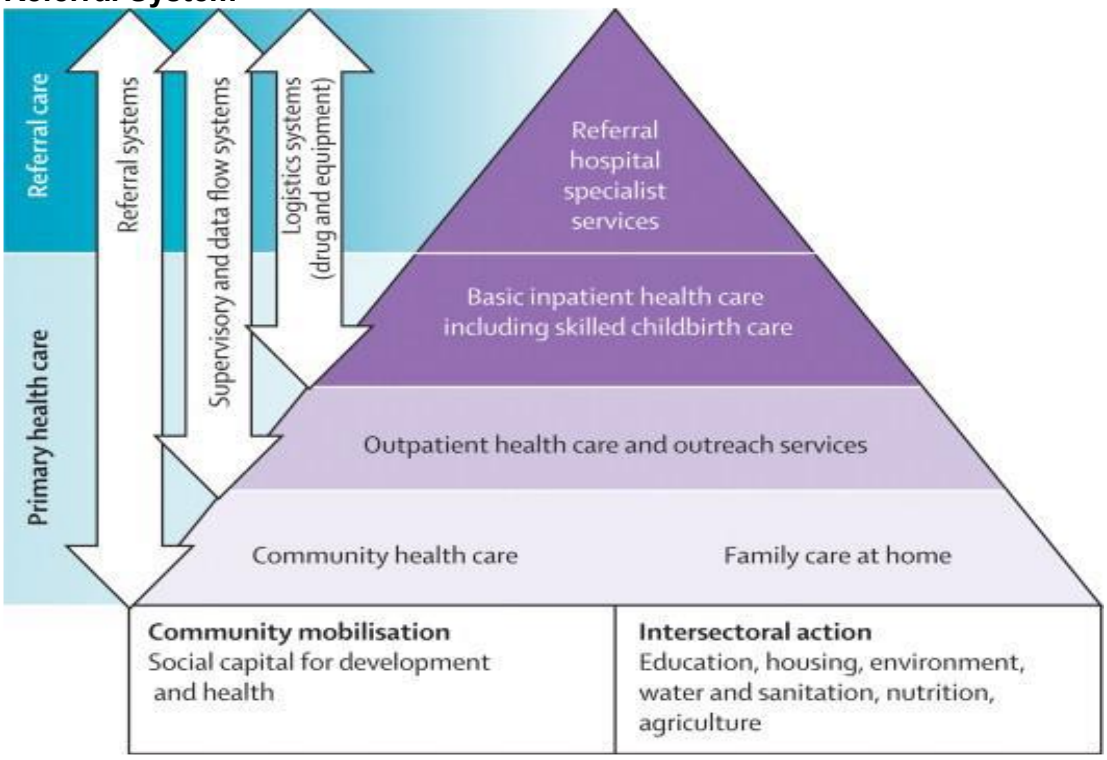
Levels of Health Care Services in Kenya

Health facilities in Kenya are grouped into six levels.

Tiers

Tier 4 - Referral Hospitals – National Referral
Tier 3 - County Level – County Referral Hospitals (Level 5) - Primary referral services
Tier 2 - PHC level – Dispensaries, Health Centres, Sub County and County Hospitals
Tier 1 - Community/Village/Household/Individuals

Referral System



4.0. HEALTH CARE PROVIDERS AND STAKEHOLDERS

Health Care Providers

- Government, Non-governmental organizations (NGOs), Faith-based organizations (FBOs), private sector
- The MoH and external donors support the health services offered by NGOs and the private sector in several ways. Depending on their comparative advantage, NGOs, FBOs, and community-based organizations (CBOs) undertake specific health services. The MoH provides support to mission health facilities by training their staff as well as seconding staff to these facilities and offering drugs and vaccines.

Stake Holders

- Community members, leaders, organizations, professionals, government, religious organizations, community based health care providers, donors, volunteers, institutions, patients, clienst and UN agencies (WHO, UNICEF, UNESCO, HABITAT, UNEP)

5.0. COMMUNITY HEALTH STRTAEGY

5.1. Introduction

- The Kenya Community Health Strategy is an approach that aims to actively engage households and communities in their own health care and rights.
- The Kenya Health Policy, 2012 – 2030 states that community health services are constituted of:
  i) Interventions focusing on building demand for existing health and related services, by improving community awareness and health seeking behaviors
  ii) Taking defined interventions and services closer to the clients / households
- The Kenya Health Sector Strategic and Investment Plan (KHSSP) further defines the specific interventions and services to be delivered categorized into five cohorts.
- Community strategy document sets out the approach to be taken to ensure that Kenyan communities have the capacity and motivation to take up their essential role in health care delivery

- Overall goal is to enhance community access to health care in order to improve productivity and thus reduce poverty, hunger, and child and maternal deaths, as well as improve education performance across all the stages of the life cycle
- This will be accomplished by establishing sustainable community level services aimed at promoting dignified livelihoods throughout the country through the decentralization of services and accountability
- 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
- NHSSP 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 II should 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
- Strategy outlines 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.
- Both the health sector reforms (HSRs) and the primary health care (PHC) concept have advocated for better health for Kenyans through people's active initiative and involvement
- HSR expanded the community-based health care (CBHC) principles by decentralization to formalize people's power in determining their own health priorities and to link them with the formal health system in order to reflect their decisions and actions in health plans
- People should participate in resource mobilization, allocation and control supported by government reforms to ensure the effectiveness of decentralization of services

5.2. Community Based Approach (CBA)

- CBA is the mechanism through which **households and communities** take an active role in health and health-related development issues
- It targets the major priority health and related problems affecting all cohorts of life at the community and household levels – level 1 of the KEPH-defined service delivery
- It is envisioned that households and communities will be actively and effectively involved and enabled to increase their control over their environment in order to improve their own health status
- CBA in intended to
  i) Build the capacity of communities to assess, analyse, plan, implement and manage health and health related development issues, so as to enable them to contribute effectively to the country's socio-economic development
  ii) Empower communities to demand their rights and seek accountability from the formal system for the efficiency and effectiveness of health and other services

5.3. Community Strategy Objectives

- The community strategy intends to improve the health status of Kenyan communities through the initiation and implementation of life-cycle focused health actions at tier 1 by:
  1. Providing level 1 services for all cohorts and socioeconomic groups, including the "differently-abled", taking into account their needs and priorities.
  2. Building the capacity of the community health extension workers (**CHEWs**) and community-owned resource persons (**CORPs**) to provide services at tier 1

3. Strengthening health facility–community linkages through effective decentralization and partnership for the implementation of TIER ONE SERVICES.
4. Strengthening the community to progressively realize their rights for accessible and quality care and to seek accountability from facility based health services.

5.4. Essential Elements Of The Community Strategy

	Element	Description
1.	Community units	• Approximately 1000 households or 5000 people who live in the same geographical area sharing resources and challenges. • Served by community health workers report to the community health extension worker. • Workers can either be a trained community worker or trained technician
2.	Community Health committee	• Elected for the whole unit or sub location and each village of the unit is represented • Has 12 members and is chaired by respected members of the community and community health extension worker (CHEW) is the secretary
3.	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 • 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 • CBHC relies on available resources within the community
4.	Community Communication	• Facilitate behaviour change of individuals at family/household level supported through advocacy & social mobilization • Maximize the use of traditional and multi-media channels as opportunities to effect behavior change • Transfer of knowledge and skills on health matters between individuals and families to make informed choices and decisions for behavior change • Creates demand for better health services and builds mutual understanding and trust among key actors within the community
5.	Advocacy	• Advocacy efforts are intensified as a means of communication focusing focuses on policy and decision making processes and influence support or action on T1 services at all levels • Channels - direct contacts, meetings, group discussions and popular theatre • This process will involve o Promoting political and social commitment, mobilizing resources, and stimulating development of supportive policies o Explaining the role of the community and other influential people o Informing leaders and other influential individuals about the aims, objectives, strategies and activities
6.	Social Mobilization	• Effective SB activities ensure that community interest is created, community members are motivated and influenced to take action or to support initiatives that are beneficial for themselves • Opportunities - village gatherings, village health days, seminars, popular theatre, youth groups, women's groups, and print and electronic media • Should sensitize and motivate social partners to work together in raising awareness and pooling resources, targeting interested organizations, individuals and health related sectors, along with CBOs, NGOs, professional associations and the private sector

5.5 Responisbilities Of Households

	Resonsbility	Key aspects
1.	Health promotion	a. Ensure a healthy diet for people at all stages in life in order to meet nutritional needs b. Build healthy social capital to ensure mutual support in meeting daily needs and coping with shocks in life c. Demand health and social entitlements as citizens d. Monitor health status to promote early detection of problems for timely action e. Take regular exercise f. Ensure gender equity g. Use available services to monitor nutrition, chronic conditions and causes of disability
2.	Disease prevention	a. Practice good personal hygiene in terms of washing hands, using latrines, etc. b. Use safe drinking water. c. Ensure adequate shelter, and protection against vectors of disease. d. Prevent accidents and abuse, and taking appropriate action when they occur e. Ensure appropriate sexual behaviour to prevent transmission of STIs
3.	Care seeking and compliance with treatment and advice	a. Give sick household members appropriate home care for illness b. Take children as scheduled to complete a full course of immunizations c. Recognize and acting on the need for referral or seeking care outside the home d. Follow recommendations given by health workers (treatment, follow up and referral) e. Ensuring that every pregnant woman receives antenatal and maternity care services
4.	Governance and management of health services	a. Attend and take an active part in meetings to discuss trends in coverage, morbidity, resources and client satisfaction, give feedback to the service system directly or through representation b.
5.	Claiming rights	a. Know what rights communities have in health b. Build capacity to claim the rights progressively c. Ensure that health providers in the community are accountable for effective health service delivery and resource use, and above all are functioning in line with the Citizen's Health Charter

6.0 COMMUNITY HEALTH SERVICES

6.1 Introduction

- Communities are the foundation of affordable, equitable and effective health care (tier 1 level of health services)
- Kenyan communities have the capacity & motivation to take up their essential role in health care delivery
- Community level activities focus on effective communication aimed at behavior change, disease prevention, and access to safe water and basic care

6.2 Tier 1 Services

1) Disease prevention and control to reduce morbidity, disability and mortality
   a) Communicable disease control: HIV/AIDS, STI, TB, malaria, epidemics
   b) First aid and emergency preparedness/treatment of injuries/trauma
   c) IEC for community health promotion and disease prevention

2) Family health services to expand family planning, maternal, child and youth services
   a) MCH/FP, maternal care/obstetric care, immunization, nutrition, C-IMCI, Adolescent reproductive health

b) Non-communicable disease control - CVS diseases, diabetes, neoplasms, anaemia, nutritional deficiencies, mental health, eye disease, oral health, etc.
c) Community-based day-care centres and referral system (in emergencies)
d) Paying for first-contact health services provided by CORPs

3) Hygiene and environmental sanitation
   a) IEC for water, hygiene, sanitation and school health
   b) Excreta/solid waste disposal
   c) Water supply and safety, including protection of springs
   d) Food hygiene
   e) Control of insects and rodents
   f) Personal hygiene
   g) Healthy home environment - sanitation, development of kitchen gardens
   h) Organizing community health days

6.3 Approaches

- Three main approaches include the use of

1) Mobile clinics
   - Used to take services to remote places, where the distribution of health facilities network is inadequate
   - A wide range of outpatient services can be provided through these affordable clinics, including preventive services- immunization, health education, family planning, antenatal and postnatal care, child growth monitoring and immunization; limited screening for cervical cancer, HIV testing and diagnosis and treatment of common sexually transmitted diseases
   - Drawbacks,
     i) Cost involved in transport and welfare of staff
     ii) Monthly or quarterly visits do not permit continuity of care

2) Community-based distribution (CBD))
   - Particularly the distribution of family planning commodities.
   - CBD workers can also be trained to
     - Elicit health problems in the community e.g. malnourished children and refer
     - Convey health education on various health conditions, including STIs, reproductive organ cancers
     - Encourage early reporting of symptoms at health facilities

3) Social marketing of health commodities
   - Involves empowering retailers to market commodities off-the-counter, normally the non-prescription types, and usually at subsidised prices e.g. painkillers
   - Besides contraceptives (e.g. condoms and pill), social marketing has been utilized to promote use of mosquito nets and oral rehydration therapy, among others. Social marketing is an important approach to making these services more easily available at places which are accessible to the people, i.e. the local duka
   - NOTE: Social marketing approach must be backed up by accessible health facilities where clients can get clinical evaluation and treatment, as necessary

6.4 Workers

- Is underpinned on the concept of using community members to render certain basic health services to the communities from which they come has a 50-year history at least
- Chinese barefoot doctor programme is the best known of the early programmes, but Thailand, made use of village health volunteers and communicators since the early 1950s

- Barefoot doctors were health auxiliaries who began to emerge from the mid-1950s and became a nationwide programme from the mid-1960s, ensuring basic health care at the brigade
- In response to the successes of this movement and the inability of conventional allopathic health services to deliver basic health care, a number of countries subsequently began to experiment with the village health worker concept
- The role of the village health workers (VHWs) as health care providers and advocates for the community and social change agents functioning as a community mouthpiece to fight against inequities and advocate community rights and needs to government structures has been well documented
- In David Werner's famous words, the health worker as "liberator" rather than "lackey" (Werner, 1981). This view is reflected in the Alma Ata Declaration, which identified CHWs as one of the cornerstones of comprehensive primary health care
- Advantages
  1) Easily communicate with and gain trust from their patients
  2) Develop culturally relevant and highly accessible health materials and information
  3) Help adapt the health care system to better suit their population's needs
  4) Cost-effective extensions of the healthcare system
  5) Successfully engage significant numbers of consumers in increasing knowledge and reducing barriers to health care quality
  6) Serve as trusted liaisons between communities and the formal healthcare system
  7) Provide invaluable progress in the removal of barriers to healthcare

1) Community Health Extension Workers (CHEWS)

- Are trainied health workers at the primary health facilities
- Roles
  1) Community entry, mobilization, organization and sensitization
  2) Establishing the information system, and the planning, implementation, monitoring, evaluation and feedback process
  3) Report writing
  4) Training of committees and CORPs
  5) Recognition and classification of common conditions and decision for action (treatment or referral)
  6) Home visiting
  7) Communication through evidence based dialogue
  8) Growth monitoring
  9) Supervision

2) Community Health Voluteers (CHVs)

- Described as 'gate keepers' of health in the community
- Are lay members of communities who work as volunteers in association with the local health care system in both urban & rural environments and usually share ethnicity, language, socioeconomic status & life experiences with community members they serve
- Have been identified by many titles such as community health advisors, lay health advocates, outreach educators, community health representatives, peer health promoters, and peer health educators
- Are effective in dialoguing with the households on actions for health since they shared a common situation and experience
- Provide a fundamental level of health care for residents in the community in which they live and have been shown to make a tremendous contribution to public health and community development
- CHVs are managed by CHC
- Roles of CHWs
  1) Offer interpretation and translation services
  2) Provide culturally appropriate health education and information

3) Assist people in receiving the care they need
4) Give informal counseling and guidance on health behaviors
5) Advocate for individual and community health needs
6) Provide some direct services such as first aid and blood pressure screening

- Volunteers form the largest group of community own resource persons
- Different communities have different needs and civil society organizations have their own priority focal areas so they are often considerable overlap between the names, roles and responsibilities of their volunteers.
- Some examples include:
  1) Health educators, health promoters, community based resource persons, community health volunteers, and community health workers tend to concentrate on the promotion of health, disease prevention and rehabilitation.
  2) Peer educators/counsellors/community counsellors
  3) Village/Community/Clinic Health Committee members and many community health volunteers serve as a link between the community and the health facility and lead the community in community based responses to TB, HIV and AIDS

3) Community Owned Resource Persons (CORPS)

- Are persons trained to promote health and welfare at community level
- Include Traditional Healers, Traditional Birth Attendants, Home-Based Caregivers, Community Health Workers (CHWs), Peer Counsellors, Health Educators, Health Promoters, Family Visitors and other persons engaged in health, as well as extension workers from other sectors.
- Roles
  1) Community entry, organization, sensitization
  2) Registering households, data gathering
  3) Collation of data on chalkboards
  4) Community dialogue for change
  5) Record keeping and report writing
  6) Health promotion
  7) Recognition and classification of common conditions and decision for action
  8) Home visiting
  9) Training and supporting home caregivers

4) Traditional Birth Attendants (TBAs)

- Highly respected in African communities and have been the main health care providers for women during childbirth by attending to majority of deliveries in the rural areas of developing countries
- Perform cultural rituals and provide essential social support to women during childbirth and are trusted by their clients and share their secrets with them
- WHO defines a TBA as “a person who assists the mother during childbirth and who initially acquired her skills by delivering babies herself or by working with other TBAs”
- Help with initiating breastfeeding; providing health education by visiting mothers during and shortly following delivery; educate them on danger signs; and accompany them on referrals to the health facilities for complicated deliveries
- Without modern training on how to attend to pregnant women, however, TBAs are unable to recognise and respond appropriately to complications of pregnancy making deliveries attended by untrained TBAs risky for women and their babies, leading to poor health outcomes and even death
- Training TBAs has been a key strategy for improving maternal and child health care in many African countries. This has improved their effectiveness in areas such as the reduction of neonatal tetanus, increasing the provision and use of antenatal care, and increasing referrals in case of complications but not reduction in maternal mortality

- TBAs cannot be substitutes for skilled providers but meet vital community needs in supporting women throughout pregnancy, childbirth and the post-partum periods
- Tuba's to work closely with health planners, health professionals and other members of the formal health system as a strong link between the community and the health services and should be included in community education and mobilisation efforts

5) Skilled Birth Attendants(SBAs)

- WHO advocates for "skilled care at every birth". Ensuring quality maternity care services can save the lives of women and newborns
- These services require "an accredited health professional – such as a midwife, clinical officer, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns"
- These health professionals should be motivated and located in the right place at the right time and need to be supported by appropriate policies, essential supplies including medicines and operating under appropriate regulatory frameworks

6.5 Leadership/Management - Community Health Committee (CHC)

- CHC (members are elected at the assistant chief's *baraza* and generally are elders or of respectable social status)
- Together, these administrative and managerial structures constitute the community health strategy and shape the roles of CTC providers.
- Roles of CHC
  1) Identifying community health priorities
  2) Planning community health actions
  3) Participating in community health actions
  4) Monitoring and reporting on planned health actions
  5) Mobilising resources for health actions
  6) Coordinating CHWs activities
  7) Organising and implementing community health days
  8) Reporting to level 2 on priority diseases and other health conditions
  9) Leading community outreach and campaign initiatives
  10) Advocating for good health in the community

TOPIC 8: COMMUNITY AND HOME BASED CARE AND SCHOOL HEALTH SERVICES

Learning outcomes

- At the end of the lesson the learner shall be able to
  1) Describe community and home based care
  2) Explain the concepts of palliative care
  3) Discuss the school health services

1.0 HOME AND COMMUNITY BASED HEALTH CARE (HCBC)

1.1 Introduction

- Care given to the patients at home via family participation and community involvement with available resources in collaboration with health care workers.
- Objectives include
  1) To facilitate continuity of care from the health facilities to the home and community
  2) To promote family and community awareness of care and prevention .
  3) To empower the family/community with knowledge needed to ensure long-term care and support
  4) To raise the acceptability levels by family & community in order to reduce the stigma
  5) To streamline the patient/client referral from the institution into the community and from the community to appropriate health and social facilities
- Services provided include: -
  1) Care, counselling and support
  2) Addressing the needs of child-headed households
  3) Linking families and caregivers with programmes that address poverty
  4) Providing food parcels and food supplements
  5) Establishing support groups and promoting information sharing
  6) Providing trauma and therapeutic counselling
  7) Providing information to improve access to social, educational, housing, material and healthcare services
  8) Encouraging young people, women and men to become involved in prevention
  9) Providing medicines/drugs
  10) Providing palliative care including home based care (HBC) programmes

1.2 Importance of HBC

1) Sick person learns safe health care skills & positive living
2) Family or care giver learns new skills to cope more effectively with the condition
3) Community health workers link the family and patients to other health services
4) Health care system is less burdened

1.3 Key Players in HBC

	Player	Description and role
1.	The sick	• 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 • Resolve in taking personal responsibility for improvement and prevention of spread • Advocate for behaviour change and informing other
2.	Family	• Care for the sick at home collaborating with other care providers e.g. religious institutions, health and social institutions • Consult and involve the sick on matters concerning them

	Player	Description and role
		• Help them to accept the reality of the situation i.e. the sick to accept the reality • Help the sick person to prepare for death (terminal illness)
3.	Community	• Accept the situation of the sick and accept them in the family without stigma • Collaborate with the existing agencies to meet the needs of those affected • Support the family of the sick
4.	Health facility	• Make initial diagnois and also deliver technical care • Recruiting the sick into the programme (identify needs at various levels and prepare sick for 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
5.	Government	• Create a supportive policy and environment • Provide/coordinate home based training and care standards • Provide essential drugs and commodities

1.4 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
3) Social support-information and referral to support welfare and legal advices for individuals and families and where possible provision of material assistance 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) Environmental cleanliness
7) Referral

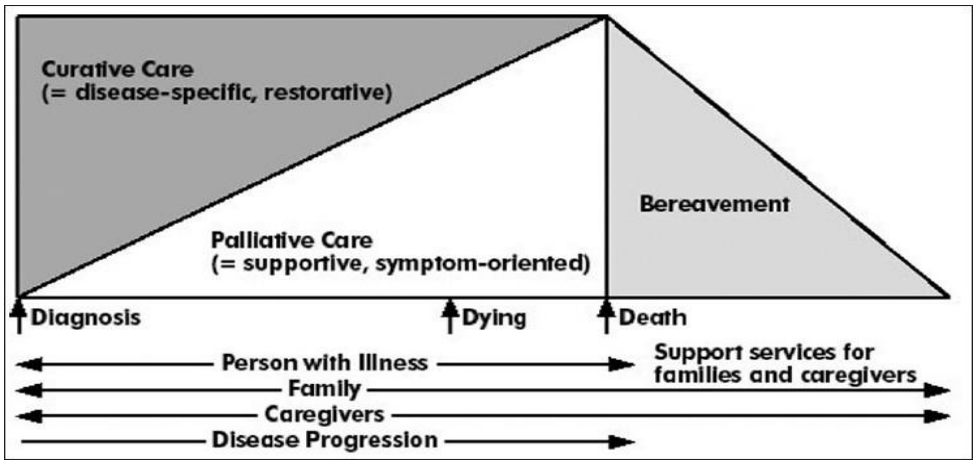
2.0 PALLIATIVE CARE (PC)

2.1 Introduction

- PC is an urgent humanitarian need worldwide for people with cancer and other chronic fatal diseases
- Palliative care is an approach that improves the quality of life of patients who have a serious life threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual (WHO)
- Particularly needed in places where a high proportion of patients present in advanced stages and there is little chance of cure
- Should also provide support to families in their bereavement
- Effective palliative care services are integrated into the existing health system at all levels of care, especially community and home-based care.
- Palliative care
  1) Provides relief from pain and other distressing symptoms
  2) Affirms life and regards dying as a normal process
  3) Intends neither to hasten or postpone death
  4) Integrates the psychological and spiritual aspects of patient care
  5) Offers a support system to help patients live as actively as possible until death
  6) Offers a support system to help the family cope during the patients' illness and in their own bereavement
  7) Uses a team approach to address the needs of patients and their families, including bereavement counselling
  8) Enhances quality of life and may also positively influence the course of illness

2.2 WHO Definition of Palliative Care for Children

- PC for children represents a special, albeit closely related field to adult palliative care
- WHO's definition of palliative care appropriate for children and their families is as follows; the principles apply to other paediatric chronic disorders
  1) PC for children is the active total care of the child's body, mind and spirit, and also involves giving support to the family
  2) It begins when illness is diagnosed, and continues regardless of whether or not a child receives treatment directed at the disease
  3) Health providers must evaluate and alleviate a child's physical, psychological, and social distress
  4) Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited
  5) It can be provided in tertiary care facilities, in community health centres and even in children's homes



2.3 Skills

- Palliative care services require skills in the following areas:
  1) Communication
  2) Decision-making
  3) Management of complications of treatment and the disease
  4) Management of pain and symptoms
  5) Psychosocial care for the patient and family
  6) Spiritual understanding and approaches
  7) Care of the dying
  8) Bereavement care

2.4 Needs

- Spiritual, dignity, hope and respect

2.5 Levels

Level	***Description***	***Activities***
I	*Palliative Care Approach*	• Palliative care principles should be practiced by all health care professionals • Should be a core skill of every clinician at hospital and community level • Many patients with progressive and advanced disease will have their care needs met comprehensively and satisfactorily without referral to SPC units or personnel • Aims to promote both physical and psychosocial well-being

		• It is a vital part of all clinical practice, whatever the illness or its stage and is informed by knowledge and practice of palliative care principles
II	*General Palliative Care*	• A proportion of patients and families will benefit from the expertise of health care professionals who, although not engaged full time in palliative care, have had some additional training and experience in palliative care, perhaps to diploma level • Expertise may be available in hospital or community settings
III	*specialist palliative care*	• Services whose core activity is limited to the provision of palliative care • Involved in the care of patients with more complex and demanding care needs, and consequently, require a greater degree of training, staff and other resources • Provided by an inter-disciplinary team, under the direction of a consultant physician in palliative medicine • Available in primary care settings, acute general hospital settings and specialist inpatient units (i.e. hospices)

2.6 Instruments

1) Needs assessment
2) Emotional support
3) Information and communication
4) Clinical ethics as the method for decisions
5) Team work (change in the micro organization)
6) Change in the organization of resources
7) Education, training, and research

3.0 SCHOOL HEALTH SERVICES (SHS)

3.1 Introduction

- Coordinated school health components work together to improve the lives of students and their families

3.2 Stakeholders

Who are the stakeholders of SHP?

3.3 Objectives

1) Early detection and care of students with health problems
2) Development of healthy attitudes and healthy behaviors by students
3) Ensure a healthy environment for children at school
4) Prevention of communicable diseases at school

3.4 Activities

1) Comprehensive Health Education

- Health education is a planned, sequential, curriculum and program that addresses the physical, mental and emotional, and social dimensions of health
- Allows students to develop and demonstrate increasingly essential health-related knowledge, attitudes, skills, and practices
- Topics covered include personal health, family health, community health, consumer health, environmental health, family living, mental and emotional health, injury prevention and safety, CPR, nutrition, prevention and control of disease and substance use and abuse

- Proceed by qualified professionals e.g. health educators, teachers, school counsellors, clinicians, school nurses, registered dietitians, and community health care professionals provide health education.

2) Health Services

- Are provided to appraise, protect, and promote the health of students
- Include assessment, planning, coordination of services and direct care for all children, including those with special health care needs
- Services are designed and coordinated with community health care professionals to
  - i) Ensure early intervention
  - ii) Access and referral to primary health care services
  - iii) Foster appropriate use of primary health care services
  - iv) Prevent and control communicable disease and other health problems
  - v) Provide emergency care for student and staff illness or injury
  - vi) Provide daily and continuous services for children with special health needs
  - vii) Promote and provide optimum sanitary conditions for a safe school facility and school environment
  - viii) Provide educational and counselling opportunities for promoting and maintaining individual, family and community health
  - ix) Screening activities – medical examination
- Qualified professionals e.g. clinicians, physicians, psychiatrists, psychologists, dentists, health educators, school health nurses, registered dietitians, school counsellors, and allied health personnel including speech therapists and occupational or physical therapists provide these services

3) Nutrition Services

- Assure access to a variety of nutritious, affordable and appealing meals in school that accommodate the health and nutrition needs of all student
- Example - School feeding program (SFP)

4) Physical Education/Physical Activity

- Follows national standards in providing developmentally appropriate, cognitive content and learning experiences in a variety of physical activity areas such as basic movement skills; physical fitness; rhythm and dance; cooperative games; team, dual, and individual sports; tumbling and gymnastics; and aquatics
- Quality physical education promotes, through a variety of planned individual and cooperative physical activities and fitness assessments, each student's optimum physical, mental, emotional and social development; and provides fitness activities and sports that all students, including students with special needs, can enjoy and pursue throughout their lives
- Qualified professionals such as physical education teachers and physical activity specialists provide physical education and related fitness activities

5) Healthy School Environment

- Concerns the quality of the physical and aesthetic surroundings; the psychosocial climate, safety, and culture of the school; the school safety and emergency plans
- Factors and conditions that influence quality of physical environment include the school building and the area surrounding it; transportation services; any biological or chemical agents inside and outside the school facilities that are detrimental to health; and physical conditions such as temperature, noise, lighting, air quality and potential health and safety hazards
- Quality of the psychological environment includes the physical, emotional and social conditions that affect the safety and wellbeing of students and staff

- Qualified staff such as principals, school and community counsellors, social workers, psychologists, clinicians, public health officers, school health nurses, health educators, and school safety officers assess and plan for these factors and conditions in the school environment

6) School Counselling, Psychological and Social Services

- Provided to assess and improve the mental, emotional, and social health of every student
- Include developmental classroom guidance activities and preventative educational programs to enhance and promote academic, personal, and social growth
- Students with special needs are served through the administration and interpretation of psychometric and psycho-educational tests, observational assessments, individual and group counselling sessions, crisis intervention for emergency mental health needs, family consultation, and/or referrals to outside community-based agencies when appropriate
- Professional skills of counsellors, psychologists, and social workers, along with school health care providers are utilized
- Qualified professionals provide these services

7) Student, Family and Community Involvement

- Involvement of students, parents, community representatives, health specialists, and volunteers in schools provides an integrated approach for enhancing the health and wellbeing of students both at school and in the community
- School administrators, teachers, and school health staff solicit family involvement and engage community resources, expertise, and services to respond effectively to the health-related needs of students and families
- Qualified professionals such as principals, teachers, and school health staff, along with students, parents and volunteers, provide leadership in this area.

8) School-Site Health Promotion for Staff

- Wellness opportunities such as health assessments, health education and physical fitness activities are provided to all school staff
- Encourage staff to pursue a healthy lifestyle that contributes to their improved health status and morale, greater personal commitment to the overall school health program
- Activities conducted on-site improve productivity, decrease absenteeism, and reduce health insurance costs
- Qualified professionals such as principals, supervisors, health educators, school health nurses and school personnel/human resources directors provide leadership in this area

3.5 Advantages and Challenges

What are the advantages of SHP?
What are the challenges facing SHP in Kenya?