COURSE GUIDE

NSC 303
CONCEPTS AND STRATEGIES IN PUBLIC COMMUNITY HEALTH

Course Team Mr. K.S. Olubiyi (Developer/Adapter) – NOUN
Dr. Alberta David Nsemo (Course Reviewer) – University of Calabar
Mrs. Eunice Opeyemi Olokoba (Course Coordinator) – NOUN

NATIONAL OPEN UNIVERSITY OF NIGERIA

National Open University of Nigeria Headquarters
14/16 Ahmadu Bello Way
Victoria Island
Lagos

Abuja Office
No. 5 Dar es Salaam Street
Off Aminu Kano Crescent
Wuse II, Abuja

Nigeriae-mail: centralinfo@nou.edu.ng
URL: www.nou.edu.ng

Published By:

National Open University of Nigeria

CONTENT PAGE

Introduction………………………………………… iv
Course Aim………………………………………… iv
Course Objectives………………………………….. iv
Working through this Course………………………. v
Study Units…………………………………………. v
Presentation Schedule………………………………. vi
Assessment…………………………………………. vi
How to get the most from the Course………………. vi
Final Examination and Grading……………………. vii
Grading Criteria……………………………………. vii
Online Facilitation…………………………………. viii
Course Information………………………………… viii
Course Team……………………………………….. viii

INTRODUCTION

Nigeria currently comprises 47.25 per cent of rural population. There is a great imbalance in provision of medical care facilities, and it has become a great challenge to provide health services to the very large population. Primary health care has been considered as the main instrument of action for providing Health for All. Primary Health Nursing addresses the health needs of the community at all levels of care- Primary, Secondary and Tertiary, in homes, school, health centers and hospitals etc.

The course on Primary Health Nursing is divided into three Modules. Module 1 focuses on the introduction to Community- Public health, The module highlights various concepts related to Community-Public Health, Historical background, and models of disease causation. Module 2 focuses on Primary Health Care: Health for All approach. Concepts and Principles of Primary Health Care (PHC), Health for All and Organisations of health systems based on Primary Health Care were emphasized. Module 3 focuses on Family Healthcare which covers the aspects of Sustainable Development Goals (SDGs) and the roles of PHC in achieving SDGs. Maternal and Child Health as well as Health Promotion is largely dealt with in this module. Study of maternal and child health is extremely essential because these constitute the larger and vulnerable segment of population. Each module has its own objectives.

COURSE AIM

The aim of this course is to update your knowledge on the health needs of the community at all levels of care: primary, secondary, and tertiary, in homes, school, health centers and hospitals etc.

COURSE OBJECTIVES

On successful completion of the course you should be able to:

- Discuss Community and Public Health in Nigeria
- State the determinants of health
- Explain Globalisation of health
- Discuss the Models of disease causation
- Describe the Concepts and Principles of Primary Health Care
- Explain Health For All approach of Primary Health Care
- Analyse organisations of healthcare systems based on Primary Health Care
- List Healthcare resources
- Discuss Monitoring and Evaluation of health services

- Outline the Role of the nurse in Primary Healthcare
- Define the Concepts of family and family health
- Discuss the Sustainable Development Goals and components
- Enumerate Health related SDGs
- List the components of Maternal and Child Health care
- Explain the importance of male involvement in MCH/Family Planning
- Define the Concepts of Health Promotion
- Describe the Elements and Principles of Health Promotion
- Discuss Health Promotions activities at various levels of healthcare services

WORKING THROUGH THIS COURSE

This course has been carefully put together bearing in mind that you might be new to the field. However, efforts have been made to ensure that adequate explanation and illustrations were made to enhance better understanding of the course. For successful completion of the course, students are required to read each module and its unit, read the textbooks materials suggested for further study as provided by the National Open University of Nigeria. Reading the referenced materials can also be of great assistance. Each unit has Self-Assessment Exercises (SAEs) which you are advised to do and at the end answers to each SAEs are provided to guide the students. Each unit also has Tutor-Marked Assignments which every student is expected to do and submit within the assigned time frame. At the end of the course, there will be final examination to assess students" knowledge and skills. The course should take you about 17 weeks to complete. This course guide will provide you with all the components of the course, how to go about studying and how you should allocate your time to each unit to finish on time and successfully.

STUDY UNITS

This comprises of three modules that are broken down into nine units. They are listed below:

MODULE 1 INTRODUCTION TO COMMUNITY-PUBLIC HEALTH

Unit 1 Basic Concepts and Definitions in Community-Public Health
Unit 2 History of community and Public health
Unit 3 Model of disease causation theories
Unit 4 community and Public Health in Nigeria

MODULE 2 PRIMARY HEATH CARE (PHC): HEALTH FOR ALL APPROACH

Unit 1	Concepts and Principles of Primary Health Care
Unit 2	Health For All
Unit 3	Organisation of Health Systems based on Primary Health Care
Unit 4	Health care Resources and Monitoring and Evaluation of Health Services

MODULE 3 FAMILY HEALTH CARE

Unit 1	Basic Concepts and Definitions of family and family health
Unit 2	Sustainable Development Goals
Unit 3	Maternal and Child Healthcare
Unit 4	Health Promotion

PRESENTATION SCHEDULE

There is a timetable prepared for the early and timely completion and submissions of all assignments as well as attending the tutorial classes. You are required to submit all your assignments by the stipulated time and date.

ASSESSMENT

There are three aspects to the assessment of this course. The first one is the self-assessment exercises, the second is the tutor-marked assignments, and the last one is the written examination to be taken at the end of the course. Students are required to carry out the exercises or activities in the unit by applying the information and knowledge acquired during the course. The tutor-marked assignments must be submitted to your facilitator for formal assessment in accordance with the deadlines stated in the presentation schedule and the assignment file. The work submitted to your tutor for assessment will count for 30% of your total course work. At the end of this course, you must sit for a final or end of course examination of about a three-hour duration which will count for 70% of your total course work.

HOW TO GET THE MOST FROM THE COURSE

The National Open University of Nigeria employs open and distance learning mode of study; therefore, the study units replace the university lecturer in the conventional university system. This is one of the

advantages of distance learning mode; you can read and work through specially designed study materials at your own pace and at a time and place that suit you best. The study guide tells you what to read, when to read and the relevant texts to read for further information. You are provided with exercises at appropriate points, just as a lecturer might give you an in-class exercise. Each of the study unit follows a common format. The first item is an introduction to the subject matter of the unit and how a particular unit is integrated with the other units and the course. Next to this is a set of learning objectives. These learning objectives are meant to guide your studies. The moment a unit is completed, you must go back and check whether you have achieved the objectives or not. If you make this your habit, then you will significantly improve your chances of passing the course examination. The main body of the units also guides you through the required readings from other sources. This will usually be either from a textbook or from other sources. Self-assessment exercises are provided throughout the unit, to aid personal studies and answers are provided at the end of the unit. Working through these self-tests will help you to achieve the objectives of the unit and also prepare you for tutor marked assignments and examinations. You should attempt each self-test as you encounter them in the units.

FINAL EXAMINATION AND GRADING

The final examination for course NSC303 will be pen-on-paper and has a value of 70% of the total course grade. The examination Pass mark is 50%.

GRADING CRITERIA

The total of 100% for this course shall be made up as follows:
Continuous Assessment - 30%
End of Course Examination - 70%
Total-100%

GRADING SCALE

A = 70-100
B = 60 - 69
C= 50 – 59
F = < 49

ONLINE FACILITATION

There are hours of facilitation to support this course material. You will be notified of the dates, times, and locations of these facilitation as well as the names and phone numbers of your facilitator.

COURSE INFORMATION

Course Code: NSC 303
Course Title: Concepts and Strategies in Public-Community Health
Credit Unit: 2Credit Units
Year: 3
Pre-Requisite: All courses in the BNSC degree programme in the year 1 to 2
Course Status:
Course Blub:
Semester: First semester
Course Duration: 17 weeks
Required Hours for Study

COURSE TEAM

Course Developer: NOUN
Course Writer: Mr. K.S. Olubiyi (Developer/Adapter) - NOUN
Dr. Femi Peters (Editor) - NOUN
Professor O.C. Nwana (Prog. Leader) - NOUN
Mr. K.S. Olubiyi (Course Coordinator) – NOUN
Content Editor:
Instructional Designer:
Learning Technologists:
Copy Editor

NSC 303: CONCEPTS AND STRATEGIES IN PUBLIC - COMMUNITY HEALTH (1-1-0) 2 UNITS

MODULE 1 INTRODUCTION TO COMMUNITY-PUBLIC HEALTH

Unit 1	Basic Concepts and Definitions in Community-Public Health
Unit 2	History of community and public health
Unit 3	Model of disease causation theories
Unit 4	community and Public Health in Nigeria

Glossary

Environment: refers to surroundings or the conditions under which a person or a thing exists and develops his/her own character. It covers both physical and cultural elements.

Family: a group of persons united by blood, adoptive, marital, or equivalent ties, usually sharing the same dwelling unit. The **extended family** is muti-generational; the **nuclear family**, in contrast, is a single generation family, usually husband-wife-children, but is often headed by a single parent.

Globalization: is the process of increasing economic, political, and social interdependence that takes place as capital, traded goods, persons, concepts, images, and values diffuse across the state boundaries.

Health Economics: economics principles applied to the health field. One role of health economics is to provide a set of analytical techniques to assist decision-making, usually in the health care sector, to promote efficiency and equity.

Health Education: is a process with intellectual, psychological and social dimensions affecting their personal, family and community wellbeing.

Health Policy: is a set of statements and decisions defining health priorities and main directions for attaining health goals.

Health Promotion: a concept, set of activities, or process aimed at increasing people's ability to control and improve their health, and to reduce specific diseases and associated risk factors that reduce the health, wellbeing, and productive capacity of the individual and the society.

Health: a complete sate of mental, physical, social, and emotional well-being, not merely the absence of disease or infirmity.

Hygiene: means the science of health and embraces all factors which contribute to healthful living.

Immunization: protection of susceptible individuals from communicable diseases through administration of a living modified agent, a suspension of killed organisms (E.g., pertusis), a non-infective portion of an infective agent (e.g., hepatitis B), or an inactivated toxin (e.g. , tetanus toxoid) .

Intersectoral Collaboration is referred to the activities involving several sectors of the government, e.g., health, education, housing, industrial, etc., that, working together, can enhance health conditions more effectively than when working independently of one another.

Lifestyle: is the set of habits and customs that is influenced, modified, encouraged, or constrained by the lifelong process of socialization. These habits and customs include use of substances such as alcohol, tobacco, tea, coffee; dietary habits, exercise, etc, which has important for health and are often the subject of epidemiological investigations.

Personal Hygiene: good personal hygiene means taking care of yourself every day, from your hair to your feet, by following the rules of proper washing and grooming, healthful nutrition, and getting enough physical activity and rest.

Policy: a system that provides the logical framework and rationality of decision making for the achievement of intended objectives. It is the statements that guide and provide discretion within limited boundaries. Policy is a guide to action to change what would otherwise occur, a decision about and allocation of resources: the overall amount is a statement of commitment to certain areas of concern; the distribution of the amount shows the priorities of decision makers. Policy sets priorities and guides resources allocations. Prevention is an intervention or intervention that interrupts the web of causality leading to one or more aspects of ill health.

Prevention: refers to the goals of medicine that are to promote health, to preserve health, to restore health when it is impaired, and to minimize suffering and distress.

Public Health: is defined as “organized community efforts aimed at the prevention of disease and promotion of health. It links many disciplines and rests up on the scientific core of epidemiology”; predominantly

observational and committed to health of the populations. Ultimately, its many components must accommodate multiple causes acting in the dimensions of time, space, and structure, and thus at several relevant levels of organization (from molecules to the encompassing environment).

Strategy: is the determination of the basic long-term goals of an organization or government and the adoption of courses of an action and the allocation of resources necessary for carrying out these goals.

MAIN COURSE

CONTENT **PAGE**

MODULE 1 INTRODUCTION TO COMMUNITY-PUBLIC HEALTH……1

Unit 1 Basic Concepts and Definitions in Community-Public Health………………………1
Unit 2 History of community and Public health………..25
Unit 3 Model of disease causation theories ……………42
Unit 4 community and Public Health in Nigeria……….53

MODULE 2 PRIMARY HEATH CARE (PHC): HEALTH FOR ALL APPROACH……77

Unit 1 Concepts and Principles of Primary Health Care……………………………………...77
Unit 2 Health For All…………………………………..96
Unit 3 Organisation of Health Systems based on Primary Health Care………………………..111
Unit 4 Health care Resources and Monitoring and Evaluation of Health Services…………………129

MODULE 3 FAMILY HEALTH CARE…………..154

Unit 1 Basic Concepts and Definitions of family and family health……………………....157
Unit 2 Sustainable Development Goals……………....171
Unit 3 Maternal and Child Healthcare………………..194
Unit 4 Health Promotion……………………………...227

MODULE 1 INTRODUCTION TO COMMUNITY-PUBLIC HEALTH

Unit 1 Basic Concepts and Definitions in Community-Public Health
Unit 2 History of community and public health
Unit 3 Model of disease causation theories
Unit 4 community and Public Health in Nigeria

Unit Structure

UNIT 1 CONCEPTS AND DEFINITIONS

1.1 Introduction
1.2 Intended Learning Outcomes
1.3 Concept of Health and other related definitions
    1.3.1 Concept of community
    1.3.2 Public, Community, Population and Global Health
1.4 Dimensions of Health
    1.4.1 Physical Dimension
    1.4.2 Mental Dimension
    1.4.3 Social Dimension
    1.4.4 Spiritual Dimension
1.5 Determinants of Health
    1.5.1 Heredity
    1.5.2 Environment
    1.5.3 Lifestyle
    1.5.4 Socioeconomic Conditions
    1.5.5 Health and Family Welfare Services
1.6 Personal Health activities versus Community and Public Health activities
    1.6.1 Personal Health activities
    1.6.2 Community and Public Health Activities
1.7 Factors that affect the health of a community
    1.7.1 Physical factors
    1.7.2 Social factors
1.8 Community organising
1.9 Globalisation and Health
1.10 Summary
1.11 References/Further Readings and Web Resources
1.12 Possible answers to SAEs

1.1 Introduction

You would have already studied the concepts of health in your basic Nursing Program. We shall now review and try to build on that to help you gain a deeper understanding of health. This will enable you to develop knowledge and skill in promoting the health of the people you serve. Health is considered a fundamental human right and a worldwide social goal. In this unit, we shall try to concentrate on the concept and definition of health and other related concepts, as well as the concept of positive health and well-being. Good health is holistic and must be enjoyed in four dimensions i.e., physical, mental, social and spiritual well-being. These dimensions will be explained in Section 1.4. Health is affected by various interlinked factors. We shall describe the five determinants of health in Section 1.5. You will also learn about the difference between personal and community health activities as well as discuss the factors that influence a community's health. We hope that this knowledge will help you to contribute effectively towards promotion of health.

1.2 Intended Learning Outcomes

By the end of this unit, you will be able to:

- Define the terms health, community, community health, population health, public health, public health system, and global health.
- Discuss concept of positive health and well being
- List and explain various dimensions of health
- Briefly describe the five major determinants of health.
- Explain the difference between personal and community health activities.
- List and discuss the factors that influence a community’s health.

1.3 Concept of Health

The word health is derived from hal, which means “hale, sound, whole.” When it comes to the health of people, the word health has been defined in several different ways—The most widely quoted definition of health was the one created by the World Health Organization (WHO) in 1946, which states “health is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity.”

Further, the WHO has indicated that "health is a resource for everyday life, not the object of living, and is a positive concept emphasizing social and personal resources as well as physical capabilities." Others have stated that health cannot be defined as a state because it is ever changing. Therefore, some authors have chosen to define **health** as a dynamic state or condition of the human organism that is multidimensional (i.e., physical, emotional, social, intellectual, spiritual, and occupational) in nature, a resource for living, and results from a person's interactions with and adaptations to his or her environment. Therefore, it can exist in varying degrees and is specific to each individual and his or her situation. "A person can have a disease or injury and still be healthy or at least feel well.

1.3.1 Concept of Community

Traditionally, a community has been thought of as a geographic area with specific boundaries—for example, a neighborhood, city, county, or state. However, in the context of community and public health, a **community** is "a collective body of individuals identified by common characteristics such as geography, interests, experiences, concerns, or values." Communities are characterized by the following elements: (1) membership—a sense of identity and belonging; (2) common symbol systems—similar language, rituals, and ceremonies; (3) shared values and norms; (4) mutual influence—community members have influence and are influenced by each other; (5) shared needs and commitment to meeting them; and (6) shared emotional connection—members share common history, experiences, and mutual support. A community may be as small as the group of people who live on a residence hall of a university or as large as all of the individuals who make up a nation. "A healthy community is a place where people provide leadership in assessing their own resources and needs, where public health and social infrastructure and policies support health, and where essential public health services, including, quality health care, are available."

1.3.2 Public, Community, Population, and Global Health

Prior to defining the four terms public health, community health, population health, and global health, it is important to note that often the terms are used interchangeably by both laypeople and professionals who work in the various health fields. When the terms are used interchangeably, most people are referring to the collective health of those in society and the actions or activities taken to obtain and maintain that health. The definitions provided here for the four terms more precisely define the group of people in question and the origin of the actions or activities.

Of the four terms, public health is the most inclusive. The Institute of Medicine (IOM) defined **public health** in 1988 in its landmark report The Future of Public Health as "what we as a society do collectively to assure the conditions in which people can be healthy."

The **public health system**, which has been defined as "activities undertaken within the formal structure of government and the associated efforts of private and voluntary organizations and individuals," is the organizational mechanism for providing such conditions. Even with these formal definitions, some still see public health activities as only those efforts that originate in federal, state, and local governmental public health agencies such as the Centers for Disease Control and Prevention and local (i.e., city and county) health departments. **Community health** refers to the health status of a defined group of people and the actions and conditions to promote, protect, and preserve their health. For example, the health status of the people of Elizabethtown, Pennsylvania, and the private and public actions taken to promote, protect, and preserve the health of these people would constitute community health. The term population health is similar to community health. Although the term has been around for a number of years, it is appearing more commonly in the literature today. As such it has been defined in several different ways. The most common definition used for **population health** is "the health outcomes of a group of individuals, including the distribution of such outcomes within the group." Another term that has been used increasingly more in recent years is global health. **Global health** is a term that describes "health problems, issues, and concerns that transcend national boundaries, may be influenced by circumstances or experiences in other countries, and are best addressed by cooperative actions and solutions." Therefore, an issue such as COVID-19 disease can be viewed as a global health issue. Much of the rise in concern about global health problems comes from the speed of international travel and how easy it is for people who may be infected with a disease to cross borders into another country.

Self-Assessment Exercises 1

1. How did the WHO define health in 1946? How has that definition been modified?
2. What is public health?
3. What are the differences between community health, population health, and global health?

4.1 Dimensions of health

The definition given by WHO as mentioned above (in sub-section......) covers three dimensions of health, i.e. physical, mental and social (Fig......). But as per the advances in knowledge you can think of more dimensions, which could be spiritual, emotional, vocational and political, etc. Of these we shall focus mainly on three dimensions and also the spiritual dimension.

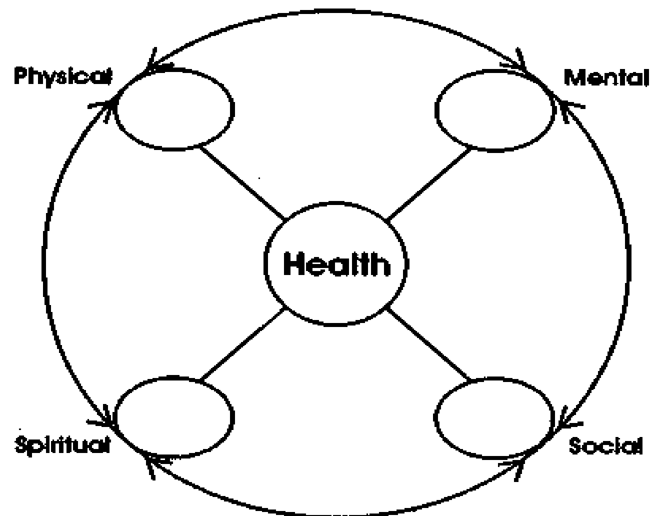


Fig. 1.4: Dimensions of Health

1.4.1 Physical dimension

It means normal functioning of a body or we can say that it is a state of health in which every cell of the body functions at optimum level and there is a balance in functioning within organs and the systems of body. Physical health includes a good complexion, clean and healthy skin, good body maintenance, good clothing, cleanliness, good appetite, happy disposition, sound sleep, regular activity of bowels and bladder. Other signs include normal pulse rate at rest, normal blood pressure and normal exercise.

We spoke about physical health 'and its components, now we shall talk about assessment of physical health which includes:

- self-assessment of overall health
- general observation -clinical examination
- nutrition and dietary assessment
- biochemical and laboratory investigation.

You will know more about this under Block 2 in Family Health Care and in your courses in subsequent years. If you are working in a community, the overall health status of the community can be assessed

by knowing the mortality rate and life expectancy of the community.

1.4.2 Mental Dimension

As we said that health is more than mere absence of illness, similarly we can say that mental health is not merely the absence of mental disease or mental illness. Mental health and physical health are interdependent. A poor mental health adversely affects the physical health and vice versa. Mental health is the ability of an individual to adjust to varied situations and to respond to varied experiences with a sense of purpose and with flexibility. Mental illness is not simply the absence of mental illness, but it is the ability to find happiness and fulfillment to adjust and change and to grow throughout one's life.

Mental health is happiness, the ability

- to get along with other people
- to cope up with the demands of the world without undue stress
- to be satisfied with the sense of achievement and personal fulfillment.

Mental health has been defined as:

A state of balance between the individual and the surrounding world. A state of harmony between the individual and the surrounding world. A state of harmony between oneself and others, a coexistence between the realities of self, those of other people, and the environment. Mental ill-health can lead to disturbances in physical and psychological functioning of the body and may lead to illness like hypertension, peptic ulcer, and bronchial asthma.

We hope you have now understood the definition of mental health. We will now explain the characteristics or attributes of a mentally healthy person.

a. A mentally healthy person is free from internal conflicts; he/she is not at 'war' with himself/herself.
b. He/she is well adjusted, i.e., he/she can get along well with others. He/she accepts criticism and is not easily upset.
c. He/she searches for identity
d. He/she has a strong sense of self esteem
e. He/she knows himself/herself, his/her needs, problems and goals.
f. He/she knows his/her strengths and weaknesses
g. He/she has good self-control-balances rationality and emotionality.
h. He/she faces problems and tries to solve them intelligently, i.e.,

problems of stress and anxiety.

1.4.3 Social dimension

We spoke about the physical and mental dimensions. Now we come to the third dimension of health, i.e., social health. This aspect visualizes the individual as a member of a family, community and the world and focuses on the well-being of a person socially and economically.

Social wellbeing has been defined by J.E. Park as:

"The quality and quantity of an individual's interpersonal ties and extent of involvement with the community".

This means that social wellbeing implies harmony and integration within the individual, between each individual and other members of society and between individuals and the world in which they live.

The social dimension includes practicing social skills, social functioning and the ability of a person to see himself as a member of larger society.

If you try to recall the discussion on the dimensions of health, you will realize that all the three are interrelated and interdependent. We cannot take them in isolation. If an individual is physically unhealthy, this will affect his mental health as well as social health and vice versa. If physical health is affected, there will be imbalance within the individual, which will affect his mental as well as social health.

1.4.4 Spiritual dimension

You will agree that another important dimension which could be examined is the spiritual dimension. This includes a study of principles of ethics, beliefs, purpose in life and commitment to some higher being. Spiritual well-being is not in isolation from mental well-being of a person. It is now believed that spiritual values influence our behaviour and mental wellbeing e.g., if you do meditation, it helps to keep you free of mental worries and stresses of daily life and gives freshness and peace of mind.

To sum up the above discussion on dimension of health we can say that the individual functions as a whole or as an integrated unit with each dimension of health having an influence upon other dimensions. For instance, physical illness influences one's emotional wellbeing, spiritual state, and social relationships. The psychosomatic aspects of health also illustrate dynamic interrelation among these dimensions of health. For example, an individual beset with social and emotional problem has

physical problems of high blood pressure or peptic ulcer.

All the concepts related to dimensions of health introduce us to the concept of positive health, which can be stated as follows: If an individual is in a state of well-being biologically, psychologically, socially and spiritually he is said to have positive health.

The next question is: what are the factors that affect the health of an individual? The answer to this question is given in Section 1.5, i.e., determinants or factors affecting health.

1.5 Determinants of health

The health of an individual is affected by factors within the individual and within the society in which he or she lives. These factors may be health promoting or deleterious. These factors are given below (Fig. 1.5).

- Heredity
- Environment
- Lifestyle
- Socioeconomic conditions
- Health and family welfare services

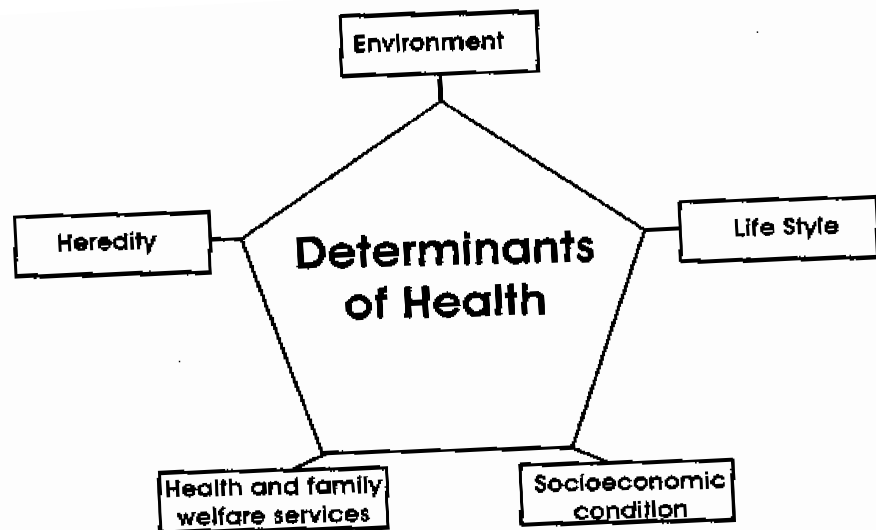


Fig. 1.5: Determinants of health

We shall now discuss these determinants in detail.

1.5.1 Heredity

An individual's physical and mental characteristics are inherited from his parents and these physical and mental traits of an individual are determined by genes during conception. The health of the mother, her nutritional status, the drugs she takes and the investigation she undergoes influence the health of the foetus. The genetic characteristics cannot be altered after conception and the genetic influence of the parents can lead to some genetic disorder in the child, which could be chromosomal anomalies like, hemophilia and Down's syndrome, errors of metabolism and mental retardation, etc. Thus, the health status of an individual depends to some extent on his genetic constitution.

1.5.2 Environment

Environment refers to the surroundings in which an individual lives. The environment may be internal as well as external. The internal environment or microenvironment pertains to the tissues, organs and systems of the body and the harmonious relationship between them. The external environment or macro environment consists of all those things to which an individual is exposed after conception such as, air, water, food, housing, etc. Environment is divided into three components: physical, biological, and psychosocial; each of these have a direct impact on the physical, mental, and social well-being os human beings. Now we shall have a quick look at different types of environments.

i. *Physical environment*

Physical environment includes housing, water, light, noise, excreta disposal, etc., with which man is in constant interaction. A defective physical environment continues to be a major health problem in developing countries including Nigeria.

The environmental hazards could be water pollution, air pollution, noise pollution and urbanization, etc. We shall further try to explain this with the example given below.

Consider that if a person lives in an environment where there are no sanitary drains, no proper housing, no proper disposal of refuse and excreta and no water supply. There will be fly breeding. You can now imagine the hazards that man will be exposed to in this physical environment which will affect his health. These hazards would be diarrhea, cholera, typhoid etc. On the contrary, if he lives in a safer environment, with proper sanitary conditions, he is less exposed to hazards of health.

ii. Biological environment

Biological environment includes all living things which surround man, including man himself. The living things may be viruses, bacteria, insects, rodents, animals and plants some of which may act as disease producing agents, reservoirs of infection, intermediate host and vectors of diseases in their interaction with man.

iii. Psychosocial environment

Psychosocial environment refers to the people who live around the individual -may be at home, at school, at workplace, at neighbourhood and in professional organization. This implies that man is a member of a social group, member of a family, of a tribe, of a community and of a nation. If a person has healthy interactions with all these groups, he feels healthy and happy. If he is frustrated in his interactions, he feels mentally unhappy, which affects his health.

1.5.3 Lifestyle

Lifestyle refers to the way of living or the way the people live. It reflects social values, attitudes and activities of an individual. It refers to the way we behave, work, eat, rest sleep, and perform other activities of daily living. It consists of cultural and behavioural patterns and personal habits of an individual. Lifestyle affects the health of an individual. A healthy lifestyle helps to promote health and a poor lifestyle has ill effects on health. For example, in Nigeria due to persistence of a poor traditional lifestyle especially in highly densely populated areas of our cities, there are risks of death and illness connected with lack of sanitation, poor nutrition, personal hygiene habits, customs and cultural patterns. Some lifestyles can promote health, e.g. adequate nutrition, enough sleep, sufficient physical activity, adequate education and employment.

Many of our health practices are those that we have learnt from our parents I or have adopted at an early age. These have become so intricately woven into the fabric of our current health behaviours that to become aware of them and their possible harmful effects requires a conscious effort to examine our lives from the perspective of health. We further have to make a concerted effort to change habits, which die hard, eg. dangers of cigarette smoking are well known; every cigarette pack carries a warning that 'Smokers are liable to die young'. There are media campaigns to alert people to this danger; but despite this people continue to smoke. Another factor is the quality of modem life styles, which are often the source of health problems. Due to a fast-moving life, man is exposed to stress and strain, which are caused, by pollution, poor

nutrition and psychological stress.

1.5.4 Socioeconomic conditions

The health of an individual is determined by his socioeconomic development, e.g., per capita G.N.P., education, nutrition, employment, housing, and the political system of the country. We shall glance through these components to have an overview.

i. *Economic status:* This is an important factor in seeking health care as it determines the purchasing power, standards of living, lifestyle, and family size-which affects our health.
ii. *Education:* This is a major factor which influence health. Illiteracy leads to ignorance which can result in poverty, malnutrition, high infant, and child mortality rates etc. Even if the health facilities are available the people, because of ignorance, with not be able to avail them. They also will not have healthy habits, thereby leading to ill-health.
iii. *Occupation:* This is a crucial factor which determines health. A person who is involved in some productive work or is employed will be healthy as compared to one who is unemployed, because unemployment means loss of income and inability to meet even basic needs. This can result in physical as well as mental damage.
iv. *Political system:* The health system is influenced by the political system of the country. Implementation of health technologies, choice of technology, resource allocation, manpower policy, and the degree of availability and accessibility of health services depends, to greater extent, on political will and political decisions. This affects the health of a community.

Poor health patterns can only be changed by changing the entire socio-political system in each community. The health hazards of the people related to their working and living environments can only be removed by social, economic, and political actions.

1.5.5 Health and family welfare services

The health services cover a wide range of individual and community services for prevention and treatment of disease and promotion of health. Health and Family Welfare Services aim at improving the health status of a population. This concept is clarified in the following example: Immunizing the children can reduce the threat of incidence of communicable diseases like polio, diphtheria, and whooping cough. Water-borne disease can be prevented by provision of safe and wholesome water supply to a community. Maternal and child health services will help to reduce the morbidity and mortality in women and

children, If we analyze the above examples we can conclude that immunization, provision of safe water, and care of pregnant women are the health and family welfare services preventing communicable disease, water borne disease and infant and maternal mortality which is the ultimate goal of the health services.

1.6 Personal Health Activities versus Community and Public Health Activities

To further clarify the definitions presented in this chapter, it is important to distinguish between the terms personal health activities and community and public health activities.

1.6.1 Personal Health Activities

Personal health activities are individual actions and decision-making that affect the health of an individual or his or her immediate family members or friends. These activities may be preventive or curative in nature but seldom directly affect the behavior of others. Choosing to eat wisely, to regularly wear a safety belt, and to visit the physician are all examples of personal health activities.

1.6.2 Community and Public Health Activities

Community and public health activities are activities that are aimed at protecting or improving the health of a population or community. Maintenance of accurate birth and death records, protection of the food and water supply, and participating in fund drives for voluntary health organizations such as the American Lung Association are examples of community health activities.

Self-Assessment Exercises 2

1. What are the five major domains that determine a person's health?
2. What is the difference between personal health activities and community and public health activities?

1.7 Factors That Affect the Health of a Community

Many factors affect the health of a community. As a result, the health status of each community is different. These factors may be physical, social, and/or cultural. They also include the ability of the community to organize and work together as a whole as well as the individual behaviors of those in community (see **Figure 1.7**).

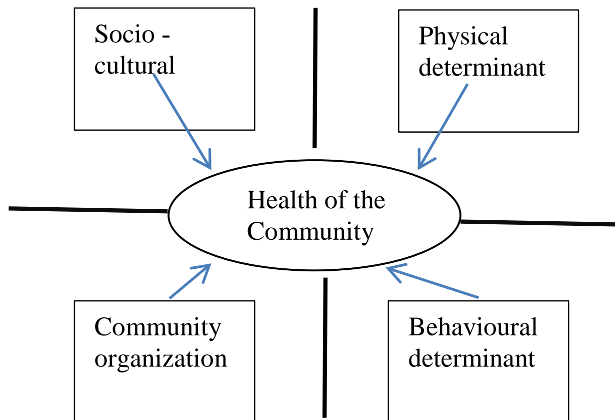


Fig 1.7 Factors that affect community health

1.7.1 Physical Factors

Physical factors include the influences of geography, the environment, community size, and industrial development.

Geography

A community's health problems can be directly influenced by its altitude, latitude, and climate. In tropical countries where warm, humid temperatures and rain prevail throughout the year, parasitic and infectious diseases are a leading community health problem. In many tropical countries, survival from these diseases is made more difficult because poor soil conditions result in inadequate food production and malnutrition. In temperate climates with fewer parasitic and infectious diseases and a more than adequate food supply, obesity and heart disease are important community and public health problems.

Environment

The quality of our natural environment is directly related to the quality of our stewardship of it. Many experts believe that if we continue to allow uncontrolled population growth and continue to deplete nonrenewable natural resources, succeeding generations will inhabit communities that are less desirable than ours. Many feel that we must accept responsibility for this stewardship and drastically reduce the rate at which we foul the soil, water, and air. When speaking about the environment we must also consider the impact the built environment has on community and public health. The term **built environment** refers to "the design, construction, management, and land use of human-made

surroundings as an interrelated whole, as well as their relationship to human activities over time."It includes but is not limited to: transportation systems (e.g., mass transit); urban design features (e.g., bike paths, sidewalks, adequate lighting); parks and recreational facilities; land use (e.g., community gardens, location of schools, trail development); building with health-enhancing features (e.g., green roofs, stairs); road systems; and housing free from environmental hazards. The built environment can be structured to give people more or fewer opportunities to behave in health enhancing ways.

Community Size

The larger the community, the greater its range of health problems and the greater its number of health resources. For example, larger communities have more health professionals and better health facilities than smaller communities. These resources are often needed because communicable diseases can spread more quickly and environmental problems are often more severe in densely populated areas. For example, the amount of trash generated by the approximately 8.5 million people in New

York City is many times greater than that generated by the entire state of Wyoming, with its population of 584,153. It is important to note that a community's size can have both a positive and negative impact on that community's health. The ability of a community to effectively plan, organize, and utilize its resources can determine whether its size can be used to good advantage.

Industrial Development

Industrial development, like size, can have either positive or negative effects on the health status of a community. Industrial development provides a community with added resources for community health programs, but it may bring with it environmental pollution and occupational injuries and illnesses. Communities that experience rapid industrial development must eventually regulate (e.g.,laws and ordinances) the way in which industries (1) obtain raw materials, (2) discharge by-products, (3) dispose of wastes,(4) treat and protect their employees, and (5) clean environmental accidents. Unfortunately, many of these laws are usually passed only after these communities have suffered significant reductions in the quality of their life and health.

1.7.2 Social and Cultural Factors

Built environment "the design, construction, management, and land use of human-made surroundings as an interrelated whole, as well as their relationship to human activities over time." Social factors are those that arise from the interaction of individuals or groups within the community. For example, people who live in urban communities, where life is fast paced, experience higher rates of stress-related illnesses than those who live in rural communities, where life is more leisurely. On the other hand, those in rural areas may not have access to the same quality or selection of health care (i.e., hospitals or medical specialists) that is available to those who live in urban communities. Cultural factors arise from guidelines (both explicit and implicit) that individuals "inherit" from being a part of a particular society. Some of the factors that contribute to culture are discussed in the following sections.

Beliefs, Traditions, and Prejudices

The beliefs, traditions, and prejudices of community members can affect the health of the community. The beliefs of those in a community about such specific health behaviors as exercise and smoking can influence policy makers on whether or not they will spend money on bike lanes on the roads and recreational bike trails and work toward no-smoking ordinances. The traditions of specific ethnic groups can influence the types of food, restaurants, retail outlets, and services available in a community. Prejudices of one specific ethnic or racial group against another can result in acts of violence and crime. Racial and ethnic disparities will continue to put certain groups, such as black Americans or certain religious groups, at greater risk.

Economy

Both national and local economies can affect the health of a community through reductions in health and social services. An economic downturn means lower tax revenues (fewer tax dollars) and fewer contributions to charitable groups. Such actions will result in fewer dollars being available for programs such as welfare, food stamps, community health care, and other community services. This occurs because revenue shortfalls cause agencies to experience budget cuts. With fewer dollars, these agencies often must alter their eligibility guidelines, thereby restricting aid to only individuals with the greatest need. Obviously, many people who had been eligible for assistance before the economic downturn become ineligible. Employers usually find it increasingly difficult to provide health benefits for their employees as their income drops. Those who are unemployed and underemployed face poverty and

deteriorating health. Thus, the cumulative effect of an economic downturn significantly affects the health of the community.

Politics

Those who happen to be in political office can improve or jeopardize the health of them community by the decisions (i.e., laws and ordinances) they make. In the most general terms, the argument is over greater or lesser governmental participation in health issues. For example, there has been a longstanding discussion in the United States on the extent to which the government should involve itself in health care. Historically, Democrats have been in favor of such action while Republicans have been against it. State and local politicians also influence the health of their communities each time they vote on health-related measures brought before them, such as increasing the minimum legal sales age (MLSA) for tobacco products to 21 years.

Religion

A number of religions have taken a position on health care and health behaviors. For example, some religious communities limit the type of medical treatment their members may receive. Some do not permit immunizations; others do not permit their members to be treated by physicians. Still others prohibit certain foods. Some religious communities actively address moral and ethical issues such as abortion, premarital intercourse, and homosexuality. Still other religions teach health-promoting codes of living to their members. Obviously, religion can affect a community's health positively or negatively

Social Norms

The influence of social norms on community and public health can be positive or negative and can change over time. Cigarette smoking is a good example. During the 1940s, 1950s, and 1960s, it was socially acceptable to smoke in most settings. As a matter of fact, in 1965, 51.2% of American men and 33.7% of American women smoked. Thus, in 1965 it was socially acceptable to be a smoker, especially if you were male. Now, in the second decade of the twenty-first century, those percentages have dropped to 18.8% (for males) and 14.8% (for females), and in most public places it has become socially unacceptable to smoke. The lawsuits against tobacco companies by both the state attorneys general and private citizens provide further evidence that smoking has fallen from social acceptability. Because of this change in the social norm, there is less secondhand smoke in many public places, and in turn the health of the community has improved. Unlike smoking, alcohol consumption represents a continuing negative social norm in America,

especially on college campuses. The normal expectation seems to be that drinking is fun (and almost everyone wants to have fun). Despite the fact that most college students are too young to drink legally, approximately 59.5% of college students' drink.

Socioeconomic Status

Differences in socioeconomic status (SES) whether "defined by education, employment, or income, both individual- and community-level socioeconomic status have independent effects on health." There is a strong correlation between SES and health status—individuals in lower SES groups, regardless of other characteristics, have poorer health status. This correlation applies both across racial groups and within racial groups.

1.7.3 Community Organising

The way in which a community is able to organise its resources directly influences its ability to intervene and solve problems, including health problems. **Community organising** is "the process by which community groups are helped to identify common problems or change targets, mobilise resources, and develop and implement strategies for reaching their collective goals." It is not a science but an art of building consensus within a democratic process. If a community can organise its resources effectively into a unified force, it "is likely to produce benefits in the form of increased effectiveness and productivity by reducing duplication of efforts and avoiding the imposition of solutions that are not congruent with the local culture and needs." For example, many communities in the Nigeria have faced community-wide drug problems. Some have been able to organise their resources to reduce or resolve these problems, whereas others have not.

1.7.4 Individual Behavior

The behavior of the individual community members contributes to the health of the entire community. It takes the concerted effort of many—if not most—of the individuals in a community to make a program work. For example, if everyone consciously recycles his or her trash each week, community recycling will be successful. Likewise, if each occupant would wear a safety belt, there could be a significant reduction in the number of facial injuries and deaths from car crashes for the entire community. In another example, the more individuals who become immunised against a specific communicable disease, the slower the disease will spread, and the fewer people will be exposed. This concept is known as **herd immunity**.

Self-Assessment Exercises 3

1. Define the term community.
2. What are four major factors that affect the health of a community? Provide an example of each.

1.9 Globalisation and Health

Globalisation is the process of increasing political and social interdependence and global integration that takes place as capital, traded goods, persons, concepts, images, ideas and Values diffuse across the stated boundaries (Jenkins, 2004).

Globalisation must ensure that people, particularly the poor, enjoy better health that is the most important factor in improving the economic wellbeing of the population in general and in reducing poverty. The effects of Globalisation on health are diverse; these can be positive, negative, or mixed. Some of the effects of Globalisation are listed here under.

Effects of Globalisation on health includes

> Externalities of some diseases due to increased communication decreased human mobility
> Accelerated economic growth and technological advances have enhanced health and life expectancy in many population
> Increasing effects of international and bilateral agencies (structural adjustment programs and Global initiatives)
> Jeopardising population health Via erosion of social and environmental conditions and exacerbating inequalities
> Other health risks of Globalisation include:
- Fragmentation and weakening of labor markets due to greater power of mobile capital
- Tobacco induced diseases

- Food markets & obesity as well as chemicals in food
- Rapid spread of infectious diseases
- Depression in aged and fragmented population
- Adverse effects on the environment

Self-Assessment Exercises 4

1. What is the influence of globalisation on community health?

2. Do you think that globalisation affects the overall health situation of your country? How?

1.10 Summary

- This unit discussed a number of key terms associated with the study of community and public health, including health, community, community health, population health, public health, public health system, and global health.
- We also explained dimensions of health, i.e., physical dimension which refers to the physical wellbeing of an individual; mental dimension refers to the ability of an individual to adjust to varied situations and act purposefully and the social dimension which relates to the relationship of an individual with the society or the people with whom he lives. If an individual experience wellbeing in all these dimensions, he is said to enjoy positive health.
- You have also learnt about the determinants of health which include: heredity-the effect of genes on the physical and physiological characters of an individual; environment, i.e. physical, biological and psychosocial environments of the individual which influences health, and his life styles or ways of living (the standards of living, i.e. eating, behaving, rest, sleep, etc.); socioeconomic conditions, i.e. level of income and education which affect the health of an individual and health services which cover individual and community, services for prevention and treatment of disease.
- The differences between personal and community health as well as four factors that affect the health of a community are physical (e.g., community size), social and cultural (e.g., religion), community organisation, and individual behaviors (e.g., exercise and diet) was also discussed.
- Community Organising which is the way in which a community is able to organise its resources was explained.
- . Globalisation and its effect on the health of the populace was also highlighted in this unit

1.11 References/Further Readings/Web Resources

Challi Jira, Amsalu Feleke, Getnet Mitike (2003) Health Science Management for Health Science Students. Lecture Note Series. Jimma University: Faculty of Public Health

G. P. Ranken, R. Amonoo - Laptaskan, G.J. Ebrahim, H.H. Lovel: District Health Care Challenges For Planning, Organization, And

Evaluation for Developing Countries; Macmillan 2nd Edition 1996.

Green, Anderson. Community Health, 4th edition.

Gupta. Essential Preventive Medicine

Health and Health Related indicators 2003/2004. By the Federal Ministry Of Health

Jenkins, R. (2004). Globalization, production, employment and poverty: debates and evidence. *Journal of International Development*, *16*(1), 1-12.

JGetnet Mitike (2003), Health Education for Health Science Students. Lecture Note Series. Addis Ababa University-Department of Community Health

Schneider, M.-J. (2017). Introduction to Public Health, 5th ed. Burlington,MA:Jones and
Bartlett Learning.

Institute of Medicine (2003). The Future of the Public's Health in the 21st Century. Washington, DC: National Academies Press.

National Center for Health Statistics. (2016). Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities.Hyattsville, MD: CDC, National Center for Health Statistics. Available at http://www.cdc.gov/nchs/data/hus/hus15.pdf

Institute of Medicine (1988). The Future of Public Health. Washington,DC:National Academies press.

Kindig, D., and G. Stoddart (2003). "What Is Population Health?"American Journal of Public Health, 93(3): 380–383.

Bunker, J. P., H. S. Frazier, and F. Mosteller (1994). "Improving Health: Measuring Effects of Medical Care." Milbank Quarterly,72: 225–258.

Institute of Medicine (1997). America's Vital Interest in Global Health: Protecting Our People, Enhancing Our Economy, and Advancing Our International Interests. Washington, DC: National
Academies Press. Available at http://books.nap.edu/openbook.php?record_id=5717&page=R1.

Davidson, A. (2015). Social Determinants of Health: A Comparative Approach. Ontario, Canada: Oxford University Press.

World Health Organization (2016). Glossary of Globalization, Trade, and Health Terms. Geneva, witzerland: Author. Available at http ://www.who.int/trade/glossary/story046/en/.

Turnock, B. J. (2016). Public Health: What It Is and How It Works,6th ed. Burlington, MA: Jones & Bartlett Learning.

World Health Organization (2016). The Determinants of Health. Available at http://www.who.int/hia/evidence/doh/en/.

McGinnis, J. M., P. Williams-Russo, and J. R. Knickman (2002). "The Case for More Active Policy Attention to Health Promotion." Health Affairs, 21(2): 78–93.

Israel, B. A., B. Checkoway, A. Schulz, and M. Zimmerman (1994). "Health Education and Community Empowerment: Conceptualizing and Measuring Perceptions of Individual, Organizational, and Community Control." Health Education Quarterly,21(2):149–170.

Minkler, M., and N. Wallerstein (2012). "Improving Health through Community Organization and Community Building: Perspectives from Health Education and Social Work." In M. Minkler, ed., Community Organizing and Community Building for Health and Welfare, 3rd ed.New Brunswick,NJ:Rutgers University Press,37–58. 25.

Ross, M. G. (1967). Community Organization: Theory, Principles, and Practice. New York: Harper & Row.

Pickett, G., and J. J. Hanlon (1990). Public Health: Administration and Practice, 9th ed. St. Louis: Times Mirror/Mosby.

Rosen, G. (1958). A History of Public Health. New York: MD Publications.

1.12 Possible Answers to SAEs

Answers to SAEs 1

1. World Health Organization (WHO) in 1946, which states "health is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity."
   Further, the WHO has indicated that "health is a resource for everyday life and is a positive concept emphasizing social and personal resources as well as physical capabilities." Other authors have viewed health to be ever changing. Therefore, have chosen to define **health** as a dynamic state or condition of the human organism that is multidimensional (i.e., physical, emotional, social, intellectual, spiritual, and occupational) in nature, a resource for living, and results from a person's interactions with and adaptations to his or her environment.
2. The Institute of Medicine (IOM) defined **public health** in 1988 in its landmark report The Future of Public Health as "what we as a society do collectively to assure the conditions in which people can be healthy."
3. **Community health** refers to the health status of a defined group of people and the actions and conditions to promote, protect, and preserve their health.

The term **population health** is "the health outcomes of a group of individuals, including the distribution of such outcomes within the group."

Global health is a term that describes "health problems, issues, and concerns that transcend national boundaries, may be influenced by circumstances or experiences in other countries, and are best addressed by cooperative actions and solutions."Example could be the COVID-19 pandemic.

Answers to SAEs 2

1. Heredity, Environment, Lifestyle, Socio-economic conditions, Health and Family welfare services
2. *Personal Health Activities* are individual actions and decision-making that affect the health of an individual or his or her immediate family members or friends eg choosing to eat wisely.
   Community and Public Health Activities are activities that are aimed at protecting or improving the health of a population or community eg protection of the food and water supply.

Answers to SAEs 3

1. A **community** is "a collective body of individuals identified by common characteristics such as geography, interests, experiences, concerns, or values."
2. i) Physical determinants eg influence of climate on health, environmental pollution and degradation, large population size which promotes health problems
   ii) Socio-cultural determinants eg those who live in urban areas experience higher rates of stress related illness than those residing in the rural areas. on the other hand, those in the rural area have less access to quality health care. Also, the beliefs, traditions, and prejudices of community members can affect the health of the community.
   iii) Community organisation eg community groups can identify health problems and mobilize resources to solving them.
   iv) Behavioural determinanats: The behavior of the individual community members contributes to the health of the entire community eg. the more individuals who become immunized against a specific communicable disease, the slower the disease will spread, and the fewer people will be exposed (**herd immunity).**

Answers to SAEs 4

1. Globalization can have positive, negative, or mixed effect on health of community members which includes.
- Externalities of some diseases due to increased communication decreased human mobility
- Accelerated economic growth and technological advances have enhanced health and life expectancy in many population
- Jeopardizing population health Via erosion of social and environmental conditions and exacerbating inequalities
- Fragmentation and weakening of labor markets due to greater power of mobile capital

- Tobacco induced diseases
- Food markets & obesity as well as chemicals in food
- Rapid spread of infectious diseases
- Depression in aged and fragmented population
- Adverse effects on the environment

2. In my country, Globalization has contributed to health improvements through diffusion of new health knowledge, low-cost health technologies, and human rights.

Globalization also have its negative effects on the health of our community members. These include some factors which are jobs insecurity, fluctuation in prices, terrorism, fluctuation in currency, capital flows bringing about poverty and hunger.

The world is today regarded as a global village. This is because we now have more information available than ever before and we can communicate at a speed and share concerns about diseases and interventions that was considered impossible just a few years ago.

Outbreaks of infectious diseases, food-borne illnesses, or contaminated pharmaceuticals and other products cannot only spread from country to country, but also impact trade and travel.
Increased greenhouse gas emissions, ocean acidification, deforestation (and other forms of habitat loss or destruction), climate change, and the introduction of invasive species all work to reduce biodiversity around the globe.

1.13 Tutor-Marked Assignment – (this should be converted to Self-assessment exercise)

1. Differentiate between community and public health (2marks)
2. State and explain the factors influencing community health (5marks)

UNIT 2 HISTORY OF COMMUNITY AND PUBLIC HEALTH

Unit Structure

2.1 Introduction
2.2 Intended Learning Outcomes
2.3 Definition of Community health, public health and Clinical medicine
  2.3.1 Definitions
  2.3.2 Core activities in Community and public health
2.4 Key Terms in the definition
  2.4.1 Health promotion
  2.4.2 Prevention
  2.4.3 Rehabilitation
2.5 History of Community and Public health
  2.5.1 Early Civilization
  2.5.2 The eighteenth century
  2.5.3 The nineteenth century
  2.5.4 The twentieth century
  2.5.5 Health Resources Development Period
  2.5.6 The Great depression and World War 11
  2.5.7 The post war years
  2.5.8 Period of social engineering
  2.5.9 Period of Health promotion to present
  2.5.10 The new public health
2.6 Major Disciplines in community and public health
2.7 Ethical issues and challenges in public health
2.8 Summary
2.9 References/Further Readings/Web Resources
2.10 Possible Answers to Self-Assessment Exercise(s)

2.1 Introduction

In Unit I you have learnt about the concept of health and related terms. You have also studied the determinants of health and factors that influence the health of a community. Now you may be interested to understand the concepts of community and public health, its activities and the challenges faced by community and public health. This unit also provide an account of some of the accomplishments and failures in community and public health in its history through the different eras. It is hoped that knowledge of the past will enable us to better prepare for future challenges to our community's health.

2.2 Intended Learning Outcomes

By the end of this unit, students will be able to:

- Define community and public health and list its core activities.
- Define the key terms in public health
- Discuss the history of public health
- Explain the principal disciplines of public health
- Discuss the ethical issues and challenges in public health.

2.3 Definition of Community health, public health and Clinical medicine

2.3.1 Definitions

Community health is a medical specialty that focuses on the physical and mental well-being of the people in a specific geographic region. This important subsection of public health includes initiatives to help community members maintain and improve their health, prevent the spread of infectious diseases and prepare for natural disasters.

"Working at the community level promotes healthy living, helps prevent chronic diseases and brings the greatest health benefits to the greatest number of people in need," reports the **Centers for Disease Control and Prevention (CDC).**

Public health is defined as the science and art of preventing diseases, prolonging life, promoting health and efficiencies through organized community effort. It is concerned with the health of the whole population and the prevention of disease from which it suffers. It is also one of the efforts organized by society to protect, promote, and restore the peoples' health. It is the combination of sciences, skills and beliefs that is directed to the maintenance and improvement of the health of all the people through collective social actions.

Clinical medicine is concerned with diagnosing and treating diseases in individual patients. It has evolved from primarily a medical and nursing service to involve a highly complex team of professionals.

2.3.2 Core activities in Community and public health

1. Preventing epidemics
2. Protecting the environment, workplace, food and water.
3. Promoting healthy behavior.

4. Monitoring the health status of the population.
5. Mobilizing community action.
6. Responding to disasters.
7. Assuring the quality accessibility, and accountability of medical care;
8. Reaching to develop new insights and innovative solutions and
9. Leading the development of sound health policy and Planning

Self-Assessment Exercises 1

1. Define public health and discuss the similarities and difference community health
2. Mention the role of public health in the health care delivery system

2.4 Key **Terms in the definition**

2.4.1 Health Promotion

Health promotion is a guiding concept involving activities intended to enhance individual and community health well-being. It seeks to increase involvement and control of the individual and the community in their own health. It acts to improve health and social welfare, and to reduce specific determinants of diseases and risk factors that adversely affect the health, well-being, and productive capacities of an individual or society, setting targets based on the size of the problem but also the feasibility of successful interventions, in a cost-effective way.

Health promotion is a key element in public health and is applicable in the community, clinics or hospitals, and in all other service settings. Raising awareness and informing people about health and lifestyle factors that might put them at risk requires teaching.

The Elements of Health promotion comprises of: -

1. Addressing the population as a whole in health-related issues, in everyday life as well as people at risk for specific diseases:
2. Directing action to risk factors or causes of illness or death.
3. Undertaking activities approach to seek out and remedy risk factors in the community that adversely affect health.
4. Promoting factors that contribute to a better condition of health of the population.
5. Initiating actions against health hazards, including communication, education, legislation, fiscal measures, organizational change, community development, and

spontaneous local activities.

6. Involving public participation in defining problems, deciding on action.
7. Advocating relevant environmental, health , and social policy ;
8. Encouraging health professionals' participation in health education and health policy.

2.4.2 Prevention

Prevention refers to the goals of medicine that are to promote, to preserve, and to restore health when it is impaired, and to minimize suffering and distress.

There are three levels of prevention:

Primary Prevention refers to those activities that are undertaken to prevent the disease and injury from occurring. It works with both the individual and the community. It may be directed at the host, to increase resistance to the agent (such as immunization or cessation of smoking), or may be directed at environmental activities to reduce conditions favorable to the vector for a biological agent, such as mosquito vectors of malaria.

Secondary Prevention is the early diagnosis and management to prevent complications from a disease. It includes steps to isolate cases and treat or immunize contacts to prevent further epidemic outbreaks.

Tertiary Prevention involves activities directed at the host but also at the environment to promote rehabilitation, restoration, and maintenance of maximum function after the disease and its complications have stabilized. Providing a wheelchair, special toilet facilities, doors, ramps, and transportation services for paraplegics are often the most vital factors for rehabilitation.

2.4.3 Rehabilitation

Rehabilitation is the process of restoring a person's social identity by repossession of his/her normal roles and functions in society. It involves the restoration and maintenance of a patient's physical, psychological, social, emotional, and vocational abilities. Interventions are directed towards the consequences of disease and injury. The provision of high-quality rehabilitation services in a community should include the following:

1. Conducting a full assessment of people with disabilities and suitable support systems.

2. Establishing a clear care plan.
3. Providing measures and services to deliver the care plan.

2.5 History of Community and Public Health

The history of community and public health is almost as long as the history of civilization. This summary provides an account of some of the accomplishments and failures in community and public health. It is hoped that knowledge of the past will enable us to better prepare for future challenges to our community's health.

2.5.1 Earliest Civilizations

Likely, the earliest community health practices went unrecorded. Perhaps these practices involved taboos against defecation within the tribal communal area or near the source of drinking water. Perhaps they involved rites associated with burial of the dead. Certainly, the use of herbs for the prevention and curing of diseases and communal assistance with childbirth are practices that predate archeological records. Excavations at sites of some of the earliest known civilizations, dating from about 2000 b.c. have uncovered archeological evidence of community health activities.

Early Civilizations

Ancient Societies (before 500 b.c.e.)

Prior to 2000 b.c..: Archeological findings provide evidence of sewage disposal and written medical prescriptions.

Circa 1900 b.c. : Perhaps the earliest written record of public health was the Code of Hammurabi; included laws for physicians and health practices.

Circa 1500 b.c.e.: Bible's Book of Leviticus written, includes guidelines for personal cleanliness and sanitation.

Classical Cultures (500 BC. .-500 BC.)

Fifth and sixth centuries b.c: Evidence that Greek men participated in games of strength and skill and swam in public facilities.

Greeks were involved in practice of community sanitation; involved in obtaining water from sources far away and not just local wells.

Romans were community minded; improved on community sanitation of Greeks; built aqueducts to transport water from miles away; built sewer systems; created regulation for building construction, refuse removal, and street cleaning and repair; created hospitals as infirmaries for slaves. Christians created hospitals as benevolent charitable organizations.

476 BC.: Roman Empire fell and most public health activities ceased.
Middle Ages (500-1500 BC.)

1. (Dark Ages): Growing revulsion for Roman materialism and a growth of spirituality; health problems were considered to have both spiritual causes and spiritual solutions, a time referred to as the spiritual era of public health.

Failure to consider the role of the physical and biological environment in the causation of communicable diseases resulted in many unrelenting epidemics in which millions suffered and died.

Deadliest epidemics were from plague ("Black Death"); occurred in 543 BC. and 1348 BC. (This one killed 25 million; half of population of London lost and in some parts of France only 1 in 10 survived).

1200 BC: More than 19,000 leper houses.

Other epidemics of period: Smallpox, diphtheria, measles, influenza, tuberculosis, anthrax, and trachoma.

1492 BC: Syphilis epidemic was last epidemic of the period.
Renaissance and Exploration (1500-1700 BC.) Rebirth of thinking about the nature of world and humankind.

Belief that disease was caused by environmental, not spiritual, factors; for example, the term malaria, meaning bad air, is a direct reference to humid or swampy air.

Observation of ill led to more accurate descriptions of symptoms and outcomes of diseases; observations led to first recognition of whooping cough, typhus, scarlet fever, and malaria as distinct and separate diseases.

1662: John Graunt published the Observations on the Bills of Mortality, which was the beginning of vital statistics.

Epidemics (e.g., smallpox, malaria, and plague) still rampant; plague epidemic killed 68,596 (15% of the population) in London in 1665.

Explorers, conquerors, and merchants and their crews spread disease to colonists and indigenous people throughout the New World.

2.5.2 The Eighteenth Century

The eighteenth century was characterized by industrial growth. Despite the beginnings of recognition of the nature of disease, living conditions were hardly conducive to good health. Cities were overcrowded, and water supplies were inadequate and often unsanitary. Streets were usually unpaved, filthy, and heaped with trash and garbage. Many homes had unsanitary dirt floors. Workplaces were unsafe and unhealthy. A substantial portion of the workforce was made up of the poor, which included children, who were forced to work long hours as indentured servants. Many of these jobs were unsafe or involved working in unhealthy environments, such as textile factories and coal mines.

Eighteenth Century (1700s)

1790: First U.S. census.
1793: Yellow fever epidemic in Philadelphia.
1796: Dr. Edward Jenner successfully demonstrated smallpox vaccination.
1798: Marine hospital services was formed

2.5.3 The Nineteenth Century

Epidemics continued to be a problem in the nineteenth century, with outbreaks in major cities in both Europe and America. In 1854, another cholera epidemic struck London. Dr. John Snow studied the epidemic and hypothesized that the disease was being caused by the drinking water from the Broad Street pump. He obtained permission to remove the pump handle, and the epidemic was abated. Snow's action was remarkable because it predated the discovery that microorganisms can cause disease. The predominant theory of contagious disease at the time was the “miasmas theory,” which postulated vapors, or miasmas, were the source of many diseases. The miasmas theory remained popular throughout much of the nineteenth century.

Real progress in the understanding of the causes of many communicable diseases occurred during the last third of the nineteenth century. One of the obstacles to progress was the theory of spontaneous generation, the idea that living organisms could arise from inorganic or nonliving matter. Akin to this idea was the thought that one type of contagious microbe could change into another type of organism. In 1862, Louis Pasteur of France proposed his germ theory of disease. Throughout the

1860s and 1870s, he and others carried out experiments and made observations that supported this theory and disproved spontaneous generation. Pasteur is generally given credit for providing the deathblow to the theory of spontaneous generation.

It was the German scientist Robert Koch who developed the criteria and procedures necessary to establish that a particular microbe, and no other, causes a particular disease. His first demonstration, with the anthrax bacillus, was in 1876. Between 1877 and the end of the century, the identity of numerous bacterial disease agents was established, including those that caused gonorrhea, typhoid fever, leprosy, tuberculosis, cholera, diphtheria, tetanus, pneumonia, plague, and dysentery. This period (1875-1900) has come to be known as the **bacteriological period of public health.**

2.5.4 The Twentieth Century

As the twentieth century began, life expectancy was still less than 50 years. The leading causes of death were communicable diseases—influenza, pneumonia, tuberculosis, and infections of the gastrointestinal tract. Other communicable diseases, such as typhoid fever, malaria, and diphtheria, also killed many people. There were other health problems as well. Thousands of children were afflicted with conditions characterized by noninfectious diarrhea or by bone deformity. Although the symptoms of pellagra and rickets were known and described, the causes of these ailments remained a mystery at the turn of the century. Discovery that these conditions resulted from vitamin deficiencies was slow because some scientists were searching for bacterial causes. Vitamin deficiency diseases and one of their contributing conditions, poor dental health, were extremely common in the slum districts of both European and American cities. The unavailability of adequate prenatal and postnatal care meant that deaths associated with pregnancy, and childbirth were also high.

2.5.5 Health Resources Development Period (1900-1960)

Much growth and development took place during the 60-year period from 1900 to 1960. Because of the growth of health care facilities and providers, this period of time is referred to as the **health resources development period**. This period can be further divided into the reform phase (1900-1920), the 1920s, the Great Depression and World War II, and the postwar years.

The Reform Phase (1900-1920*)*

During the first 20 years of the twentieth century (i.e., the **reform phase**

of public health), there was a growing concern about the many social problems in America. The remarkable discoveries in microbiology made in the previous years had not dramatically improved the health of the average citizen. By 1910, the urban population had grown to 45% of the total population (up from 19% in 1860). Much of the growth was the result of immigrants who came to America for the jobs created by new industries. Northern cities were also swelling from the northward migration of black Americans from the southern states. Many of these workers had to accept poorly paying jobs involving hard labor. There was also a deepening chasm between the upper and lower classes, and social critics began to clamor for reform.

In 1906 the plight of the immigrants working in the meat packing industry was graphically depicted by Upton Sinclair in his book *The Jungle*. Sinclair's goal was to draw attention to unsafe working conditions. What he achieved was greater governmental regulation of the food industry through the passage of the Pure Food and Drugs Act of 1906. The reform movement was broad, involving both social and moral as well as health issues. In 1909 it was noted that "[i]ll health is perhaps the most constant of the attendants of poverty." The reform movement finally took hold when it became evident to the majority that neither the discoveries of the causes of many communicable diseases nor the continuing advancement of industrial production could overcome continuing disease and poverty. Even by 1917, the United States ranked fourteenth of 16 "progressive" nations in maternal death rate.

This period also saw the birth of the first national-level volunteer health agencies. The first of these agencies was the National Association for the Study and Prevention of Tuberculosis (TB), which was formed in 1902. It arose from the first local voluntary health agency, the Pennsylvania Society for the Prevention of Tuberculosis, organized in 1892. The American Cancer Society, Inc. was founded in 1913. That same year, the Rockefeller Foundation was established in New York. This philanthropic foundation has funded a great many public health projects, including work on hookworm and pellagra, and the development of a vaccine against yellow fever.

Another movement that began about this time was that of public health nursing. The first school nursing program was begun in New York City in 1902. In 1918, the first School of Public Health was established at Johns Hopkins University in Baltimore. This was followed by establishment of the Harvard School of Public Health in 1923. Also in 1918 was the birth of school health instruction as we know it today.

In comparison with the preceding period, the 1920s represented a decade of slow growth in public health, except for a few health projects funded

by the Rockefeller and Millbank Foundations. Prohibition resulted in a decline in the number of alcoholics and alcohol-related deaths. Although the number of county health departments had risen to 467 by 1929, 77% of the rural population still lived in areas with no health services. However, it was during this period in 1922 that the first professional preparation program for health education specialists was begun at Columbia University by Thomas D. Wood, MD, whom many consider the father of health education. The life expectancy in 1930 had risen to 59.7 years.

2.5.6 The Great Depression and World War II

Until the Great Depression (1929-1935), individuals and families in need of social and medical services were dependent on friends and relatives, private charities, voluntary agencies, community chests, and churches. By 1933, after 3 years of economic depression, it became evident that private resources could never meet the needs of all the people who needed assistance. The drop in tax revenues during the Depression also reduced health department budgets and caused a virtual halt in the formation of new local health departments.

Beginning in 1933, President Franklin D. Roosevelt created numerous agencies and programs for public works as part of his New Deal. Much of the money was used for public health, including the control of malaria, the building of hospitals and laboratories, and the construction of municipal water and sewer systems. The Social Security Act of 1935 marked the beginning of the government's major involvement in social issues, including health. This legislation provided substantial support for state health departments and their programs, such as maternal and child health and sanitary facilities. As progress against the communicable diseases became visible, some turned their attention toward other health problems, such as cancer. The National Cancer Institute was formed in 1937.

Immediately following the conclusion of the war, however, many of the medical discoveries made during wartime made their way into civilian practice. Two examples are the antibiotic penicillin, used for treating pneumonia, rheumatic fever, syphilis, and strep throat, and the insecticide DDT, used for killing insects that transmit diseases. During World War II, the Communicable Disease Center was established in Atlanta, Georgia. Now called the Centers for Disease Control and Prevention (CDC), it has become the premier epidemiological center of the world.

2.5.7 The Postwar Years

The two major health events in the 1950s were the development of a vaccine to prevent polio and President Eisenhower's heart attack. The latter event helped America to focus on its number one killer, heart disease. When the president's physician suggested exercise, some Americans heeded his advice and began to exercise on a regular basis.

2.5.8 Period of Social Engineering (1960-1973)

The 1960s marked the beginning of a period when the federal government once again became active in health matters. In 1965, Congress passed the Medicare and Medicaid bills (amendments to the Social Security Act of 1935). **Medicare** assists in the payment of medical bills for older adults and certain people with disabilities, and **Medicaid** assists in the payment of medical bills for the poor. These pieces of legislation helped provide medical care for millions who would not otherwise have received it; this legislation also improved standards in health care facilities.

2.5.9 Period of Health Promotion (1974-Present)

Most scholars, policymakers, and practitioners in health promotion would pick 1974 as the turning point that marks the beginning of health promotion as a significant component of national health policy in the twentieth century. That year Canada published its landmark policy statement, *A New Perspective on the Health of Canadians*. In [1976] the United States Congress passed PL 94-317, the Health Information and Health Promotion Act, which created the Office of Health Information and Health Promotion, later renamed the Office of Disease Prevention and Health Promotion.

In the late 1970s, the Centers for Disease Control conducted a study that examined premature deaths (defined then as deaths prior to age 65, but now as deaths prior to age 75) in the United States in 1977. That study revealed that approximately 48% of all premature deaths could be traced to one's lifestyle or health behavior—choices that people make. Lifestyles characterized by a lack of exercise, unhealthy diets, smoking, uncontrolled hypertension, and the inability to control stress were found to be contributing factors to premature mortality. This led the way for the U.S. government's publication *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention (*U.S. Department of Health, Education, and Welfare 1979). "This document brought together much of what was known about the relationship of personal behavior and health status. The document also presented a 'personal responsibility' model that provided people with the

prescription for reducing their health risks and increasing their chances for good health."

2.5.10 The new public health is compressive in scope. It relates to or encompasses all community and individual activities directed towards reducing factors that contribute to the burden of disease and foster those that relate directly to improved health. Its programs range from Immunization, health promotion, and childcare to food labeling and food fortification to the assurance of well-managed, accessible health care service. The planning, management, and monitoring functions of a health system are indispensable in a world of limited resources and high expectations. This requires a well- developed health information system to provide the feedback and control data needed for good management. It includes responsibilities and coordination at all levels of government and by nongovernmental organizations (NGO'S) and participation of a well-informed media and strong professional and consumer organization. No less important are clear designations of responsibilities of the individual for his/her own health, and of the provider of care for human, high quality professional care.

2.6 Major Disciplines in Community and Public Health

- **Nutrition**: is the science of food, the nutrients and other substances therein, their action, interaction and balance in relation to health and disease.
- **Reproductive health**: is a state of complete physical, mental and social being not only absence of disease or infirmity, in all matters relating to reproductive system and to its functions and process.
- **Environmental Health** The basic approach to environmental control is first to identify specific biologic, chemical, social and physical factors that represent hazards to health or well-being and to modify the environment in a manner that protects people from harmful exposures. The principal components of environmental health are water sanitation, waste disposal, etc.
- **Health Education** is defined as a combination of learning experiences designed to facilitate voluntary actions conducive to health. It is an essential part of health promotion.
- **Epidemiology** is the study of frequency, distribution, and determinants of diseases and other related states or events in specified populations. The application of this study to the promotion of health and to the prevention and control of health problems is evident.
- **Health Economics** is concerned with the alternative uses of resources in the health services sector and with the efficient utilization of economic resources such as manpower, material and

financial resources.

- **Biostatistics** is the application of statistics to biological problems; application of statistics especially to medical problems, but its real meaning is broader.
- **Health Service Management** is getting people to work harmoniously together and to make efficient use of resources in order to achieve objectives.
- **Ecology**: is the study of relationship among living organisms and their environment. It is the science, which deals with the inter-relationships between the various organisms living in an area and their relationship with the physical environment. Human ecology means the study of human groups as influenced by environmental factors, including social and behavioral factors.
- **Research** is a conscious action to acquire deeper knowledge or new facts about scientific or technical subjects. It is a systematic investigation towards increasing knowledge. It aims at the discovery and interpretation of facts, revision of accepted theories, or laws in the light of new facts or practical application of such new theories or laws.
- **Demography** is the study of population, especially with reference to size and density, fertility, mortality, growth, age distribution, migration, and the interaction of all those with social and economic conditions.

2.7 Ethical issues and challenges in public health

Public health is usually viewed as a broad social movement, a way of asserting social justice, value, and priority to human life. On the other hand, market justice prevents the fair distribution of burdens and benefits among society.

The following are challenges and ethical concerns in public health

1. Political conservatism and public health - in this view, politics conserves the broad vision of public health and prefers it to limit into a technical enterprise focusing on controlling communicable diseases and a safety net providing medical care to the indigent.
2. Collective scope and individualism - individualistic societies resist the notion of public health's concern for the collective initiatives.
3. Economic impacts - public health regulations affects the industries (E.g. tobacco), those paying for the public health benefits may not necessarily be the beneficiaries (E.g. Regulatory actions for worker safety raising costs to consumers), people may not be willing to pay costs for benefits that would accrue in the long future (E.g. measures to limit global warming) and it is

easier to calculate current costs incurred for public health than the benefits that would come later.

4. Promoting public welfare versus individual liberty - the extent to which governments should restrict individual freedom for the purpose of improving community health (E.g., AIDS control in Cuba)
5. Paternalism versus libertarianism - restrictions on individual behavior for protecting their own health (E.g., enforcing seat belts). libertarianism claims that “the only purpose for which power can be rightfully exercised over any member of a civilized community, against her / his will is if her/his act harms others (E.g., regulate drunk behavior no drinking)
6. Public health measures and religion/moral - some public health measures are not acceptable on religious and moral grounds, (E.g., sex education and distribution of contraceptives and/or condoms to adolescences),
7. Values and responsibilities - health authorities deciding on values and choices of those they serve (e.g., whether someone should not take the responsibility on behavior causing ill health such as smokers, alcoholics, promiscuous people), decision on whether to emphasize HIV/AIDS prevention versus ARV therapy in poor countries, the extent of providing access to benefits to research subjects
8. Surveillance versus cure - involves hoe to deal with sick subjects identified in routine survey/data collection
9. Dilemmas in cost benefit analysis - the difficulty of valuing life, and values to be assigned for the rich versus the poor.

Self-Assessment Exercises 2

what are the challenges of public health practice?

2.8 Summary

This unit discussed the concepts of community and public health as well as the major disciplines related to them. It is important to be familiar with and understand the history of community and public health to be able to deal with the present and future community and public health issues. the unit also highlighted the ethical issues and challenges in public health to appreciate how market justice prevents the fair distribution of burdens and benefits among societies.

2.9 References/Further Readings/Web Resources

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Chronic Disease: A Significant Public Health Threat, **https://www.cdc.gov/nccdphp/dch/about/index.htm**

U.S. Department of Health, Education, and Welfare (1979). Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention (DHEW pub. no. 79-55071). Washington, DC: U.S. Government Printing Office

Pickett, G., and J. J. Hanlon (1990). Public Health: Administration and Practice, 9th ed. St. Louis: Times Mirror/Mosby.

Legon, R. P. (1986). "Ancient Greece." World Book Encyclopedia. Chicago: World Book.

Rosen, G. (1958). A History of Public Health. New York: MD Publications

Burton, L. E., H. H. Smith, and A. W. Nichols (1980). Public Health and Community Medicine, 3rd ed. Baltimore: Williams & Wilkins.

Woodruff, A. W. (1977). "Benjamin Rush, His Work on Yellow Fever and His British Connections." American Journal of Tropical Medicine and Hygiene, 26(5): 1055-1059.

Rosen, G. (1975). Preventive Medicine in the United States, 19001975. New York: Science History Publications.

Smillie, W. G. (1955). Public Health: Its Promise for the Future. New York: Macmillan.

Duffy, J. (1990). The Sanitarians: A History of American Public Health. Chicago: University of Illinois Press.

Lalonde, M. (1974). A New Perspective on the Health of Canadians: A Working Document. Ottawa, Canada: Minister of Health.

Green, L. W. (1999). "Health Education's Contributions to the Twentieth Century: A Glimpse through Health Promotion's Rearview Mirror." In J. E. Fielding, L. B. Lave, and B. Starfield, eds., Annual Review of Public Health. Palo Alto, CA: Annual Reviews, 67-88.

U.S. Department of Health and Human Services, Public Health Service (1980). Ten Leading Causes of Death in the United States, 1977. Washington, DC: U.S. Government Printing Office.

U.S. Department of Health, Education, and Welfare (1979). Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention (DHEW pub. no. 79-55071). Washington, DC: U.S. Government Printing Office.

McKenzie, J. F., B. L. Neiger, and R. Thackeray (2017). Planning, Implemen ting, and Evaluating Health Promotion Programs: A Primer, 7th ed. Upper Saddle River, NJ: Pearson.

U.S. Department of Health and Human Services (1980). Promoting Health/Preventing Disease: Objectives for the Nation. Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services (2016). Healthy People.gov. Available at https://www.healthypeople.gov/

2.10 Possible Answers to SAEs

Answers to SAEs 1

1. **Public health** is defined as the science and art of preventing diseases, prolonging life, promoting health and efficiencies through organized community effort. It is concerned with the health of the whole population and the prevention of disease from which it suffers.

Clinical medicine is concerned with diagnosing and treating diseases in individual patients. It has evolved from primarily a medical and nursing service to involve a highly complex team of professionals.

2. The roles of public health

- Preventing epidemics
- Protecting the environment, work place, food and water ;
- Promoting healthy behavior.
- Monitoring the health status of the population.
- Mobilizing community action.
- Responding to disasters.
- Assuring the quality accessibility, and accountability of medical care;
- Reaching to develop new insights and innovative solutions and

- Leading the development of sound health policy and Planning

Answers to SAEs 2

1. Political conservatism and public health
2. Collective scope and individualism
3. Economic impacts
4. Promoting public welfare versus individual liberty
5. Paternalism versus
6. Public health measures and religion/moral
7. Values and responsibilities
8. Surveillance versus cure
9. Dilemmas in cost benefit analysis

2.11 Tutor-Marked Assignment

1. List 4 core activities in Public Health (2 marks)
2. What ethical issues and challenges are embedded in public health and how can they be addressed (6marks)

UNIT 3 THEORIES/MODELS OF DISEASE CAUSATION

3.1 Introduction
3.2 Intended Learning Outcomes
3.3 Ancient to 19th century models/theories of disease causation
  3.3.1 Demonic theory
  3.3.2 Punitive theory
  3.3.3 Humoral theory
  3.3.4 Contagion theory
  3.3.5 Supernatural theory
  3.3.6 Personal behavior theory
  3.3.7 Miasma theory
1.4 Twenty-century to modern era models/theories of disease causation
  1.4.1 The Germ Theory
  1.4.2 Epidemiological triad theory
  1.4.3 Multifactorial theory
  1.4.4 Beings theory
  1.4.5 Web of Causation theory
  1.4.6 Wheel teory
  1.4.7 The Lifestyle Theory
  1.4.8 The Environmental Theory
  1.4.9 The Multi Causal Theory
1.5 Summary
1.6 References/Further Readings/Web Resources
1.7 Possible answers to SAEs

3.1 Introduction

A model is a representation of a system that specifies its components and the relationships among the variables. E.g. includes graphs, charts, and decision trees. In this unit the ancient to Nineteen-century theories as well as the 20th century to modern era theories will be discussed. Each effort to prevent disease in the ancient to 19th and 20th centuries to modern times were based on one or more of these theories of disease causality.

3.2 Intended Learning Outcomes

By the end of this unit, you will be able to:

- List and Discuss the major Models/Theories of disease causation of the ancient to 19th century
- List and Discuss the major Models/Theories of disease causation of the 20th century to modern era
- Evaluate the strengths and weaknesses of each of the models

3.3 The models/theories of disease causation (Ancient views to 19th century)

Each effort to prevent disease in the ancient era to 19th century was based on one or the three theories of disease causality. These are:

1. Demonic theory
2. Punitive theory
3. Humoral theory
4. Contagion theory
5. Supernatural theory
6. Personal behavior theory
7. Miasma theory

3.3.1 *Demonic* theory

Religion, philosophy, and medicine were integral part in the early part of civilization. Religion recognized multiplicity of Gods, both good and evil. Philosophy accepted the influence of inanimate bodies such as sun, moon and stars on living bodies. Thus, a co relation between these with health and disease was established in primitive ages. One concept prevalent was that the evil spirit entering the body directly and pursuing nefarious actions. Another concept was the evil spirit as a messenger of Gods giving warnings in the form of diseases. Some other concept was a human enemy with supernatural powers, send evil spirits to harm others. The souls of dead ancestors influencing his family members were another belief. Demonic possession is held by many belief systems to be the control of an individual by a malevolent supernatural being. Expressions include erased memories or personalities, convulsions, "fits" and fainting as if one were dying, access to hidden knowledge and foreign languages, drastic changes in vocal intonation and facial structure, sudden appearance of injuries (scratches, bite marks) or lesions, and superhuman strength. Many cuneiform tablets contain prayers to certain gods asking for protection from demons, while others asked the gods to expel the demons that invaded their bodies.

3.3.2 Punitive theory

Punitive theory has its origin with the religion with the belief that one's attitude toward the deity is responsible as a cause of sickness. From a period, centuries prior to the Christian era down to the present time, there have been beliefs that disease was a punishment meted out by an outraged God for the sins of the individual or the race. There are recorded statements in biblical writings where in punishment is meted for a sin of David, with devastating plague in which the whole nation suffered and which was stayed only by David's repentance and the making of a sacrifice. Such references are abundantly available in Hindu mythology also especially those related to eruptive fevers such as Smallpox, Chicken Pox etc.

3.3.3 Humoral theory

The Greeks rejected the supernatural theories and looked up on disease as a natural process. They advocated that the matter is made up of four elements- Earth, Air, Fire and Water and these elements have the corresponding qualities of being Cold, Dry, Hot and Moist. With this concept they hypothesized that these qualities are represented in the body by four humors- *Phlem, yellow bile, black bile and blood.* According to this theory, the equilibrium among these humours characterizes health *(eucrasia),* and disequilibrium *(dyscrasia)* characterizes disease. Hippocrates moved medicine from magic and metaphysics to give it a scientific basis. He introduced logic into medical thinking, elaborated the theory of humours and recognized the importance of the environment in health. He also suggested that an excess of one of the humours would result in various idiosyncrasies - hematic, phlegmatic, choleric and melancholic. The theory of humours was known in India, China, Egypt and Greece.

3.3.4 Miasmatic theory

Miasmatic theory is based on the inference that the air arising from certain kinds of ground, especially low, swampy areas, was a cause of disease. Certain places were thus given a very evil reputation, because the ground was said to exude some invisible, insensible vapour, called it miasm, which produced disease. The invention of miasma was really beginning to be scientific medicine. People were searching for a material and natural causes, instead finding shelter on god or a devil. Rational thinking that something cannot come out of nothing was the basis of this concept. The fact that malaria was prevalent in the vicinity of swampy land, and some evidence that people who ventured out in these swampy places were more likely to get the disease, lent plausibility to this theory.

It was the belief in the air as the causative agent that gave malaria its name, *mal aria* ('***bad air***' in Medieval ***Italian***). Hahnemann was fascinated with this concept and further studied the cause of chronic diseases. He observed suppression of diseases with heroic treatment available at that time was a major basis for many of the chronic diseases. He brought out new concept that suppression of itch to a miasm called *Psora* and venereal diseases to *Sycosis* and *Syphilitic* miasms.

3.3.5 Contagion theory

Some Hippocratic writings recognized that consumption (tuberculosis) is contagious. However, contagion played little role in medical explanations of disease until the work of Fracastoro who published his major treatise on contagion. Girolamo Fracastoro (1478-1553), an Italian physician, contended that there is a large class of diseases caused by contagion rather than humoral imbalances. This was based on the observation that persons could contract infections even if their humors are normally balanced. Fracastoro defined a contagion as a "corruption which develops in the substance of a combination, passes from one thing to another, and is originally caused by infection of the imperceptible particles". He called the particles the seminaria (seeds or seedlets) of contagion. Fracastoro was unable to say much about the nature of these suspected particles; bacteria were not observed by van Leeuwenhoek until 1683, and their role in infection was not appreciated until the 1860s. Fracastoro nevertheless discussed the causes and treatment of various contagious diseases. He described how contagion can occur by direct contact, by indirect contact via clothes and other substances, and by long-distance transmission. In addition, he stated that diseases can arise within an individual spontaneously. His book has chapters for the arrangement of contagious diseases. His theory remained influential for nearly three centuries, before being superseded by a fully developed germ theory.

3.3.6 Supernatural theory

Proponents of this theory argued that supernatural forces cause disease. Disease prevention measures based on this theory were important to the religious people. The view among them was that disease is a punishment for transgression of God's laws. Because epidemic took a great toll on the poor than the rich, the healthier rich can employ the supernatural theory as a justification for berating for the poor for sinful behavior i.e., presumed idleness, intemperance, and uncleanness. This theory expressed a political philosophy. People could not advocate the belief that sin causes disease without, at the same time, implicitly supporting the idea that government need to redress poverty.

3.3.7 Personal behavior theory

This theory held that disease results from wrong personal behavior. It was democratic andante authoritarian in intent since it gave responsibility to individuals to control their own lives. In this formulation the source of the disease was not tied up with the mysterious ways of God, instead people caused their own disease by living fully unhealthy. Hence, improper diet, lack of exercise, poor hygiene and emotional tension become the focus of preventive actions. This theory does not blame the poor for the illness and in many aspects; it was homage to middle-class life.

3.4 Twenty-century to Modern era models/theories of disease causation

Although economic and ideological considerations influenced the 19th century disease prevention policy, sound research determines policy during this era. The 20th century theory focuses on:

1. The Germ Theory
2. Epidemiological Triad theory
3. Multifactoral theory
4. BEINGS theory
5. Web of causation theory
6. Wheel theory
7. The Lifestyle Theory
8. The Environmental Theory
9. The Multi Causal Theory

3.4.1 Germ Theory

Germ theory was proposed by Louis Pasteur (1822 –1895) and Robert Koch (1843 –1910). Germ theory postulates that every human disease is caused by a microbe or germ, which is specific for that disease, and one must be able to isolate the microbe from the diseased human being. The Germ theory viewed diseases in terms of a causal network like that of Fracastoro, but with much more detail about the nature of germs and possible treatments. Organisms that cause disease inside the human body are called pathogens. Bacteria and Viruses are the best know pathogens. Fungi, protozoa, and parasites can also cause disease. Infectious diseases are typically classified as bacterial, viral, protozoal and so on. Knowing what bacteria are responsible for a particular disease indicates what antibiotic treatment to apply. Diseases are said to be infectious or communicable if pathogens can be passed from one person to another.

3.4.2 Epidemiological Triad

The standard model of infectious disease causation under the epidemiological triad theory states that an external agent can cause diseases on a susceptible host when there is a conducive environment. Within the epidemiological triad the agent is known as a 'necessary' factor. It has to be present for morbidity, although it may not inevitably lead to disease. For the disease to occur it needs the combination of what have been called 'sufficient' factors. These would include a host, which might be an individual or group of individuals who are susceptible to the agent. Susceptibility might be on the basis of age, sex, ethnic group or occupation. Environmental factors can also be sufficient factors that combine with the agent. The epidemiological triad can be applied to non-infectious diseases where the agent could be 'unhealthy behaviours, unsafe practices, or unintended exposures to hazardous substances'

Agent
Host
Environment
Time

3.4.3 Multi factorial theory

When the knowledge on diseases increased, one theory was not able to explain the causation of all the diseases. This lead to multi factorial theory to find rational explanation. Though many diseases are infectious, other causative factors such as Genetic, Nutritional, Immunological, Metabolic, Cytological factors were identified as the cause for specific diseases. Sydenham (1644-1689), often- called the English Hippocrates, first gave the important thought that there are different specific things which should be held responsible for different diseases. Sydenham held that disease was the result of the effort made-by the body to throw off, to expel these iiateries inorbi, the dead materials within it,' which had made the trouble.' The important result of Sydenham's studies was that a little close intelligent observation upon the part of the doctor is worth more than any amount of dosing administered in blind observance of a preconceived notion. It was a step away from the four humours and from other artificial, theories. In short, Sydenham did much to teach the medical profession the value and importance of "studying the case." Sir William Osler (1849-1919), a legendary medical teacher and physician of wrote: "The practice of medicine is an art based on science, working with science, in science and for science."

3.4.4 BEINGS theory

BEINGS concept postulates that human diseases and its consequences are caused by a complex interplay of nine different factors. By coining the first letters of these factors the theory is called BEINGS theory. These are (1) Biological factors innate in a human being, (2) Behavioural factors concerned with individual lifestyles, (3) Environmental factors as physical, chemical and biological aspects of environment, (4) Immunological factors,(5) Nutritional factors, (6) Genetic factors, (7) Social factors, (8) Spiritual factors and (9) Services factors, related to the various aspects of health care services.

3.4.5 Web of causation theory

The "epidemiological triad theory" was very effectively used by Leavel and Clark in explaining the natural history of disease and levels of prevention. The terms primary, secondary and tertiary prevention were first documented in the late 1940s by Hugh Leavell and E. Guerney Clark from the Harvard and Columbia University Schools of Public Health, respectively. Both were pioneers in Public Health. Leavell and Clark described the principles of prevention within the context of epidemiologic triangle model of Causation of diseases of Host, Agent and Environment. As per their concept, the primary prevention seeks to prevent a disease or condition at a pre-pathologic state; to stop something from ever happening. Primary prevention strategies emphasize general health promotion, risk factor reduction, and other health protective measures. These strategies include health education and health promotion programs designed to foster healthier lifestyles and environmental health programs designed to improve environmental quality. Secondary prevention focuses on individuals who experience health problems or illnesses and who are at risk of developing complication. Activities are directed at early diagnosis and prompt intervention, thereby reducing severity and enabling the client to return to normal. Its purpose is to cure disease, slow its progression, or reduce its impact on individuals or communities. Tertiary prevention occurs when a defect or disability is permanent and irreversible. It involves minimizing the effects of long-term disease or disability by interventions direct at preventing complications and deteriorations. Tertiary prevention strategies are both therapeutic and rehabilitative measures once disease is firmly established.

3.4.6 Wheel theory

As medical knowledge advanced, an additional aspect of interest that came into play is the comparative role of "genetic" and the

"environmental" (i.e. extrinsic factors outside the host) factors in causation of disease. The "triad" as well as the "web" theory does not adequately cover up this differential. To explain such relative contribution of genetic and environmental factors, the "wheel" theory has been postulated.

The theory visualizes human disease in the form of a wheel, which has a central hub representing the genetic components and the peripheral portion representing the environmental component.

Like any wheel, the outer part (environmental component) has spokes (3 in this model) and the environmental component is thus divided into 3 sub components, representing the social, biological and physical components of the environment. To maintain health, one has to take regular exercises and adequate rest, follow personal hygiene, eat nutritionally balanced diet, abstain from the abuse of drugs and alcohol, take care of one's mental well-being and develop social skills to interact in a positive manner within society.

3.4.7 The Lifestyle Theory

This holds that unhealthy lifestyles are causes for diseases. This hypothesis blames stress, lack of exercise, the use of alcohol and tobacco improper nutrition for most chronic diseases. This theory rejects the notion central to the classic germ theory, that a single disease has a single etiology. Instead, they emphasize the inter-relatedness of many variables in disease causality, principally those under the control of the individual. Nevertheless, this approach resembles the germ theory, for it conceives of disease as an individual event, the difference is that prevention, instead of requiring physicians' ministrations, demand personal behavior change. The critics surrounding this theory state that the change for lifestyle requires overall social change.

3.4.8 The Environmental Theory

Environmental theory explains that significant number of chronic diseases are caused by toxins in the environment and it implies that disease prevention, instead of requiring medical treatments or personal hygiene, demands change in the industrial production. The first aspect of the environmental hypothesis is occupational hazards, the second concentrates on toxic substances in the air water and soil (advocates of this theory places particular emphasis on radioactivity), and the third aspect focus on synthetic additives to foods, "organic foods". Two scientific disputes surround the hypothesis viz the suitability of extrapolating from animals to humans and the concept of threshold levels.

3.4.9 The Multi Causal Theory

It is also called the web of disease causation. The theory expresses that there are multiple factors for a cause of a single disease entity. But it is incapable of directing a truly effective disease prevention policy as the theories it replaces. Its shortcomings are it gives few clues about how to prevent disease, the actual prevention policies it implies are inefficient in many ways and there is a gap between what it promises and what epidemiologist's deliver.

Self-Assessment Exercises 1

Outline the strengths and weaknesses of the ancient models.

3.5 Summary

Understanding the cause of disease is the key to begin the process of finding remedies that could cure them. Every medical system has its own models of identifying the reason of diseases. Based on those concepts they develop models of treatment. This unit discussed the models and theories of disease causation from the ancient times through the 19th and 20th centuries to the modern era. The strengths and weaknesses of each theory were highlighted.

3.6 References/Further Readings/ Web Resources

Park's Textbook of Preventive and Social Medicine, 21st edition
Leon Gordis, Textbook of Epidemiology, 4th edition.

Textbook of public Health and Community medicine, AFMC,2009

Measures of prognosis, Bloomberg School of Public Health,2008
CDC, Principles of Epidemiology in Public Health Practice, 3rd Edition

The Genius of Homeopathy Lectures and Essays on Homeopathic Philosophy
By Dr Stuart M. CLOSE
http://www.open.edu/openlearn/science-maths-technology/science/health-sciences/epidemiology-introduction/content-section-3.1

Feezer L W, Theories concerning the causation of disease, Minnesota State Board of Health Minneapolis, Minnii. http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.11.10.908

3.7 Possible answers to SAEs

- Demonic possession is held by many belief systems to be the control of an individual by a malevolent supernatural being.
- Beliefs that disease was a punishment meted out by an outraged God for the sins of the individual or the race.
- The equilibrium among the humours characterizes health *(eucrasia),* and disequilibrium *(dyscrasia)* characterizes disease.
- The invention of miasma (bad air) mwas really beginning to be scientific medicine. People were searching for a material and natural causes, instead finding shelter on god or a devil. Rational thinking that something cannot come out of nothing was the basis of this concept.
- Observation that people could contract infections even if their humors are normally balanced
- Diseases result from wrong personal behaviours.

3.8 Tutor-Marked Assignment

State and explain 4 major models of disease causation of the 20th century (8mks)

UNIT 4 COMMUNITY AND PUBLIC HEALTH IN NIGERIA

4.1 Introduction
4.2 Intended Learning Outcomes
4.3 History of community and public health in Nigeria
  4.3.1 Definition of public health
  4.3.2 Context of public health practitioners/practices in traditional society
4.4 Organisations that help shape community and public health
  4.4.1 Governmental health agencies
  4.4.2 History of World Health Organisation (WHO)
  4.4.3 National health agencies
  4.4.4 State health agencies
  4.4.5 Local health departments
  4.4.6 Quasi-Government health organisations
  4.4.7 Non-Governmental organisations
4.5 Summary
4.6 References/Further Readings and Web Resources
4.7 Possible answers to SAEs

4.1 Introduction

The history of community and public health dates to antiquity. The previous unit dealt with the global history. It becomes pertinent that we study the history within our context as well. For much of that history, community and public health issues were addressed only on an emergency basis. For example, if a community faced a drought or an epidemic, a town meeting would be called to deal with the problem. It has been only in the last 100 years or so that communities have taken explicit actions to deal aggressively with health issues on a continual basis. Today's communities differ from those of the past in several important ways. Although individuals are better educated, more mobile, and more independent than in the past, communities are less autonomous and are more dependent on state and federal funding for support. Contemporary communities are too large and complex to respond effectively to sudden health emergencies or to make long-term improvements in community and public health without community organization and careful planning. Better community organizing and careful long term planning are essential to ensure that a community makes the best use of its resources for health, both in times of emergency and over the long run. In this unit, we discuss specifically the Nigerian community and public health as well as organizations that help to shape community's ability to respond effectively to health-

related issues by protecting and promoting the health of the community and its members. These community organizations can be classified as governmental, quasi-governmental, and nongovernmental according to their sources of funding, responsibilities, and organizational structure.

4.2 Intended Learning Outcomes

By the end of this unit, you will be able to:

- Discuss the history of community-public health in Nigeria
- Outline the various organisations that help to shape community-public health
- Analyse the roles each of these organisations play in shaping community-public health in Nigeria

4.3 History of Community and Public Health in Nigeria

The concept of public health has existed before the scientific coining and definition of the term. The issue of disease and health is as old as man. The African local communities have several indigenous and traditional ways of responding to disease conditions. Preventive and curative practices were in place in various Nigerian communities before the coming of the colonial masters. While some of these are still being practiced today owing to their effectiveness, some have been redefined or upgraded in the context of modern public health practice.

4.3.1 Definition of Public Health

Public health is the science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research for disease and injury prevention and detection and control of infectious diseases. Overall, public health is concerned with protecting the health of entire populations. These populations can be as small as a local neighborhood, or as big as an entire country or region of the world. However Winslow (1920) gave what could be described as comprehensive and robust definition of Public health as ―the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of the social

machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.

It is therefore obvious that public health does not only include actions taken to prevent development of diseases, but timely diagnosis, treatment and rehabilitative measures taken to prevent progression of diseases, reversal of communicability and limit disability. It is against this backdrop that public health could embrace aspects of curative and rehabilitative medicine. History of public health in Nigeria therefore should embrace historical efforts aimed at evolving or developing preventive and curative services for the purpose of improving and sustaining Health.

Self-Assessment Exercises 1

1. State the three core functions of public health in Nigeria.

4.3.2 Context of Public Health Practice in Pre-Colonial/Traditional Nigerian Society

Health even before the coming of the colonial masters has been known as the most precious of all things and the foundation of all happiness. Traditional medicine has developed in various communities in Nigeria in response to the health needs of the people. Many communities have, therefore, since creation, developed various traditional systems using locally-available resources for the alleviation of their health problems. Besides, many rural communities have great faith in traditional medicine, particularly the inexplicable aspects as they believe that it is the wisdom of their fore-fathers which also recognizes their socio-cultural and religious background. The development of traditional medicine in Nigeria has led to various categories of healers, the various healing methods, strategies and medicines or remedies now known.

Although this traditional system of health evolved separately in different micro-cultures, there is a great deal of philosophical and conceptual similarities. The origin of diseases in Africa was simplistic. It is either an enemy had cast a spell on somebody, or one is being punished by divine powers for his sins. In the same sense disease preventive practices could be associated with regular rituals and sacrifices made to ancestral beings, family and community deities and are believed to help in warding off calamities including illness and sicknesses dominantly thought to be associated with evil spirit activities.

4.3.3 Categories of Practitioners/Practices in Traditional society

Various categories of the practitioners include:

4.3.3.1 Herbalists

Herbalists use mainly herbs, that is, medicinal plants or parts of such plants to cure diseases. Traditional Birth Attendants (TBAs) These TBAs occupy a prominent position in Nigeria even till today as between 60-85 per cent of births delivered in the country and especially in the rural communities are by the TBAs. They assist the mothers at childbirth based on skills initially acquired to past participation in child delivery.

4.3.3.2 Traditional Surgeons

These function in the cutting of tribal marks, male and female circumcision (Clitori dectomy). These functions they carry out with special knives and scissors; blood-letting operations etc. The wounds that result from these operations is usually treated with local procedures such as snail body fluid or pastes prepared from plants. They also remove whitlows.

4.3.3.3 Traditional Bone setters

Traditional bone setting is recognized to have attained a level of success comparable to that in orthodox medicine in Nigeria. The skill tends to run in families or lineage as practioners tend to hand the practice over to their children or trusted relations who continue with the practice after their death.

4.3.3.4 Practitioners of Therapeutic Occultism (Spiritual healers)

These include diviners or fortune tellers, who may be seers, ―alfas and priests, and use supernatural or mysterious forces, incantations, may prescribe rituals associated with the community's religious worship and adopt all sorts of inexplicable things to treat various diseases. In some cases, it may involve consultation with ancestral spirits, community deities and water spirits.

More so Preventive practices such as Isolation cannot be said to be foreign to Nigerian indigenous communities as Individuals known to be suffering from dangerous and contagious diseases such as leprosy were

known to be isolated in secluded environment where they are kept incommunicado with other members of the community. Certain norms guide the maintenance of adequate sanitation in the communities. For instance, women and children, particularly the girls, sweep the homes/surroundings and empty refuse bins.

There are also cultural festivals that emphasize cleanliness in various communities and many such festivals persist till today. Public Health who could be seen as —the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community and Governmental efforts, cannot be said to be an entirely new concept that was introduced by the colonial masters, but various aspects of it has been in practice before the onset of colonization.

Self-Assessment Exercises 2

State the categories of traditional practices that helped shape public health in Nigeria.

4.4 Organizations that shape Public Health

4.4.1 Governmental health agencies are part of the governmental structure (federal, state, tribal and/or territorial, or local). They are funded primarily by tax and managed by government officials. Each governmental health agency is designated as having authority over some geographic area. Such agencies exist at the four governmental levels—international, national, state, and local.

The most widely recognized international governmental health organization today is the **World Health Organization (WHO).** Its headquarters is located in Geneva, Switzerland, and there are six regional offices around the world. The names, acronyms, and cities and countries of location for WHO regional offices are as follows: Africa (AFRO), Brazzaville, Congo; Americas (PAHO), Washington, D.C., United States; Eastern Mediterranean (EMRO), Cairo, Egypt; Europe (EURO), Copenhagen, Denmark; Southeast Asia (SEARO), New Delhi, India; and Western Pacific (WPRO), Manila, Philippines. (WHO,2016). Although the WHO is now the largest international health organization, it is not the oldest. Among the organizations (listed with their founding dates) that predate WHO are the following:

- International D'Hygiene Publique (1907); absorbed by the WHO
- Health Organization of the League of Nations (1919); dissolved

when the WHO was created

- United Nations Relief and Rehabilitation Administration (1943); dissolved in 1946—its work is carried out today by the Office of the United Nations High Commissioner for Refugees (UNHCR) (1950)
- United Nations Children's Fund (UNICEF) (1946); formerly known as the United Nations International Children's Emergency Fund
- Pan American Health Organization (PAHO) (1902); still an independent organization but is integrated with WHO in a regional office

Because the WHO is the largest and most visible international health agency, it is discussed at greater length in the following sections.

4.4.2 History of the World Health Organizatio*n*

Planning for the WHO began when a charter of the United Nations was adopted at an international meeting in 1945. Contained in the charter was an article calling for the establishment of a health agency with wide powers. In 1946, at the International Health Conference, representatives from all of the countries in the United Nations succeeded in creating and ratifying the constitution of the WHO. However, it was not until April 7, 1948, that the constitution went into force and the organization officially began its work. In recognition of this beginning, April 7 is commemorated each year as World Health Day. (WHO,2016). The sixtieth anniversary of the WHO was celebrated in 2008.

4.4.2.1 Organization of the World Health Organization

"WHO is a United Nations specialized agency concentrating exclusively on health by providing technical cooperation, carrying out programmes to control and eradicate disease and striving to improve the quality of human life." Membership in the WHO is open to any nation that has ratified the WHO constitution and receives a majority vote of the World Health Assembly. At the beginning of 2016, 194 countries were members including Nigeria. The World Health Assembly comprises the delegates of the member nations. This assembly, which meets in general sessions annually and in special sessions, when necessary, has the primary tasks of approving the WHO program and the budget for the following biennium and deciding major policy questions (WHO, 2016).

The WHO is administered by a staff that includes an appointed director-general, deputy director-general, seven assistant directors-general, and six regional directors. Great care is taken to ensure political balance in staffing WHO positions, particularly at the higher levels of

administration. “More than 7,000 people from more than 150 countries work for the Organization in over 150 WHO country offices, 6 regional offices, at the Global Service Centre in Malaysia and at the headquarters in Geneva, Switzerland.” (WH0,2016)

4.4.2.2 Purpose and Work of the World Health Organization

The primary objective of the WHO “shall be the attainment by all peoples of the highest possible level of health.” To achieve this objective, the WHO has 6 core functions that describe the nature of its work.

They are: WHO, (2014)

- Providing leadership on matters critical to health and engaging in partnerships where joint action is needed
- Shaping the research agenda and stimulating the generation, translation, and dissemination of valuable knowledge
- Setting norms and standards and promoting and monitoring their implementation.
- articulating ethical and evidence-based policy options
- Providing technical support, catalyzing change, and building sustainable institutional capacity
- Monitoring the health situation and assessing health trends

The work of the WHO is financed by its member states with assessed and voluntary contributions. Each member state is assessed according to its ability to pay; the wealthiest countries contribute the most. Voluntary contributions also come from the member states and account for more than three quarters of the budget financing.

Although the WHO has sponsored and continues to sponsor many worthwhile programs, an especially noteworthy one was the work of the WHO in helping to eradicate smallpox. At one time, smallpox was the world's most feared disease until it was eradicated by a collaborative global vaccination program led by WHO. In 1979, the World Health Assembly declared the global eradication of this disease. More recently, the WHO has led the efforts to contain the outbreaks of Ebola. Since July 2014 unparalleled progress has been made in establishing systems and tools that allow for rapid and effective response. Thanks to the diligence and dedication of tens of thousands of responders, scientists, researchers, developers, volunteers, and manufacturers, there are now six rapid diagnostic tools that can detect the Ebola virus in a matter of hours, 24 worldwide testing laboratories, an Ebola vaccine, registered foreign medical teams, and thousands of trained responders who can rapidly deploy to outbreaks.

The work of WHO is outlined in its "general programme of work." This document, which is a requirement of the WHO constitution, "provides a vision and is used to guide the work of the organization during a pre-determined period of time." The categories of work covered in this document include communicable diseases, noncommunicable diseases, health throughout the life cycle, health systems, preparedness, surveillance, and response; and corporate services and enabling functions.

In addition to the program of work, much of the recent work of WHO is outlined in the United Nations Millennium Declaration, which was adopted at the Millennium Summit in 2003. The declaration set out principles and values in seven areas (peace, security, and disarmament; development and poverty eradication; protecting our common environment; human rights, democracy, and good governance; protecting the vulnerable; meeting special needs of Africa; and strengthening the United Nations) that should govern international relations in the twenty-first century. Following the summit, the *Road Map* was prepared, which established goals and targets to be reached by 2015 in each of the seven areas. The resulting eight goals in the area of development and poverty eradication were referred to as the Millennium Development Goals (MDGs). More specifically, the MDGs were aimed at reducing poverty and hunger, tackling ill health, gender inequality, lack of education, lack of access to improved drinking water, and environmental degradation. Much success was made with the MDGs. Unified efforts have produced data that prove the MDGs have saved millions of lives and improved conditions from targeted interventions, sound strategies, and adequate resources. The momentum must continue because uneven achievements and shortfalls continue to exist; therefore, the work must continue into the new development era. As noted above, the MDGs were not exclusively aimed at health, but there were interactive processes between health and economic development that create a crucial link. That is, better health is "a prerequisite and major contributor to economic growth and social cohesion. Conversely, improvement in people's access to health technology is a good indicator of the success of other development processes."(UN,2000).

Although much progress has been made, there is still much more work to be done. Moving forward, challenges will be addressed through a new universal and transformative post-2015 development agenda of MDGs supported by a set of 17 goals referred to as the **Sustainable Development Goals** (SDGs). SDGs were established to be interconnected and concentrated towards eradicating poverty, addressing climate change, and increasing economic growth. The goals were developed by world leaders in September 2015 to build on the MDGs

and improve the lives of people through a global, unified effort.

Self-Assessment Exercises 3

1. Explain what a governmental health organization is and give an example of one at each of the following levels—international, national, state, and local.
2. Discuss the role the World Health Organization (WHO) plays in community and public health.

4.4.3 National Health Agencies

Each national government has a department or agency that has the primary responsibility for the protection of the health and welfare of its citizens. These national health agencies meet their responsibilities through the development of health policies, the enforcement of health regulations, the provision of health services and programs, the funding of research, and the support of their respective state and local health agencies. In the United States, the primary national health agency is the Department of Health and Human Services (HHS). HHS "is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves." It is important to note, however, that other federal agencies also contribute to the betterment of our nation's health. For example, the Department of Agriculture inspects meat and dairy products and coordinates the Special Supplemental Nutrition Program for Women, Infants, and Children, better known as the WIC food assistance program; the Environmental Protection Agency (EPA) regulates hazardous wastes; the Department of Labor houses the Occupational Safety and Health Administration (OSHA), which is concerned with safety and health in the workplace; the Department of Commerce, which includes the Bureau of the Census, collects much of the national data that drive our nation's health programs; and the Department of Homeland Security (DHS) deals with all aspects of terrorism within the United States.

a) Administration for Children and Families (ACF)

The ACF is composed of a number of smaller agencies and is responsible for providing direction and leadership for all federal programs to ensure children and families are resilient and economically secure. One of the better-known programs originating from this division is Head Start, which serves nearly one million preschool children. Other programs are aimed at family assistance, refugee resettlement, and child

support enforcement. In 2015, Head Start celebrated 50 years of service in school readiness of young children from low-income families.

b) ***Agency for Health Care Research and Quality (AHRQ)***

Prior to 1999, this division of the HHS was called the Agency for Health Care Policy and Research, but its name was changed as part of the Health Care Research and Quality Act of 1999. AHRQ is "the Nation's lead federal agency for research on health care quality, costs, outcomes, and patient safety." AHRQ sponsors and conducts research that provides evidence-based information on health care outcomes; quality; and cost, use, and access. The information helps health care decision makers—patients and clinicians, health system leaders, and policy makers—make more informed decisions and improve the quality of health care services.

c) ***Agency for Toxic Substances and Disease Registry (ATSDR)***

This agency was created by the **Superfund legislation** (Comprehensive Environmental Response, Compensation, and Liability Act) in 1980. This legislation was enacted to deal with the cleanup of hazardous substances in the environment. ATSDR's mission is to "serve the public through responsive public health actions to promote healthy and safe environments and prevent harmful exposures."

d) ***Centers for Disease Control and Prevention (CDC)***

The CDC, located in Atlanta, Georgia, "is the nation's leading health agency, dedicated to saving lives and protecting the health of Americans."[19] "The CDC serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States." Once known solely for its work to control communicable diseases, the CDC now also maintains records, analyzes disease trends, and publishes epidemics by; Detecting and responding to new and emerging health threats; Tackling the biggest health problems causing death and disability for Americans; Putting science and advanced technology into action to prevent disease; Promoting healthy and safe behaviors, communities, and environment; Developing leaders and training the public health workforce, including disease detectives; Taking the health pulse of our nation.

e) Food and Drug Administration (FDA)

The FDA touches the lives of virtually every American every day. It "is charged with protecting the public health by ensuring the safety,

efficacy, and security of human and veterinary drugs, biological products, and medical devices; ensuring the safety of foods, cosmetics, and radiation-emitting products; and regulating tobacco products. Specifically, FDA is responsible for advancing the public health by:

- Helping to speed innovations that make medicines and foods safer and more effective
- Providing the public with the accurate, science-based information they need to use medicines and foods to improve their health
- Regulating the manufacture, marketing, and distribution of tobacco products to protect the public and reduce tobacco use by minors

Addressing the nation's counterterrorism capability and ensuring the security of the supply of foods and medical products."

f) Centers for Medicare and Medicaid Services (CMS)

Established as the Health Care Financing Administration (HCFA) in 1977, the CMS is responsible for overseeing the Medicare program (health care for the elderly and the disabled), the federal portion of the Medicaid program (health care for low-income individuals), and the related quality assurance activities. Both Medicare and Medicaid were created in 1965 to ensure that the special groups covered by these programs would not be deprived of health care because of cost. Currently, about 124 million Americans are covered by these programs.[27] In 1997, the State Children's Health Insurance Program (SCHIP), now known as the Children's Health Insurance Program (CHIP), also became the responsibility of the CMS. Medicare, Medicaid, and CHIP are discussed in greater detail elsewhere in the text.

g) Health Resources and Services Administration (HRSA)

The HRSA is the principal primary health care service agency of the federal government that provides access to essential health care services for people who are low income, uninsured, or who live in rural areas or urban neighborhoods where health care is scarce. It "is the primary federal agency for improving access to health care services for people who are underinsured, isolated, or medically vulnerable." The cited mission of HRSA is "to improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs."HRSA "maintains the National Health Service Corps and helps build the health care workforce through training and education programs." The agency "administers a variety of programs to improve the health of mothers and children and serves people living with HIV/ AIDS through the Ryan White CARE Act programs."[12] HRSA is also responsible for overseeing the nation's organ

transplantation system.

h) Indian Health Service (IHS)

The IHS "is responsible for providing federal health services to American Indians and Alaska Natives." Currently, it "provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who belong to 567 federally recognized tribes in 35 states." "The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. This relationship, established in 1787, is based on Article I, Section 8 of the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders. The IHS is the principal federal health care provider and health advocate for Indian people." The mission of the IHS is "to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level," while its goal is "to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people."

i) National Institutes of Health (NIH)

Begun as a one-room Laboratory of Hygiene in 1887, the NIH today is one of the world's foremost medical research centers, and the federal focal point for medical research in the United States. The mission of the NIH "is to seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce the burdens of illness and disability. Although a significant amount of research is carried out by NIH scientists at NIH laboratories in Bethesda and elsewhere, a much larger portion of this research is conducted by scientists at public and private universities and other research institutions. These scientists receive NIH funding for their research proposals through a competitive, peer-review grant application process. Through this process of proposal review by qualified scientists, NIH seeks to ensure that federal research monies are spent on the best-conceived research projects.

j) Substance Abuse and Mental Health Services Administration (SAMHSA)

The SAMHSA was established in 1992 as the primary federal agency responsible for ensuring that up-to-date information and state-of-the-art practice are effectively used for the prevention and treatment of addictive and mental disorders. "SAMHSA's mission is to reduce the

impact of substance abuse and mental illness on American's communities." Within SAMHSA, there are four centers—the Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP), and the Center for Mental Health Services (CMHS), and the Center for Behavioral Health Statistics and Quality (CBHSQ), formerly known as the Office of Applied Studies. Each of these centers has its own mission that contributes to the overall mission of SAMHSA.

In Nigeria specifically, the following agencies play vital roles in shaping the community-public health:

i) National Primary Health Care Development Agency (NPHCDA)

National Primary Health Care Development Agency (NPHCDA)'s mission is to provide leadership that supports the promotion and implementation of high quality and sustainable primary health care for all through resource mobilization, partnerships, collaboration, development of community-based systems and functional infrastructure.

ii) **National Agency for Food Drug Administration and Control (NAFDAC)**

The National Agency for Food and Drug Administration and Control (NAFDAC) is a Nigerian federal agency under the Federal Ministry of Health established by Decree 15 of 1993 with the purpose of preventing the circulation of illicit and counterfeit products in Nigeria under the country's health and safety law.Later amended by Decree 19 of 1999, the Agency is currently regulated under the National Agency for Food and Drug Administration and Control Act, Cap N1, Laws of the Federation of Nigeria (LFN), dating back to 2004.NAFDAC is responsible for controlling the manufacture, import-export, advertisement, distribution, sale and use of food, drugs, cosmetics, chemicals, detergents, medical devices and packaged water. Its main goal is to raise public and international awareness on fundamental safety issues and eliminate counterfeit pharmaceuticals, food and beverages that are not manufactured in Nigeria, ensuring that available medications are safe and effective. In particular, the regulated products categories are:

- Food
- Drugs
- Chemicals
- Biochemicals
- Medical devices
- Cosmetics

- Herbals
- Veterinary

iii) National Health Insurance Scheme (NHIS)

NHIS is to provide social health insurance in Nigeria where health care services of contributors are paid from the common pool of funds contributed by the participants of the Scheme. It is a pre-payment plan where participants pay a fixed regular amount.

iv) Nigeria Centre for Disease Control (NCDC)

As the nation's health protection agency, CDC **saves lives and protects people from health threats**. To accomplish our mission, CDC conducts critical science and provides health information that protects our nation against expensive and dangerous health threats and responds when these arise. CDC in the 21st Century

- **On the cutting edge of health security** – confronting global disease threats through advanced computing and lab analysis of huge amounts of data to quickly find solutions.
- **Putting science into action** – tracking disease and finding out what is making people sick and the most effective ways to prevent it.
- **Helping medical care** – bringing new knowledge to individual health care and community health to save more lives and reduce waste.
- **Fighting diseases before they reach our borders** – detecting and confronting new germs and diseases around the globe to increase our national security.
- **Nurturing public health** – building on our significant contribution to have strong, well-resourced public health leaders and capabilities at national, state and local levels to protect Americans from health threats.

v) National Agency For The Control Of AIDS (NACA)

The National Agency for the Control of AIDS (formerly National Action Committee on AIDS) was established in February 2000 to coordinate the various activities of HIV/AIDS in the country. Among other purposes, NACA's mandates are to:

- Coordinate and sustain advocacy by all sectors and at all levels for HIV/AIDS/STDs Expanded Responses in Nigeria.

- Develop the framework for collaboration and support from all stakeholders for a multi-sectoral and multi-disciplinary response to HIV/AIDS in Nigeria.
- Develop and present to the Presidential Council on AIDS, PCA, all plans on HIV/AIDS in Nigeria for policy decisions.
- Develop and articulate a strategic plan for an Expanded National Response to HIV/AIDS in Nigeria.
- Coordinate, monitor and evaluate the implementation of the Strategic National Plan for the control of HIV/AIDS/STDs in Nigeria and all other approved policies.
- Coordinate and facilitate the mobilization of resources for an effective and sustainable response to HIV/AIDS/STDs in Nigeria, and
- Undertake any other duties as assigned by the PCA from time to time.

4.4.4 State Health Agencies

All 50 states have their own state health departments. Although the names of these departments may vary from state to state (e.g., Ohio Department of Health, Indiana State Department of Health), their purposes remain the same: to promote, protect, and maintain the health and welfare of their citizens. These purposes are represented in the core functions of public health, which include assessment of information on the health of the community, comprehensive public health policy development, and assurance that public health services are provided to the community. These core functions have been defined further with the following 10 essential public health services.

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.

   Enforce laws and regulations that protect health and ensure safety.
6. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
7. Ensure a competent public health and personal health care workforce.
8. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

4.4.5 Local Health Departments

Local-level governmental health organizations, referred to as local health departments (LHDs), are usually the responsibility of the city or county governments. In large metropolitan areas, community health needs are usually best served by a city health department. In smaller cities with populations of up to 50,000, people often come under the jurisdiction of a county health department. There are most of the population is concentrated in a single city, a LHD may have jurisdiction over both city and county residents. In sparsely populated rural areas, it is not uncommon to find more than one county served by a single health department. There are approximately 2,800 agencies or units that met the Profile definition of an LHD. However, for the 2013 Profile Study 2,532 LHDs were included in the study population; of that number, 61% were located in nonmetropolitan areas and 49% were in metropolitan areas.

i) Whole School, Whole Community, Whole Child (WSCC) Model

Few people think of public schools as governmental health agencies. Consider, however, that schools are funded by tax, are under the supervision of an elected school board, and include as a part of their mission the improvement of the health of those in the school community. Because school attendance is required throughout the United States, the potential for school health programs to make a significant contribution to community and public health is enormous, especially when it comes to promoting the health and safety of young people and helping them establish lifelong healthy behavior patterns. In fact, it has been stated that schools could do more perhaps than any other single agency in society to help young people, and the adults they will become, to live healthier, longer, more satisfying, and more productive lives. Current thinking is that schools, along with government agencies, community organizations, and other community members, can be a part of a collaborative and comprehensive approach to have a positive impact on the health outcomes of young people.

4.4.6 Quasi-Government Health Organisations

The **quasi-governmental health organizations** organizations that have some official health responsibilities but operate, in part, like voluntary health organizations—make important contributions to community health. Although they derive some of their funding and legitimacy from governments and carry out tasks that may be normally thought of as government work, they operate independently of government supervision. In some cases, they also receive financial support from

private sources. Examples of quasi-governmental agencies are the American Red Cross (ARC), the National Science Foundation, and the National Academy of Sciences.

4.4.7 Non-Governmental Health Organisations

Nongovernmental health agencies are funded by private donations or, in some cases, by membership dues. There are thousands of these organizations that all have one thing in common: They arose because there was an unmet need. For the most part, the agencies operate free from governmental interference as long as they meet Internal Revenue Service guidelines with regard to their specific tax status. In the following sections, we discuss the types of nongovernmental health agencies—voluntary, professional, philanthropic, service, social, religious, and corporate.

1) Voluntary Health Agencies

Each of these agencies was created by one or more concerned citizens who thought that a specific health need was not being met by existing governmental agencies. In a sense, these new voluntary agencies arose by themselves, in much the same way as a “volunteer” tomato plant arises in a vegetable garden. New voluntary agencies continue to be born each year. Examples of recent additions to the perhaps 100,000 agencies already in existence are the Alzheimer's Association and the First Candle (formerly SIDS Alliance). A discussion of the commonalities of voluntary health agencies follows.

- **Organization of Voluntary Health Agencies**

Most voluntary agencies exist at three levels—national, state, and local. At the national level, policies that guide the agency are formulated. A significant portion of the money raised locally is forwarded to the national office, where it is allocated according to the agency's budget. Much of the money is designated for research. By funding research, the agencies hope to discover the cause of and cure for a particular disease or health problem. There have been some major successes. The March of Dimes, for example, helped to eliminate polio as a major disease problem in the United States through its funding of immunization research.

- **Purpose of Voluntary Health Agencies**

Voluntary agencies share four basic objectives: (1) to raise money to fund their programs, with the majority of the money going to fund research, (2) to provide education both to professionals and to the

public, (3) to provide service to those individuals and families that are afflicted with the disease or health problem, and (4) to advocate for beneficial policies, laws, and regulations that affect the work of the agency and in turn the people they are trying to help.

2) **Professional Health Organizations/Associations**

Professional health organizations and associations are made up of health professionals who have completed specialized education and training programs and have met the standards of registration, certification, and/or licensure for their respective fields. Their mission is to promote high standards of profession- the health of society by improving the people in the profession. Professional organizations are funded primarily by membership. Examples of such organizations are the American Medical Association, the Nigerian Medical Association, the American Dental Association, the Nigerian Dental Association, the American Nursing Association, theNational Association of Nigerian Nurses and Midwives,etc. Although each professional organization is unique, most provide similar services to their members. These services include the certification of continuing education programs for professional renewal, the hosting of annual conventions where members share research results and interact with colleagues, and the publication of professional journals and other reports. Some examples of journals published by professional health associations are the *Journal of the American Medical Association* (*JAMA*), the *American Journal of Public Health*, and *Health Promotion Practice*.

Like voluntary health agencies, another important activity of some professional organizations is advocating on issues important to their membership. The American Medical Association, for example, has a powerful lobby nationally and in some state legislatures. Their purpose is to affect legislation in such a way as to benefit their membership and their profession. Many professional health organizations provide the opportunity for benefits, including group insurance and discount travel rates. There are hundreds of professional health organizations in the United States, and it would be difficult to describe them all here.

3) Philanthropic Foundations Philanthropic foundations have made and continue to make significant contributions to community and public health in the United States and throughout the world. These foundations support community health by funding programs and research on the prevention, control, and treatment of many diseases. Foundation directors, sometimes in consultation with a review committee, determine the types of programs that will be funded. Some foundations fund an array of health projects, whereas others have a much narrower scope of interests. Some foundations, such as the Bill and Melinda Gates Foundation, fund global health projects, whereas others restrict their funding to domestic projects. The geographical scope of domestic foundations can be national, state, or local. Local foundations may restrict their funding to projects that only benefit local citizens. The activities of these foundations differ from those of the voluntary health agencies in two important ways.

First, foundations have money to give away, and therefore no effort is spent on fundraising. Second, foundations can afford to fund long-term or innovative research projects, which might be too risky or expensive for voluntary or even government-funded agencies. The development of a vaccine for yellow fever by a scientist funded by the Rockefeller Foundation is an example of one such long-range project.

Some of the larger foundations, in addition to the Bill and Melinda Gates Foundation, that have made significant commitments to community health are the Commonwealth Fund, which has contributed to community health in rural communities, improved hospital facilities, and tried to strengthen mental health services; the Ford Foundation, which has contributed greatly to family-planning and youth sexuality efforts throughout the world; the Robert Wood Johnson Foundation, which has worked to improve the culture of health and policies dealing with health-related systems; the Henry J. Kaiser Family Foundation, which has supported the health care reform and community health promotion; the W. K. Kellogg Foundation, which has funded many diverse health programs that address human issues and provide a practical solution; and the Milbank Memorial Fund, which has primarily funded projects dealing with the integration of people with disabilities into all aspects of life.

4) Service, Social, and Religious Organizations

Service, social, and religious organizations have also played a part in community and public health over the years. Examples of service and social groups involved in community health are the Jaycees, Kiwanis Club, Fraternal Order of Police, Rotary Club, Elks, Lions, Moose, Shriners, American Legion, and Veterans of Foreign Wars. Members of these groups enjoy social interactions with people of similar interests in addition to fulfilling the groups' primary reason for existence—service to others in their communities. Although health may not be the specific focus of their mission, several of these groups make important contributions in that direction by raising money and funding health-related programs. Sometimes, their contributions are substantial. Examples of such programs include the Shriners' children's hospitals and burn centers; the Lions' contributions to pilot (lead) dog programs and other services for those who are visually impaired, such as the provision of eyeglasses for school-aged children unable to afford them; and the Lions' contributions to social and emotional learning of PreK-12 children via the educational program named "Lions Quest".

Self-Assessment Exercises 4

1. What is meant by the term quasi-governmental agency? Name one such agency.
2. Describe the characteristics of a non-governmental health agency.
3. What are the major differences between a governmental health organization and a voluntary health agency?

4.5 Summary

This unit discussed the history of community-public health in Nigeria to create a clear understanding of the Nigerian situation. Contemporary society is too complex to respond effectively to community and public health problems on either an emergency or a long-term basis. This fact necessitates organizations and planning for health in our communities which is explained in this unit. The different types of organizations that contribute to the promotion, protection, and maintenance of health in a community can be classified into three groups according to their sources of funding and organizational structure—governmental, quasi-governmental, and nongovernmental.

4.6 References/Further Readings/Web Resources

Green, L. W. (1990). "The Revival of Community and the Public Obli gation of Academic Health Centers." In R. E. Bulger and S. J. Reiser, eds., Integrity in Institutions: Humane Environments for Teaching, Inquiry and Health. Iowa City: University of Iowa Press, 163-180.

World Health Organization (2016). World Health Organization. Geneva, Switzerland: Author. Available at http://www.who.int /about/en/.

World Health Organization (1946). World Health Organization. Available at

World Health Organization (2014). Twelfth General Programme of Work 2014-2019. Available at http://apps.who.int/iris /bitstream/10665/112792/1/GPW_2014-2019_eng.pdf?ua=1.

World Health Organization (2016). Ebola Response in Action. Available at http://apps.who.int/ebola/our-work/achievements.

United Nations (2000). United Nations Millennium Declaration. New York: Author. Available at http://www.un.org/millennium /declaration/ares552e.htm.

United Nations (2002). Road Map Towards the Implementation of the United Nations Millennium Declaration. New York: Author. Available at http://www.un.org/millenniumgoals/sgreport2001

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (2016). CMS Fast Facts. Available at https://www.cms.gov/fastfacts/.

Health Resources and Services Administration (2016). About HRSA. Available at http://www.hrsa.gov/about/index.html.

Indian Health Service (2015). Indian Health Service Introduction. Rockville, MD: Author. Available at http://www.ihs.gov/aboutihs/.

National Institutes for Health (2015). Questions and Answers about NIH. Bethesda, MD: Author. Available at http://www.nih.gov/about /mission.htm.

Substance Abuse and Mental Health Services Administration (2014). SAMSHA: Who Are We? Rockville, MD: Author. Available at http://beta.samhsa.gov/about-us/who-we-are.

National Academy of Sciences, Institute of Medicine (1988). The Future of Public Health. Washington, DC: National Academies Press.

Center for Disease Control and Prevention (2014). National Public Health Performance Standards: The Public Health System and the 10 Essential Public Health Services. Available at http://www.cdc.gov */nphpsp/essentialservices.html.*

4.7 Possible answers to SAEs

Answers to Self-Assessment Exercise 1

Three core functions of public health in Nigeria are the science and art of:

- preventing disease,
- prolonging life, and
- promoting physical health and efficiency through organized community efforts.

Answers to Self-Assessment Exercise 2

The categories of traditional practices that helped shape public health in Nigeria are:

Answers to Self-Assessment Exercise 3

1. **Governmental health agencies** are part of the governmental structure (federal, state, tribal and/or territorial, or local). They are funded primarily by tax and managed by government officials. Each governmental health agency is designated as having authority over some geographic area. Such agencies exist at the four governmental levels—international, national, state, and local.
   Examples: International -WHO, National-Nigerian Centre for Disease Control, Local-LACA,

2. WHO has 6 core functions that describe the nature of its work.

They are:

- Providing leadership on matters critical to health and engaging in partnerships where joint action is needed
- Shaping the research agenda and stimulating the generation, translation, and dissemination of valuable knowledge
- Setting norms and standards, and promoting and monitoring their implementation;
- articulating ethical and evidence-based policy options
- Providing technical support, catalyzing change, and building sustainable institutional capacity
- Monitoring the health situation and assessing health trends

Answers to Self-Assessment Exercise 4

1. The **quasi-governmental health organizations** organizations that have some official health responsibilities but operate, in part, like voluntary health organizations—make important contributions to community health. Although they derive some of their funding and legitimacy from governments and carry out tasks that may be normally thought of as government work, they operate independently of government supervision. In some cases, they also receive financial support from private sources. Examples of quasi-governmental agencies are the American Red Cross.

2. Nongovernmental health agencies are funded by private donations or, in some cases, by membership dues. There are thousands of these organizations that all have one thing in common: They arose because there was an unmet need. For the most part, the agencies operate free from governmental interference as long as they meet Internal Revenue Service guidelines with regard to their specific tax status.

3. Governmental health agencies are part of the governmental structure (federal, state, tribal and/or territorial, or local). They are funded primarily by tax and managed by government officials. Each governmental health agency is designated as having authority over some geographic area.

While

Voluntary agencies share four basic objectives: (1) to raise money to fund their programs, with the majority of the money going to fund research, (2) to provide education both to professionals and to the

public, (3) to provide service to those individuals and families that are afflicted with the disease or health problem, and (4) to advocate for beneficial policies, laws, and regulations that affect the work of the agency and in turn the people they are trying to help.

4.8 Tutor-Marked Assignment

1. List 3 major organisations that help to shape community health in Nigeria (11/2 marks)
2. Discuss their roles in shaping community health (6 marks)

MODULE 2 PRIMARY HEATH CARE (PHC): HEALTH FOR ALL APPROACH

Unit 1 Concepts and Principles of Primary Health Care
Unit 2 Health For All
Unit 3 Organisation of Health Systems based on Primary Health Care
Unit 4 Health care Resources and Monitoring and Evaluation of Health Services

Glossary
Health resources: all the means available for a health system's operation, including manpower, money, materials, building, equipment, supplies, skills, knowledge and technology and operational time.

Health status: the general term for the state of health of an individual, group or population measured against accepted standards at a point of time.

Evaluation: is the systematic assessment of the achievement of the stated objectives in terms of its relevance, adequacy, progress, efficiency, effectiveness, and impact of a health programme. It gives feedback to correct deficiencies.

Relevance: a programme is relevant if it answers the needs and social and health policies and priorities it has been designed to meet.

Adequacy: a programme is adequate if it is proportionate to requirements. Efficiency: a programme is efficient if the effort expended on it is as good as possible in relation to the resources devoted to it.

Effectiveness: it is effective if the results obtained conform with the objectives and targets for reducing the extent of the problem or improving an unsatisfactory situation.
Impact: it is the overall effect on health status and socioeconomic development.

Cost benefit: is the relationship between the cost of an activity and the benefits that accrue from it.

Cost effectiveness: is the relationship between cost and the extent to which a pro- gramme or other activity is contributing to the attainment of the objectives and targets for reducing the problem or improving an unsatisfactory situation.

UNIT 1 CONCEPTS AND PRINCIPLES OF PRIMARY HEALTH CARE

Unit Structure

1.1 Introduction
1.2 Intended Learning Outcomes
1.3 Concepts of Primary Health Care
1.4 Definition and element of primary health care
  1.4.1 Definition
  1.4.2 Element of primary health care
1.5 Principles of primary health care
  1.5.1 Equitable Distribution of Resources
  1.5.2 Manpower Development
  1.5.3 Community Participation
  1.5.4 Appropriate Technology
  1.5.5 Intersectoral Coordination
1.6 Role of the Nurse in Promoting Primary Health Care
1.7 Summary
1.8 References/Further Readings
1.9 Answers to Self-Assessment Exercises (SAEs)

1.1 Introduction

In module I you have learnt about the concept of health and prerequisites for good health. It was explained to you that health is a state of physical, mental, and social wellbeing of an individual. It is not merely the absence of disease or infirmity. You have also understood how health is affected by many factors, like heredity, environment, ways of living, socioeconomic status, health services etc. Now you may be interested to know how an individual or community can attain these three important dimensions or aspects of health: namely, physical, mental, and social wellbeing. The answer to this question is given in this unit i.e., by focusing on primary health care so that individual can attain a desirable level of health.

You know that during the last two decades the common slogan for health, in all countries, has been "Health For All"; and Nigeria is politically committed to achieve this goal. The Alma Ata Declaration has stated that primary health care is the strategy to achieve this goal. In

this unit you will learn about the concept of primary health care, which is an essential care, which is acceptable, accessible, and affordable to an individual, community, and the country. You will also learn about Alma Ata Declaration and the components of primary health care. The principles of primary health care is also explained in this unit. At the end we will discuss the role of the nurse in promoting primary health care.

1.2 Intended Learning Outcomes

By the end of this unit, you will be able to:

- Discuss the concept of primary health care,
- Define Primary health care
- Analyse the elements of Primary Health care
- Explain the Principles of Primary Health care
- illustrate the role of a nurse in promoting primary health care.

1.3 Concept of Primary Health care

You have heard and learnt about primary health care and all of you are providing this care in the areas of your practice i.e. hospital, clinic or community setting. Before we start the discussion on this concept, you should try to decide which kind of care the nurse is providing in each of the situations described below;

- A nurse assisting a surgeon in mitral valvotomy in a specialized institution.
- A nurse assisting a doctor while doing appendectomy in a district hospital; and
- A female health worker immunizing a child at a health centre.

If you think for a while, you will be able to realize that the female health worker is providing primary health care, but the other two nurses are engaged in secondary or tertiary care.

Primary health care is now a widely disseminated concept, but most of us are still not clear as to its current meaning. We shall, therefore, try to explain how the concept of PHC has evolved.

You know when a new programme or technology in any area is implemented, it becomes imperative to evaluate its effectiveness. It is the same with health care approaches. Primary health care has evolved from e-examination and evaluation of existing health care approaches

and assimilation of new experiences. The implementation of new knowledge and technology in terms of vertical programme, for eradication of disease did not achieve expected results' and it was realized that there was a need for establishment of permanent health services in rural areas to deal with the day-to-day work in the control and prevention of diseases and promotion of health (see Fig.3.1) It was realized that the world's priority health problems required development of new approaches for their solution. Hence the approach in health services was shifted from curative to a preventive approach; from urban to rural populations; from privileged to the underprivileged; from unipurpose to multipurpose workers and from vertical mass campaigns to a system of integrated health services forming a component of overall social and economic development.

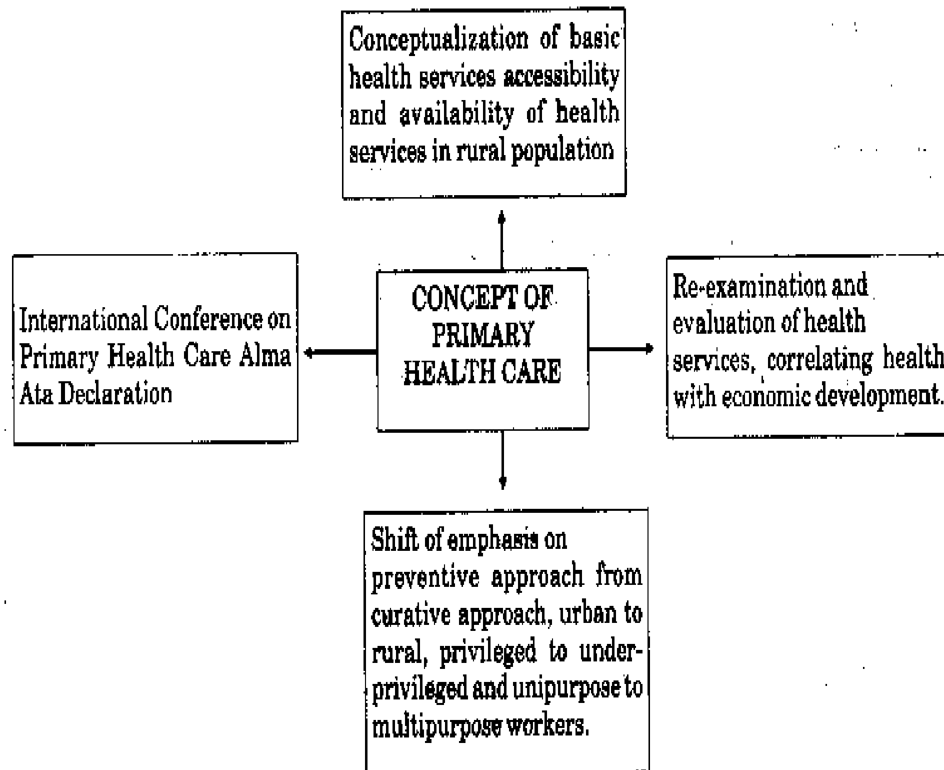


Fig. 3.1: Concept of primary health care

Based on this, a shift in emphasis on health services to Basic Health Services Approach was conceptualized in 1970. This concept focused on increasing accessibility and availability of health services to the rural populations of developing countries. It was conceived as first level care or first contact care. Now the concept of Basic Health Services paved the way for Primary Health Care; the ideas contained in Basic Health Services were further expanded to cover accessibility, availability, acceptability, affordability, and appropriateness of health services.

In May 1977, the Thirtieth World Health Assembly adopted a resolution in which it was decided that the main social target of Governments and of the *j* World Health Organization in coming decades should be "Health For All" 11 by the year 2000 AD. The basis of "Health for All" strategy is the Primary Health Care. In 1978, an international conference on primary health care was held at Alma Ata in the then USSR jointly by WHO and UNICEF. This led to the concept of Primary Health Care. This concept of pHC was recommended by various health committees in our country starting from 1946.

This clearly indicates that PHC concept has its roots in the initial stages of our national health care approach. Ultimately, after reviewing the health situation from time to time, World Health Assembly, in its meeting in May 1977 decided that in coming decades the slogan for all the countries should be to achieve the goal of 'Health For All (HFA) by 2000 AD'. It was only after that the Primary Health Care (PHC) was the strategy to achieve this goal. Later, in 1978 an International Conference on PHC was organized at Alma Ata in USSR, jointly by WHO and UNICEF, which made many declarations in addition to defining Primary Health Care (PHC). We hope you may be interested to go through these recommendations which is given in Appendix I and then we shall turn our attention to the definition and elements of PHC.With all the above concept in mind, let us now concentrate on the definition of PHC.

Self-Assessment Exercises 1

i) What is meant by basic health services?
ii) Basic Health Service concept came in……….
iii) A conference in Alma Ata was held in Sept. By……

1.4 Definition and Elements of Primary Health Care

1.4.1 Definition

Primary Health Care is defined in Alma-Ata Declaration (1978). The Alma Ata Declaration states:

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

If you look at the definition, you will find that it involves. accessibility, which means, continuing and organized supply of care that is geographically, financially, culturally within easy reach of the whole community.

- Acceptability implies that care has to be appropriate and adequate in quality and quantity to satisfy the health needs of people and has to be provided by methods acceptable to them within their socio-cultural norms.
- Affordable implies that whatever the methods of payment used, the services should be affordable by community and country.
- Appropriate technology which means using appropriate methods, techniques and locally available supplies and equipment which together with the people using them can contribute significantly to solving a health problem.

Primary health care is based on socially accepted methods which the country can afford. Thus, self-reliance and self-determination are emphasized.

Thus, we can say primary health care is a practical approach to make essential health care universally accessible to individuals, families and community in an acceptable and affordable way and with their full participation. The significance of PHC is to have contract with members of the community for providing continuing health care in the light of national health system. PHC focuses on promotive, preventive, curative, rehabilitative and emergency care to meet the main health problems in the community, giving special attention to the vulnerable groups such as mother and child. So combining all these ideas of Primary Health Care, we can briefly say that PHC is based on socially accepted methods which the country can afford. Thus, self-reliance and self-determination are emphasized.

Self-Assessment Exercises 2

i) Define Primary health care
ii) The key words in primary health care are
iii) Tick the appropriate PHC activities, from the list given below:
a) A nurse is assisting the doctor in mistral valvotomy
b) A nurse is giving an intramuscular injection of antibiotic to an adult patient having pneumonia
c) A Nurse is giving post-operative care to a patient who has undergone appendectomy.
d) A female health worker is immunizing a child at a Health centre.
e) A nurse is giving Inj. T.T. in the hospital emergency room to a child who met with a road accident.

1.4.2 Element of Primary Health Care

We hope our discussion on concept and definition of PHC may have benefited you. Now you will be interested to know what this Primary Health Care includes or what type and what level of care is involved. PHC constitutes the first element of a continuing health care process. The essential elements or components of Primary Health Care as outlined in the Alma-Ata Declaration are:

- health education concerning prevailing health problems,
- promotion of food supply and proper nutrition,
- adequate supply of safe water and basic sanitation,
- maternal and childcare including family planning,
- immunization against major infectious diseases,
- prevention and control of locally endemic diseases,
- appropriate treatment for common ailments and injuries,
- supply of essential drugs.
- Oral Health
- Mental Health

In 1988, ten years after Alma-Ata year, the WHO sponsored a follow-up meeting at Riga to review the progress on Primary Health Care declaration globally. At the end of the review meeting, participants were satisfied with the progress made so far and concluded that Primary health care concept had made strong positive contribution to the health and well-being of people in all nations and felt that the remaining problems should be tackled through increased political commitments and making permanent, principles in the spirit of health for all.

Hope you have got the idea of the components of primary health care. In order to achieve the target of Health For All (HFA), every health professional should be committed and concerned with the above care context so that he makes it a part of his daily health care practice.

Self-Assessment Exercises 3

i) Which of the above-mentioned components do you think nurses have a major role to play?
ii) Select one component and give two reasons

To conclude, primary health care has evolved partly in the light of

experience, positive and negative, gained in basic health services in a number of countries. With this understanding and definition of primary health care and its elements we introduce you to the principles of primary health care which are given below.

1.5 Principles of Primary Health Care

The description and meaning of the five basic principles which provide the framework of the primary health care approach can be summarized as follows:

i) Equitable distribution of resources
ii) Manpower development
iii) Community involvement or participation
iv) Appropriate technology
v) Intersectoral coordination

These principles are indicated in Fig. 1.5 Let us now briefly discuss each of these principles**.**

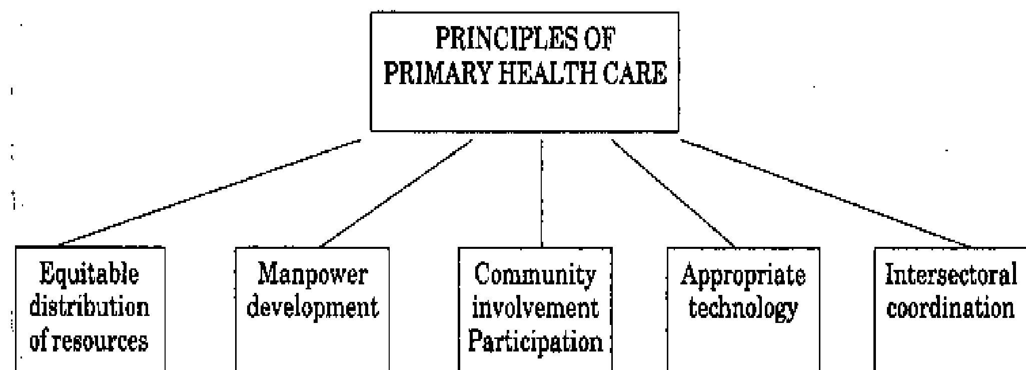


Fig. 1.5: Principles of PHC

1.5.1 Equitable distribution of resources

As you know, the attainment of a high level of health is the fundamental right of an individual or you can also say that all human beings have an equal right to health. You will be interested to know how people can ensure this right. The answer is that all the people of the world/country should be provided with equal opportunities to develop health to the fullest and maintain it. So, we can say that equitable distribution means that health services must be shared equally by all people irrespective of their ability to pay; and all the people -rich or poor, rural or urban -must have access to health services.

If we look at health statistics, you will find that the health situation as indicated by health status indicators, e.g. infant mortality rate (IMR), maternal mortality rate (MMR), birth rate (BR), death rate (DR), etc. is lower in urban areas than in rural areas. Why this difference? It is because health services are mainly concentrated in cities and towns, thus resulting in inequality of care for rural people. These statistics reflect how health-related resources are distributed with the countries - including access to health services, education, and income-earning opportunities. This is called social injustice. The inability to receive health care services by majority of rural people and those living in urban slums is inaccessibility.

The aim of PHC is to bridge this gap by shifting this concentrated health care system from cities or urban areas (where three quarters of health budget is spent) to the rural areas (where three quarters of the people live) and bring the services as near as possible to them. The other feature of health equity in society is health status of women and the disparity in health between genders which indicates that women suffer more from health problems than men. This is a critical indication of health inequality. What can you, as a health care provider do? You can only provide care to an individual, diseased or healthy, irrespective of any disparity; but in general, these facts call for explicit policies and strategies to reduce inequalities in health.

1.5.2 Manpower development

The manpower development in the context of health includes both professional and auxiliary health personnel, members of community and supporting staff. Primary health care aims at mobilizing the human potential of the entire community by making use' of all available resources. This can only be achieved if the individuals and families accept greater responsibility for their health. The requirement of health manpower will vary according to the varying needs of groups of the population and desired outputs.

Primary health care focuses on:

- Education and training of health workers to perform functions relevant to countries health problems
- Reorientation of health personnel.
- Planning health manpower according to the needs of health system, in terms of the right kind of manpower, the right number, at the right time and in the right place.

At the first level of contact between individual and health care system, primary health care is provided by community health workers acting as a

team. These workers have to be trained and retrained so that they can play a progressive role in providing primary health care.

The second categories of health personnel are traditional medical practitioners and birth attendants. They are often part of the local communities, culture and traditions and exert influence on local health practices. Therefore, these indigenous practitioners need to be trained accordingly for improving the health of the community.

Lastly, we can say that family members are often main providers of health care, mainly women play an important role in promoting health, thus they can contribute significantly to primary health care, especially in ensuring the application of preventive measures. Women's organization can be taught and encouraged to discuss on question as nutrition, childcare, sanitation and family planning. School teachers and adolescent girls can be trained on human sexuality and home nursing. Similarly young people can be educated on health matters. They can be effective in carrying these messages to their homes thus promoting primary health care.

1.5.3 Community participation

We now come to the most essential and sensitive principle of PHC, i.e., community participation. Community participation is the process by which individuals, families and communities assume the responsibility in promoting their own health and welfare. By their own health decisions, they develop the capacity to contribute to their own and the community's development. Realizing the fact that a community can become the agent of its own development, a continuous effort should be made towards the involvement of the local community in planning, implementation, and maintenance of health services.

The term community involvement in health describes a process in which partnership is established between government and local communities in planning and implementation of health activities. It aims at building local self-reliance and gaining social control over primary health care infrastructure and technology. For example, one such approach which is followed in our country (Nigeria) is training of village health workers and aides. They are selected by the local community and are trained locally in the delivery of primary health care and are involved in planning the care for the community. This concept is an essential feature of PHC. The individuals in the community know their own situation better and are motivated to solve their common problems. Thus, it can be stated that involvement of community in health matters will require attainment of capacity by individuals to appraise a situation, weigh the various possibilities and estimate what can be their own contribution.

Your contribution in community participation, as a member of the health system, is to motivate the community to learn and solve their own health problems, explain, advise, and provide clear information about favourable and adverse consequences of the health interventions proposed as well as their relative cost.

Having understood the idea of community participation, you will be interested to know about the areas in which individuals, families and communities can participate. Involvement of these is:

- involvement of the community in assessment of the situation, and
- definition of the problem and setting of priorities.
- Planning of the primary health care activities and subsequently cooperating fully when these activities are carried out.

All these mean acceptances of a high degree of responsibility by the individuals for their own health care, for example, by adopting a healthy lifestyle, by applying principles of good nutrition and hygiene and by making use of immunization services.

1.5.4 Appropriate technology

Appropriate technology means the technology that is scientifically or technically sound, adaptable to local needs, culturally acceptable (i.e. acceptable 0 those who apply it and for whom it is used) and financially feasible. This implies that technology should be in keeping with the local culture. It must be capable of being adapted and further developed, if necessary.

In addition, it should be easily understood and applicable by the community. The health for all target requires first and foremost scientifically sound health technology that people can understand and accept and which the non-expert an apply. It also implies use of cheaper, scientifically valid, acceptable, and available equipment, procedures, and techniques rather than those costlier and non-affordable and non-accessible to the community. For e.g., oral dehydration fluid, locally prepared weaning food and standpipes rather than house to house connection, cooperative food stores.

It is socially, economically, and professionally acceptable to take the technology closer to the people, consumer, wherever possible. For example, making dehydration salts, for babies available to mothers in every home is likely to be more useful than expecting the mothers to take the baby to the special center.

We cannot afford to continue the use of sophisticated technology which is appropriate for meeting the local health needs of people. For example, we know that expensive hospitals which are inappropriate to local needs are being built. These absorb a major part of the national budget, thereby affecting the improvement of general health services.

the concept of appropriate technology can further be explained by taking the example of ORT (oral rehydration therapy). The ORT packets, for diarrhoea, prescribed by WHO cannot be made available to each home; so the community s taught how to prepare sugar and salt solution to combat dehydration in a child with diarrhoea. With these concepts in mind, we shall discuss the principles of intersectoral coordination.

1.5.5 Intersectoral coordination

We now come to the principle which focuses on the concept that health of m individual, family and community is affected by other sectors in addition to health sector. Let us now try to learn more about this principle.

It is now realized that health cannot be attained and/or primary health care PHC) cannot be provided by the health sector alone. PHC requires the support of other sectors; these sectors serve as entry points for the developments and implementation of PHC. In our country the sectors responsible for economic development, antipoverty measures, food production, water purification, sanitation, housing, environmental protection, and education all contribute to health.

Development of PHC will rest on proper coordination at all levels between the health and all sectors concerned.

Declaration of Alma-Ata states that:

Primary Health Care involves in addition to the health sector all related services and aspects of national and community development; in particular, agriculture, animal husbandry, food, industry, education. Housing, public works, communication, and other sectors," WHO (1978, HFA Series No.1).

We shall now explore the importance of these related sectors in providing PHC. We shall first discuss the importance of agriculture sector, water supply, sanitation, and housing, then we will talk about public works, communication and education sector and mass media. So let us begin with agriculture sector first.

Agriculture sector ensures the production of food for family

consumption. Also nutritional status can be improved through programmes in agriculture, e,g. 'grow more food' and 'kitchen garden projects'. Similarly, you know that water supply is very important for household use. A regular supply of clean water helps to decrease mortality and morbidity, among infants and children. You are aware that many diseases like cholera, typhoid, diarrhoea, viral hepatitis are waterborne. Safe disposal of wastes and excreta also has a significant influence on health.

Housing has a positive' aspect on health, provided it is properly adapted to local climatic and environmental conditions. Housing needs to be proof against insects and rodents that carry diseases.

We have so far discussed the effect of agriculture sector, water supply and sanitation and housing on primary health care, now we shall discuss about public works, communication, education sector and mass media. Certain aspects of public works and communication are of strategic importance to primary health care. Feeder roads not only connect people to the market but make it easier for them to reach other villages, bringing in new ideas and also the supplies needed for health. TV and radio communication serve as important vehicles for learning regarding health and health practices. Mass media can play a supportive educational role by providing valid information on health and ways of attaining it and depicting the benefits to be derived from improved health practices. It could help to create awareness regarding various health programmes, i.e., family planning, immunization, growth monitoring, diarrhoeal disease and ORS etc. in the people who are isolated. We all know that various messages are carried on TV or radio, regarding FP, ORS, nutrition, diarrhoeal diseases etc.

Now we come to educational sector which has a vital role to play in development and operation of PHC. Community education helps people to understand their health problems, possible solutions to them and the cost of different alternatives. Instructional material/literature can be developed and distributed through the educational system. Associations of parents and teachers can assume certain responsibilities for primary health care activities within schools or the community: such as sanitation programmes, food for health campaigns or Courses on nutrition and first aid, adult literacy programmes, kitchen garden projects, Courses on human sexuality and home nursing.

Self-Assessment Exercises 4

i) List the principles of primary health care:
ii) Fill in the blanks with appropriate words.
   a) Equitable distribution means that health services must be by all people.
   b) In community participation individuals, family and assume. in promoting their own health and welfare.
   c) Appropriate technology means technology that is sound. to local needs and feasible.
iii) List the areas where community can be involved
iv) The health related sectors are

1.6 Role of the nurse in promoting primary health care

Four main aspects of the Nursing Role in Primary Health care were identified WHO study group in their meeting in Geneva from 9-13 December 1985 (W*HO Technical Report Series* No. 738). The roles identified are:

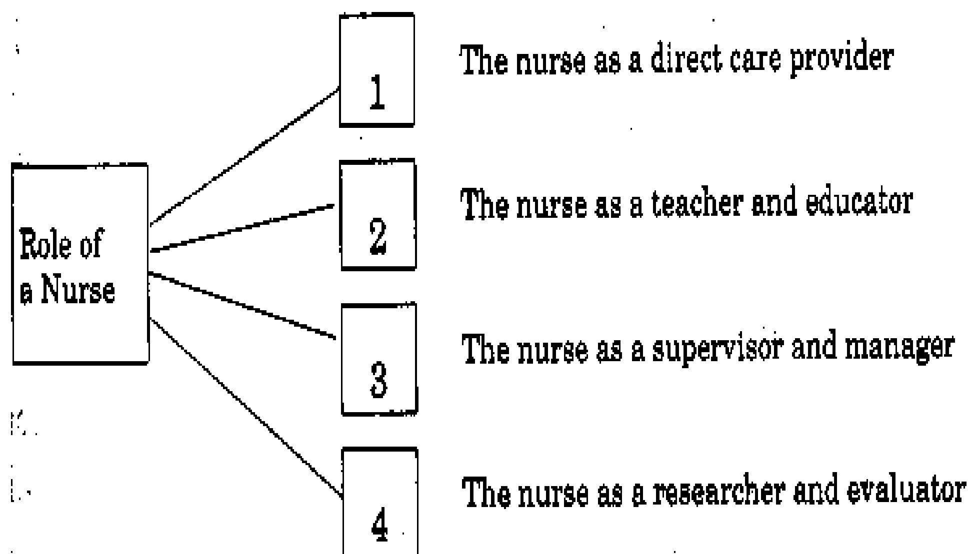


Figure 1.6 **Role of the nurse in promoting primary health care**

Let us now discuss each one of them *for* better understanding.
The nurse as a *direct care provider:* You as a nurse need *to* develop a variety of skill which you have *to* utilize in both clinical and community

settings, in order to participate actively in providing care in relation *to* the components of PHC.

In the foregoing section you have already learnt about the essential eight components of primary health care. So, in order *to* provide and participate in such care, you have *to* develop a variety of clinical and community skills. It's by developing these skills that you shall be able to provide the proper nursing care *to* the patients, individuals, families and community. For example, if we take one of the components of PHC, i.e., control of communicable PHC, community center and hospital is *to* identify and give immunization *to* children and educating the parents regarding the control of these diseases. similarly, in providing MCH care, you as a health provider not only have *to* examine the mothers *to* identify risk factors, and give T. T., but also teach them about mother craft, immunization, nutrition, *rest* and sleep, exercise etc.

The nurse as a teacher and educator: Your central concern as a nurse is promotion of health, prevention of disease and disability. This calls *for* your 'ole as an educator when you have *to* educate the individuals and family about 1 healthy life style and the community on the primary prevention of ill-health IS well as protective and supportive health measures. Your role as a teacher involves the training of other health care personnel, professional colleagues, and auxiliary personnel. This brings us *to* the role of nurse as supervisor and manager.

The nurse as supervisor and manager: If you are engaged in providing Primary Health Care, you must exercise leadership. Your duties in this regard include supervising other personnel in providing care, planning health service for the community in conjunction with other members of the health team and organizing and administering community health ices. While performing these functions you are involved in:

- assessing the health needs of the community,
- listening to the community's view on these needs,
- communicating with the community, and
- advising them accordingly.

As a community organizer, your role is to involve people in their own health and explain the importance of cooperation of other sectors of society concerned with health e.g. housing, sanitation, agriculture, industry and education sector. So, from your role as a direct care provider and teacher and educator you, as a primary health care nurse, assume the role of a manager wider scale.

The nurse as a researcher and evaluator: Primary health care system must dynamic, as it deals with living human beings. Hence a nurse must

be dynamic in her services by bringing about changes and innovations in the health care provided based on facts. For this she must be prepared to take the role of a researcher and evaluator.
This role involves monitoring, observing, analyzing the health conditions, health services and the health care provided. For example, when an individual falls sick, then you, as primary care provider, are in a better position to determine the individual patient's health needs and to understand problems involved in meeting these needs. With your knowledge, you can recommend changes or innovations in primary health services. For you to play this role effectively you need to have updated records.

Self-Assessment Exercises 5

l) List the four main aspects of the nurse's role in primary health care.

1.7 Summary

In this unit we discussed the concepts and definition of Primary Health Care. Primary Health Care is a practical approach to making essential health care universally accessible to individuals, families and community in an acceptable and affordable way and with their full participation. You also learnt that the elements of primary health care are education concerning preventing health problems, promotion of good supply and proper nutrition, adequate supply of safe water and basic sanitation, maternal and child health, immunization, treatment of common diseases and injuries, and provision of drugs and vaccine. Principles of Primary Health Care have also been explained in detail. These are:

- equitable distribution, which means that health services must be shared equally by all people -rich or poor, rural or urban.
- manpower development
- community participation: or the process by which individuals, families and communities assume the responsibilities in promoting their own health and welfare and take their own health decisions.
- appropriate technology which means that technology that is scientifically or technically sound adaptable to local needs, cultural acceptable and financially feasible; and

- the principle of intersectoral coordination which focuses on the concept that the health of an individual, family and community is affected by other sectors in addition to the health sector.

  At the end we discussed the role of the nurse in promoting primary health care. The four roles are identified as (1) Nurse as direct care provider; (2) Nurse as teacher and educator (3) Nurse as a supervisor and manager and (4) Nurse as a researcher and evaluator.

1.8 References/Further Readings/Web Resources

Packard, Randall (2016). *A History of Global Health*. Baltimore: Johns Hopkins. pp. 227–229. ISBN 9781421420332.

World Health Organization. Declaration of Alma-Ata. Adopted at the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978.

Starfield, Barbara (2011). "Politics, primary healthcare and health". *J Epidemiol Community Health*. **65** (8): 653–655. doi:10.1136/jech.2009.102780. PMID 21727176.

Marcos, Cueto (2004). "The ORIGINS of Primary Health Care and SELECTIVE Primary Health Care". *Am J Public Health*. 22. **94** (11): 1864–1874. doi:10.2105/ajph.94.11.1864. PMC 1448553. PMID 15514221.

White F. Primary health care and public health: foundations of universal health systems. Med Princ Pract 2015 doi:10.1159/000370197

WHO. "International Conference on Primary Health Care, Alma-Ata: twenty-fifth anniversary" (PDF). *Report by the Secretariat*. WHO. Retrieved 28 March 2011.

Bulletin of the World Health Organization (October 2008). "Consensus during the Cold War: back to Alma-Ata". World Health Organization. Archived from the original on July 9, 2012.

Bulletin of the World Health Organization (December 2008). "China's village doctors take great strides". World Health Organization. Archived from the original on December 12, 2008.

1.9 Possible Answers to Self-Assessment Exercises

Answer to Self-Assessment Exercise 1

i) It is first level care which focuses on increasing access and availability of health services to the rural population, and which is affordable.
ii) ii) 1970
iii) September 1978; WHO and UNICEF.

Answer to Self-Assessment Exercise 2

i) Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and appropriate technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.
ii) Accessibility, availability, acceptability, affordability, appropriateness.
iii) b,c,d,e,

Answer to Self-Assessment Exercise 3

i) Maternal and child health care including family welfare immunization against major infectious diseases.
Education concerning promotion of health and prevention of illness.
ii) Nutrition
Mothers and children form the largest group of the population (About 70%)

Mothers and children are at a high risk/more vulnerable groups.

Answer to Self-Assessment Exercise 4

i) -Equitable distribution -Manpower development -Community participation -Appropriate technology -Intersectoral approach
ii) a) Shared equally by all people b) Community, responsibility
a) Scientifically, adaptable, financially.
iii) Assessment of situation or a problem

Definition and setting of priorities

Planning the activities for providing primary health care

iv) Agriculture sector

Water supply and sanitation/public works
Housing, Communication and mass media, Education sector

Answer to Self-Assessment Exercise 5

Direct care provider
Teacher and education
Supervisor and manager Researcher and evaluator.

1.10 Tutor-Marked Assignment

1. Define PHC (1mark)
2. Explain the principles of PHC (4 marks)
3. What are the roles of a nurse in promoting PHC (5 marks)

UNIT 2 HEALTH FOR ALL

Unit Structure

2.1 Introduction
2.2 Intended Learning Outcomes
2.3 Health For All
 2.3.1 Concept of Health for All
 2.3.2 Definition and meaning of health for All
2.4 Strategy for Health for All
 2.4.1 Global strategy
 2.4.2 National strategy of Health for All by the year 2000AD
2.5 Nursing in Support of Health For All
 2.5.1 Strategies and actions proposed at international level
 2.5.2 Strategies and actions proposed at national level
2.6 Summary
2.7 References/Further Readings/Web Resources
2.8 Answers to Self-Assessment Exercises (SAEs)

2.1 Introduction

In Unit 1 we have discussed about Primary Health Care (PHC); its concept, principles, elements and role of nurses in promoting the primary health care. You have seen that primary health care is the essential care which should be easily available, acceptable, accessible and affordable to an individual and community as a whole. You have also become aware of Alma-Ata Declaration **(see Appendix 1**) which affirms that primary health care is considered as the basic strategy for achieving goal of Health For All by the year 2000 AD.

As you have learnt in Unit 2 that in May 1977 the thirtieth World Health Assembly adopted a resolution in which it was decided that main social target of Governments and of World Health Organization in the coming decades should be the attainment by all people of the world by the year 2000 AD of a level of health that will permit them to lead socially and economically productive life. This is popularly known as health for all by the year 2000 AD *(HFA/2000).* In this unit we shall discuss the concept, definition and meaning of Health For All. Achievement of goal of health for all aims at restructuring of health system and reorientation and training at different categories of health workers/professionals. Fulfillment of these aims is only possible through development of an appropriate strategy. We shall discuss the global and national strategies for HFA, in Section 3.3 and focus on achievements and targets of HFA. At the end we shall discuss nursing in support of health for all at

international level and national level. As you go through this unit you are required to refer the appendices given at the end of this unit for broader perspective wherever indicated in the text.

2.2 Intended Learning Outcomes

By the end of this unit, you will be able to:

- Define health for all.
- Discuss the meaning of health for all,
- Describe global strategy for attaining health for all.
- Explain the national strategy adopted to achieve the goal of health for all.
- List the targets and achievement in Health For All, and
- Discuss the role of nursing services in support of Health For All

2.3 **Health** for All

We shall discuss about the concept and definitions of Health For All in the following subsections.

2.3.1 Concept of health for all

As you know, there is a vast contrast in the health status of people in developed and developing countries despite of much scientific and techno- logical advances in health care. You are also aware that most people in developed countries and elites of the developing countries including Nigeria enjoy good health, nutrition, sanitation, safe drinking water, education, income etc.

In Nigeria 80% of the population lives in rural area and urban slums in contrast to 10-20% who live in urban areas. It is only this small fraction of urban people who enjoy ready access to health services and facilities whereas the rest of the 80-85% are living in rural and urban slum areas do not have access to health services and/or facilities. Similarly, if we look at health status of Nigeria as reflected by the number of indicators of health, the need for urgently improving our health status is obvious.
The disparities in health and socio-economic conditions between rich and poor, within countries and between countries, and the concern of members of WHO regarding status of health and deterioration of existing health status led to new thinking in provision of health care in order to narrow this gap and finally eliminate it. It was also realized that the underprivileged population constituting 80% of the total population

have an equal claim to their rights and privileges of health services such as.

- health care,
- protection from vaccine prevented communicable diseases (VPD) of childhood e.g., Diphtheria, Tetanus, T.B., Whooping cough, Polio etc.,
- maternal and child health care, and
- treatment and control of non-communicable disease.

So there was felt a need among health planners/administrators for evolving a health care approach that would answer the problems and needs of under- privileged. Ultimately the thirtieth World Health Assembly resolved in May 1977 that the main social target of Governments and WHO in the coming decades should be the attainment of health for all by year 2000 AD.

Further, there are several other experiences and developments which led to the evolution of goal of 'Health For All' by the year 2000 which are as follows:

- In 1972-73 a WHO study on the development of health services concluded that there was a widespread dissatisfaction among people with their health care systems which were failing to cope with primary health care problems in countries at all stages of development.

In developed countries, health care system despite their expensive and impressive infrastructure and highly specialized technologies, the emerging health problems of people are not being solved. The principal reason for this discrepancy is that new health problems require completely new approaches, which emphasize individual self-reliance and commitment to good health.

- Similarly most of the developing countries including Nigeria face major problems with control of infectious disease, provision of safe water and basic sanitation services, the provision of care during pregnancy and delivery and elevating standard of living to a 'minimum acceptable level'.

- In the rural areas and rapidly expanding urban areas, millions of people remain without access to essential health care and life saving measures.

All the above concepts led to a continuing discussion of how health care

system should evolve and how WHO could best support countries struggling to improve their health systems.

Expressing the ideas that were dominating the International discussion during 1960s and early 1970s, the World Health Assembly (WHA) decided in a ground breaking resolution in 1977 that "main social targets of governments and WHO in the coming decades should be the attainment of all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" with the adoption of this resolution the HFA movement was born and the slogan was created.

With this concept in mind, we shall discuss next the definition and meaning of Health For All, after examining your memory.

Self-Assessment Exercises 1

li) The approach to achieve the goal of Health For All by the year 2000 is

a) Hospital Care
b) Technological Development
c) Primary Health Care
d) Research

The basis for evolution of Heath For All concept include;

a)
b)
c)
d)
e)

2.3.2 Definition and meaning for health for all (HFA)

HFA has been defined as "the attainment of a level of health that will enable every individual to lead a socially and economically productive life".

If you analyse this definition you will realize that the goal of HFA implies realization of goal by all people of the highest possible level of health which includes, physical, mental and social wellbeing; secondly it also implies that as a minimum, all people in all countries should at least have such a level of health that they are capable of being economically productive, removal of unemployment and poverty) and participating actively in the social life' of the community in which they live, i.e., have education, housing, water supp y and sanitation.

Health for all means that health care/services are to be made accessible/within reach of every individual in each community.
It implies the removal of obstacles to health, that is, elimination of ignorance, malnutrition, disease, contaminated water supply, unhygienic housing etc.

"Health For All " is a holistic concept. It calls for efforts in education, agriculture, industry, housing, or communication first, as much as in public health and medicine. It symbolizes the determination of countries of the world to provide an acceptable level of healthful living to all people. It is an expression of the feeling for social justice from all those who suffer inequity in health care services

It is intended to draw attention to the importance of health, to a serious search for new ways of solving the problems of health and to help mobilize all available resources for health. To have a correct perception of the meaning of "Health For All" you should. be convinced that HF A does not mean that as of the year 2000, we shall all be free of disease and disability.

Health for all means that health is to be brought within the reach of everyone in each country including the remotest part of a country and the poorest members of the society. By health is meant not just the availability of health services but a personal well-being and a state of health that enables a person to lead a socially and economically productive life.

"Health for all" means that health should be regarded as an objective of economic development and not merely as one of the means of attaining it.

- Health begins at home, in school and in the workplace
- People will use better approaches for preventing disease and alleviating unavoidable illness and disability.
- There will be an even distribution among the population of whatever health resources are available.

- That the essential health care will be accessible to all individuals and families, in an acceptable and affordable way and with their full involvement.

The achievement of the Health For All goal, calls for dramatic changes, and a social revolution in health development. It aims at bringing about the change in the mentality of people, restructuring of health system, and reorientation and training of health workers/professionals. So, to bring

about these changes the practical shape to the slogan of HFA could be given only through development as a strategy.

Self-Assessment Exercises 2

i) Fill in the blanks:
Health For All concept focuses on health care services brought; within the reach of every individual in a given. ii) Obstacles to the goal of health include:

2.4 Strategy for health for all

As you have seen in Unit 1, Alma-Ata conference called on all governments to formulate national policies, strategies and plans of action and set down the principles of Primary Health Care, which is the basis of "Health For All" strategy.

In 1981, global strategy of HF A was evolved by WHO through consultations with countries, regions and at the global level. That strategy defines the broad lines of action to be undertaken at policy and operational levels, nationally and internationally, both in the health sector and in other social and economic sectors.

This was followed by individual countries developing their own strategies for achieving HFA and synthesis of national strategies for developing regional strategies.

Let us discuss the global and national strategies in the following sub-sections.

2.4.1 Global strategy

The global strategy for Health For All is based on the following fundamental principles:

- Health is a fundamental human right and a worldwide social goal. The existing gross inequality in the health strategies is of common concern to all countries and must be drastically reduced.
- People have the right and the duty to participate individually and collectively in the planning and implementation of their health care.
- Governments have a responsibility for the health of their people
- Countries must become self-reliant in health matters.

Health is an integral part of the overall development of the countries.

Energy generated by improved health should be channeled into sustaining development of a country. Better use must be made of the world's resources to promote health and development, and this will help to promote world peace and prevent conflict among nations.

2.4.2 National strategy for health for all by 2000 AD

Alma-Ata declaration **(Read up Alma -Ata Declaration)** and Nigeria commitment to HFA by 2000 AD resulted in the formulation of National Health Policy.

- The Federal Government of Nigeria convened a national conference in February 1988 to discuss the national strategies and action plan to achieve Health For All.
- In July 1988 a working group on Health For All to evolve national strategies for implementation of health care programmes to move towards the goal for Health For all by 2000 AD and to suggest suitable indicators to monitor the progress achieved from time to time. The working group submitted its report in 1989 which was accepted by the Federal Government.

Thus, a National Health Policy was evolved by Government of Nigeria in 1989 which commits the government and people of Nigeria to achieve the goal of Health For All by 2000 AD. We shall briefly highlight the health strategies in health policy **(Read up health policy)**

The policy lays stress on the preventive, promotive, public health and rehabilitation aspects of health care and points to the need of establishing comprehensive primary health care services to reach the population in the remotest areas of the country.

The health policy in Nigeria has the following key elements:

- Creation of a greater awareness of health problems in the community and means to solve these by the communities,
- Supply of safe drinking water and basic sanitation using technologies that the people can afford,
- Reduction of existing imbalance in health services by concentrating more on the rural health infrastructure,
- Establishment of a dynamic health management information system to support health planning and health programme implementation.
- Provision of legislative support to health protection and promotion. Concerted actions to combat widespread malnutrition,
- Research into alternative methods of health care delivery and low-cost health technologies, and

- Greater coordination of different systems of medicine.
- The health strategies include restructuring the health infrastructure developing health manpower and research development.

WHO has established 12 global indicators as the basic point of reference to assess the progress towards health for all. The National Health Policy has laid down specific goals with respect to various health indicators to be achieved by 1990 to 2000 AD. The important indicators to achieve HFA are:

i. Reduction of Infant Mortality Rate from the present level of 87 to below 60 by 2000 AD.
ii. To raise the life expectancy at birth from present level of 58 years to 64 by 2000 AD.
iii. To reduce the crude death rate from the present level of 10.4 to 9 by 2000 AD.
iv. To reduce the crude birth rate from present level of 27 to 21 by 2000 AD.
v. To achieve a net reproduction rate of 1 by 2000 AD.
vi. To provide potable water to the entire rural population by 2000.

You must be aware that during the sixth and seventh Five Year Plans, steps were already undertaken to implement the strategies outlined in National Health Policy**. (Read up national health policy document)** Some of these are:

a. to establish one health subcentre for every 5,000 rural population (3,000 in tribal and hilly areas) with one male and female health worker.
b. To establish one primary health center for every 30,000 rural population (20,000 in hilly and tribal areas).
c. To establish Community Health Centres (CHC).
d. To train Village Health Guides (NHG) selected by the community for every village or 1,000 rural population.
e. To train traditional birth attendants (TBA) in each village.
f. Training of various categories of health personnel, e.g., multipurpose workers (MPW).

These schemes are expected to ensure the availability of adequate infrastructure and medical and paramedical manpower to take us nearer the goal of universal provision of primary health care as envisaged in the national health policy.

Self-Assessment Exercises 3

i) Fill in the blanks:
a) The basic strategy to achieve health for all is…………………….
b) Ministry of Health and Family Welfare (Nigeria) formulated National Health Policy to achieve goal of HFA in ……………..
ii) The important indicators to monitor progress towards health for all are:……………………………..

With the above background we shall now focus our attention on nursing support of Health For All in the following section.

2.5 Nursing in support of health for all

We shall begin with the development of the role of nursing in support of health for all.

In 1979, WHO and International Council of Nurses (ICN) conducted a work- shop in Nairobi on the role of nursing in primary health care for leaders of Nurses Associations in which the commitment of the nursing profession to the goal of attaining health for all by 2000 was formally confirmed. Sub- sequently, National Nurses Association planned their own strategies in relation to their own National Health Policies. The National Association of Nigerian Nurses and Midwives also participated in this exercise.

In 1981, an informal meeting was convened in Geneva by WHO on 16-20 November to consider the role of nursing in contributing to the achievement of the goal of *HFA/2000* through Primary Health Care. Strategies and actions proposed for change at international and national level are discussed in the following sub-sections.

2.5.1 Strategies and action proposed at international level

Five basic strategies have been proposed by the WHO-ICN meeting by Nurses, which are listed below. (See Fig. 3.1.)

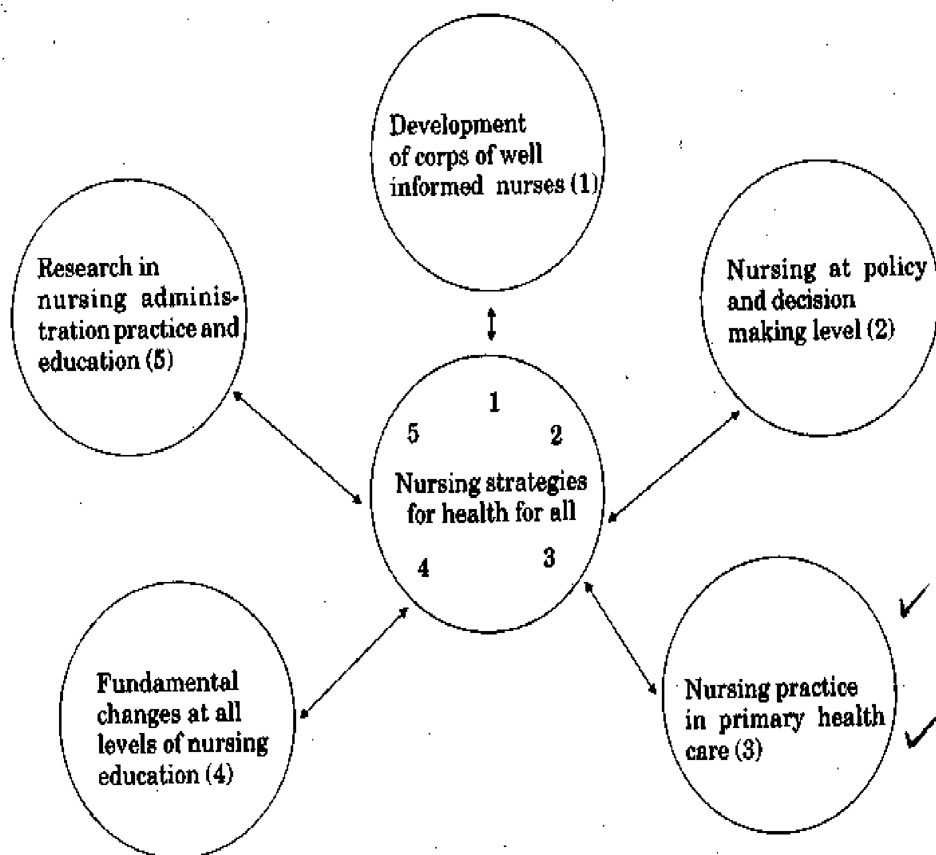


Fig. 3.1: Five strategies for change adapted by National Nurses Associations for their role in HFA through PHC

i the development in each country of a corps of nurses that is well infonned about health care and ready to bring necessary changes in the nursing system.

ii the inclusions of nursing personnel at all levels of policymaking and administration so that the profession can contribute to determining the action plan.

iii the involvement of nurses, and the use of their skills, in initiating or extending primary health care.

iv Fundamental changes at all levels of nursing education (basic, post basic and continuing) to ensure that the priority needs of population are functionally integrated into the education and into nursing practice.

Research into nursing administration practice, and education that will demonstrate nursing's contribution to primary health care.
We have listed the strategies for change. We shall now learn about the actions proposed for each strategy as given below.

i) Development of corps of well-informed Nurses

This will require.

a. arranging and developing a series of international, national and . regional workshops or other meetings, that would bring together small groups of key nursing practising professionals for orientation and guidance in planning for primary health care in their own country. The purpose of these workshops would be:

. To help the nurses to understand the thrust of PHC nationally and internationally
. To interpret needs of these countries in their struggle for HFA/2000 and enable them to develop over all nursing plans of action at local. regional and national level, taking into account local needs and resources.
. To establish the regional support system and lines of communication between and among countries for sharing plans, exchanging methodologies and report on the progress as the plan is further developed and put into effect

b. Develop texts, guides and communication aids, which will include review of current publications related to PHC and production of specific material to nursing in PHC

.

ii) Nursing at policy and decision-making levels

This will require planning and implementing training programmes and continuing educational programmes that will orient nurses and train therti in administration and management techniques, political and legislative processes, and help them to analyse existing legislation and enable them to develop action programmes to bring about necessary changes.

Creation of administrative post in nursing at all levels of Government This can be accomplished through coordinated efforts of national nursing associations.

Establishing a system for collection and compilation of information, on the supply and training of nurses as per the needs of community.

i) Nursing practice and primary health care Act

This calls for preparing and educating the nurses to assume responsibility for the provision of first level care in the community. This can be achieved by

- conducting workshops, seminars and other continuing or in-service education programmes,
- encouraging the Nurses to practice Primary Health Care.
- Providing facilities like housing, attractive remuneration and opportunity for continued learning to the public health nurses working at the periphery.
- Making efforts to close the existing gap between nursing education and nursing services.

ii) Fundamental changes at all levels of nursing education

This will require the administrative support from the national and local government in order to change the system of nursing education.
This change involves reorientation in basic nursing education, post-basic nursing education and organizing continuing education programmes. *Basic nursing education*

This will include:

- Change of curriculum for current systems of nursing education and practice, and
- Formulating strategies for bringing about a change in basic nursing education from emphasis on care of sick individuals in hospitals to community-based nursing education *post-basic nursing education*

This will involve:

- Preparation of nurses for leadership roles in administration for supervisory posts in organizations and agencies at all levels of health care planning and management, and for teaching post in primary health care.
- Preparation of nurse researchers who can conduct or direct investigations into Primary Health Care (PHC) issues as well as encourage systemic inquiry into questions related to community-based nursing practice.

Continuing education

This involves organizing workshops, seminars and in-service programmes to enable nurses to acquire additional knowledge and skills related to PHC.

v. Research in nursing administration, practice and education for primary health care

This needs inclusion of research skills in all the nursing education programmes and continuing education programmes.

- Nurses at all levels should develop an enquiring and problem-solving attitude for working towards the goal of PHC
- Priority should be given to research into. the design and evaluation of programmes in which nurses provide primary health care, and
- study of problems that arise from the nursing in primary health care field. Government and intersectoral support should be sought for proposals that will enable nurse to initiate and/or collaborate with others in research methods and design for Primary Health Care (PHC).
- Develop projects to demonstrate usefulness of research findings in nursing practice.

2.6 Summary

You have studied the concept and definition of health for all by the year 2000 AD. This implies "attainment of a level of health that will enable every individual to lead a socially and economically productive life." This concept has emerged out of the fact that existing health care approach was not able to solve the health problems mainly in developing countries including Nigeria and there is gross inequality in health service distribution within a country and among countries. You have also learnt about the global strategy, which defines the broad lines of action to be undertaken at policy and operating levels, nationally and internationally. This focuses on 1) health as a fundamental human right, 2) reduction of gross inequalities in health status, 3) participation of people in their own care, and 4) self-reliance of communities in health matters.

We have focused our discussion on national strategy that resulted in the formulation of national health policy in 1983 with laid down specific targets and goals to be achieved by the year 2000 AD. This is to be considered in relation to various health indicators like, infant mortality rate, maternal mortality rate, immunization, safe water supply and demographic data like crude death rate, and birth rate and net reproductive rate. At the end of the discussion, we have appraised you of the role of nurse in support of Health For All where we have discussed the strategies and actions proposed for achieving the goal.

These are

I. Development of corps of well-informed Nurses
II. Nurses at policy and decision-making levels
III. Nursing practice and primary health care
IV. Fundamental changes at all levels of nursing education
V. Research in nursing administration, practice and education for primary health care.

Finally, we have talked about the actions taken by National Nursing Associations and Organizations for achieving the goal of Health For All where we focused on recommendations and resolutions passed by the National Nursing Association. The main recommendation and resolution were to restructure and reorient the nursing education system as a whole towards PHC and HFA.

2.7 References /Further Readings/Web Resources

Packard, Randall (2016). *A History of Global Health*. Baltimore: Johns Hopkins. pp. 227–229. ISBN 9781421420332.

World Health Organization. Declaration of Alma-Ata. Adopted at the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978.

Starfield, Barbara (2011). "Politics, primary healthcare and health". *J Epidemiol Community Health*. **65** (8): 653–655. doi:10.1136/jech.2009.102780. PMID 21727176.

Marcos, Cueto (2004). "The ORIGINS of Primary Health Care and SELECTIVE Primary Health Care". *Am J Public Health*. 22. **94** (11): 1864–1874. doi:10.2105/ajph.94.11.1864. PMC 1448553. PMID 15514221.

White F. Primary health care and public health: foundations of universal health systems. Med Princ Pract 2015 doi:10.1159/000370197

WHO. "International Conference on Primary Health Care, Alma-Ata: twenty-fifth anniversary" (PDF). *Report by the Secretariat*. WHO. Retrieved 28 March 2011.

Bulletin of the World Health Organization (October 2008). "Consensus during the Cold War: back to Alma-Ata". World Health Organization. Archived from the original on July 9, 2012.

Bulletin of the World Health Organization (December 2008). "China's village doctors take great strides". World Health Organization. Archived from the original on December 12, 2008.

2.8 Answers to self-Assessment Exercise

Answers to self-assessment exercise 1

ii) a) cause of death and disease b) nutritional status
a) water supply and sanitation
b) literacy and economic situation e) demographic trends
i) Community
ii) ii) poverty; malnutrition; ignorance, disease; contaminated water supply; poor housing.

Answers to self-assessment exercise 2

Agriculture, industry, education, housing, and communication
the attainment of a level of health that will enable every individual to lead a socially and economically productive life.

Answers to self-assessment exercise 3

A) Primary Health Care
b) 1982
c) i) Infant mortality rate (IMR).
ii) maternal mortality rate (MMR, Crude death rate (CDR), Crude birth rate (CBR)

Net reproductive rate (NRR) Life expectancy.

2.9 Tutor-Marked Assignment

1. Explain the concept of Health For All (2marks)
2. Discuss the National Strategies adopted to achieve HFA (4marks)
3. What are the roles of Nursing services in supporting HFA (4 marks)

UNIT 3 ORGANIZATION OF HEALTH SYSTEM BASED ON PRIMARY HEALTH CARE

Unit Structure

3.1 Introduction
3.2 Intended Learning Outcomes
3.3 Meaning and characteristics of health system
3.4 Structural organisation of the health system
 3.4.1 Organisation at the federal level
 3.4.2 State Level
 3.4.3 Local Level
3.5 Structural organisation of health system based on Primary health care Agency
 3.5.1 Organisation of the Agency
 3.5.2 Representative of the National commission for women
3.6 Summary
3.7 References/Further Readings
3.8 Answers to self-assessment questions (SAQs)
3.9 Tutor-Marked Assignment

3.1 Introduction

In this Unit, we shall discuss the definition and essential characteristics of health system. We shall also focus our attention on organization health system structure at Federal, State and Local levels. And at the end we shall introduce you to the i organizational structure based on Primary Health Care, which mainly focuses on rural health services. Let us begin with the definition and characteristics of health system.

3.2 Intended Learning Outcomes

By the end of this unit, you will be able to:

- Define the health system
- List the characteristics of health system
- Describe the organizational structure of health system, at Federal, State and Local levels and.
- Explain the roles and organization of National Primary Health Care Development Agency.

3.3 Meaning and characteristics of health system

Health system can be broadly defined as a coherent whole of many interrelated component parts, both sectoral and inter-sectoral, as well as community itself, which produces a combined effect on the health of the population. Health system should consist of coordinated parts extending to the home, the workplace, the school and community.

If you try to understand the above definition you will be interested to learn that what are interrelated component parts. The components of health system include concepts (e.g., health and disease), ideas (e.g. equity coverage, effectiveness, efficiency, impact), objects (e.g. hospitals, health centers, health programmes) and persons (e.g. providers and consumers). Together these form a unified whole in which all the components interact to support one another. Of all these components discussed here we shall mainly high- light the objects and persons (health system infrastructure).

The health system aims at delivering the health services to the beneficiaries. It constitutes the management sector and involves organizational matters, and also in allocating resources, translating policies into services, evaluation and health education. The aim of health system is health development, which includes continuous and progressive improvement of the health status of a population, i.e. community. Health system encompasses promotive, preventive, curative and rehabilitative aspects and also caters care of the extremely disabled and incurable.

Hope you have now understood the meaning of health system as discussed above. We shall now turn our attention towards the essential characteristics of the health system as given below:

These characteristics/principles are applicable to all health system based on primary health care.

- The system should encompass the entire population on the basis of equality and responsibility. It should include components from the health sector and from other sectors, whose interrelated actions contribute to health (e.g. education sector, public works, animal husbandry and agricultural sector etc). Health is a subject of overall socio-economic milieu of the community.
- Primary health care, consisting of at least the essential elements included in the declaration of Alma-Ata which should be

delivered at the first point of contact between individuals and health system.

- At intermediate levels more complex problems should be dealt with and more skilled and specialized care as well as logistic support should be provided.
- Better trained staff, i.e. supervisory staff, should provide continuing education/training to primary health care workers, as well as guide the public of different communities and community health workers on practical problems arising in connection with all aspects of primary health care.
- The central level should co-ordinate all parts of the system and provide planning and management expertise. It should also provide highly specialized care, teaching for specialized staff. The staffing of such institutions (as central laboratories), and central logistic and financial support. If you think deeply for a while and analyze, what do these above-mentioned characteristics indicate? These clearly indicate that health system is not a separate entity. It includes components and actions not only from the health sector but also from other health related sectors such as agriculture, education, environment, animal husbandry communication, etc, at various levels (central, intermediate and local). We shall discuss these in the following sections.

Self-Assessment Exercises 1

Fill in the blank spaces:
a) Health system is defined as coherent whole of many. parts, both sectoral and. as well as community itself.
b) Health system aims at. ………………………………….
c) Health system constitutes ……………………………….

d) The aim of health system ………… ………………….

e) List the characteristics of health system ………………….

3.4 Structural organization of health system

You know that health system in Nigeria is organized at three levels (i.e.) Federal, State and Local levels.
Let us begin with organization at Federal level.

3.4.1 Organization at federal level

The official "organs" of the health system at the Federal level consists of:

a) The Federal Ministry of Health

b) The National Council of Health

We shall talk of the organization and function of each one of them.

(a) The Federal Ministry of Health

The Federal Ministry of Health as headed by a Minister. It is a political appointment. Currently, the Federal Ministry of Health has 5 directorates/department. These include:-

i. Department of Personnel Management
ii. Department of Finance and Supplies
iii. Department of Planning, Research and Statistics
iv. Department of Hospital services.
v. Department of Primary Health Care and Disease control.

The following are the responsibilities of the Federal Ministry of Health:

i. Take the necessary action to have review national health policy and its adoption by the Federal Government.
ii. Devise a broad strategy for giving effect to the national health policy through the implementation by Federal, State and Local Government in accordance with the provisions of the constitution.
iii. Submit for the approval of the Federal Government a broad financial plan for giving effect to the Federal component of the health strategy.
iv. Formulate national health legislation as required for the consideration of the Federal Government.
v. Act as coordinating authority on all health work in the country on behalf of the Federal Government, with a view to ensuring the implementation of this national health policy.
vi. Assess the country's health situation and trends, undertake the related epidemiological surveillance and report thereon to Government.
vii. Promote an informed public opinion on matters of health.
viii. Support State and through them Local Government in developing strategies and plans of action to give effect to this national health policy,
ix. Allocate Federal resources to foster selected activities to be undertaken by State and Local Governments in implementing their health strategies.
x. Issue guidelines and principles to help states prepare, manage, monitor and evaluate their strategies and related technical programs, services and institutions.
xi. Define standards with respect to the delivery of health care, and monitor and ensure compliance with them by all concerned;

health technology, including equipment, supplies, drugs, biological pro- ducts and vaccines, in conformity with WHO's standards; the human environment; and the education, training, licensing and ethical practices of different categories of health workers

xii. Promote research that is relevant to the implementation of this national health policy and state health strategies, and to this end, to establish suitable mechanisms to ensure adequate co-ordination among the research institutions and scientists concerned.
xiii. Promote co-operation among scientific and professional groups as j well as non-governmental organizations in order to attain the goals of this policy.
xiv. Monitor and evaluate the implementation of this national policy on behalf of Government and report to it on the findings.

a) International health

The Federal Ministry of Health shall set up an effective mechanism for the co-ordination of external cooperation in health and for monitoring the performance of the various activities. Within the overall foreign policy objectives, this national health policy shall be directed towards: -

i. ensuring. technical co-operation on health with other nations of the region and the world at large.

ii. ensuring the sharing of relevant information on health for improvement of international health.
iii. Ensuring cooperation in international control of narcotic and psychotropic substances;
iv. Collaborating with United Nation agencies, Organization of African Unity. West African Health Community, and other International Agencies on bilateral and/or regional and global health care improvement strategies without sacrificing the initiatives of national, community, and existing institutional and other infrastructural arrangements;
v. Working closely with other developing countries, especially the neighboring states within the region which have similar health problems, in the spirit of technical cooperation among developing countries, especially with regard to the exchange of technical and epidemiological information;
vi. Sharing of training and research facilities and the co-ordination of major intervention programs for the control of communicable diseases.

(b) The National Council of Health

The National Council of Health is composed of the following members:

i. The Honourable Minister of Health (Chairman)
ii. The Honourable Commissioners for Health (States)

The following are the functions of the National Council of Health
The National Council on Health shall advise the government of the Federation with respect to:

i. The development of national guidelines.
ii. The implementation and administration of the national health policy; and
iii. Various technical matters on the organization, delivery, and distribution of health services.

The council shall be advised by the Technical committee.

Technical committee

The Technical Committee of the National Council on Health shall be com- posed of:

i. The Federal and State Permanent Secretaries (M.O.H) ii. The Directors of Federal Ministry of Health
iii. The Professional heads in the state Ministries of Health. iv. A representative of Armed Forces Medical Services;
v. Director of Health Services, Federal Capital Territory, Abuja.
Expert panels
a. The Technical committee. shall set up as required, appropriate programme expert panels including the representatives of health-related Ministries:
i. Agriculture, Rural Development and Water Resources
iii. Education
iv. Science and Technology iv. Labour
v. Social Development, Youth and Sports vi. Works and Housing
vii. National Planning viii. Finance
b. Health related bodies
i. National Institute of Medical Research ii. Medical Schools
iii. Schools of allied health professionals iv. Non-governmental organizations
v. Professional associations (Health) e.g. NMA, NANNM, PSN, among others

Self-Assessment Exercises 2

Fill in the blanks:
1) The official organizing health system at the national level consists of a)
b)
2) The five departments of the Federal Ministry of Health include:
i.
2) The National Council of Health is composed of.
…………………and with the sole responsibilities of
……………………………………….

So far, we discussed the organization at the Federal level. Now we shall turn our attention to the organization at state level.

3.4.2 State level

At present there are 36 states and the Federal Capital Territory, Abuja and has many types of health administration.

In all the states, the management sector for health lies with the Ministry of Health while in some states, Health management Board also participate in the management.

*i. **State Ministry of Health Organization**:* The state Ministry of Health is headed by an Honourable Commissioner, while in Health Management Board, there is governing Board with an Executive Secretary. The Commissioner is the Political head of the Ministry while the Permanent Secretary is the administrative head. There are Directors manning the directorates assisted by Deputy and Assistant directors.

Functions: The State Ministries of Health directs and co-ordinates authority on health work within the State via:

i. Ensuring political commitment
ii. Ensuring economic support
iii. Winning over professional groups
iv. Establishing a managerial process
v. public information and education

vi. Financial and material resources provision
vii Intersectoral action
viii. Coordination within the health sector
ix. Organizing primary health care in communities
x. Federal system
xi. Logistics system

xii. Health Manpower recruitment and retraining
xiii. Priority health programmes.
xiv. Health technology.

Self-Assessment Exercises 3

Identify the organization structure of health in your state and present it diagrammatically

3.4.3 Local level

The are 774 Local Government Areas in Nigeria with various health facilities operating under the hinges of primary health care.

The Local Government Headquarters coordinates the activities of the health facilities providing manpower, funds, logistics Slid control.

The Local Government is headed by elected Chairmen during political era with council members. Supervisory councilors are also appointed to oversee various aspect of Local Government activities including Health and Social Services., The health department is always headed by a Primary Health Care coordinator.

Functions of the local government

- Provision and maintenance of essential elements of primary health care: environmental sanitation; health education
- Design and implement strategies to discharge the responsibilities assign to them under constitution and to meet the health needs of the local community under the general guidance, support and technical supervision of state health Ministries.
- Motivation of the community to elicit the support of formal and informal leaders
- Local strategy for Health activities. Examine this illustration, which provides an overview of health care delivery system at the three levels of health care i.e. primary, secondary and tertiary levels.

As you know a full range of primary health care (first level contact of individual, family and community health system) are being rendered through the agency of primary health centers.

Secondary Health Care is being provided through the establishment of cottage, General Hospitals where all basic specialist services are being

made available.

Tertiary care is being provided at Teaching and Specialist Hospitals where super specialty services including sophisticated diagnosis, specialized therapeutic and rehabilitative services are available.

3.5 Structural Organization of Health System Based on Primary Health Care Agency

As a signatory to the Alma-Ata Declaration, the Federal Government of Nigeria is committed to achieve the goal of Health for All through primary health care approach. Keeping in view the goal of "Health for All" by 2000 AD and beyond, the National Health Policy has laid down a plan of action for reorienting and shaping the existing rural health infrastructure within the framework of various year plans. The establishment of primary health centers in our country in 1986 under the National Primary Health Care Development Agency has been a valuable national asset in our efforts to increase the outreach of our health system based on primary health care.

Functions of the agency

The functions of the Agency are:

Support to health policy

a. review existing health policies, particularly as to their relevance to the development of PHC and to the integrated development of health services and health manpower and propose changes when necessary.
b. Prepare alternatives for decision makers at all levels based on scientific analysis, including proposals for health legislation.
c. Conduct studies on health plans for PHC at various levels to see whether they are relevant to the national health policy, feasible and multisectoral.
d. Promote the monitoring of PHC. Implementation of various levels.
e. To stimulate the development of PHC technical on an equitable basis in all LGAs, for example technical support to implementation of selected PHC components as required. This assistance will be provided strategically to enhance orderly development, for example, to improve upon or introduce new skills required for the services or to integrate new components into them.

Resources mobilization

a. to mobilize resources nationally and internationally in support of the programmes of the Agency.
b. To conduct or commission studies on resource mobilization for health and issues of cost and financing, with reference to equity.

Support to Monitoring and Evaluation

a. to monitor the development of the nation's PHC programme so that it keeps as much as possible within the guidelines set out for its development in the National Health Policy and PHC Guidelines and Training Manuals.
b. develop guidelines and design frame works for periodic evaluation of primary health care at various levels.
c. monitor the monitoring and evaluation process nationally, with respects to the development of capabilities of LGA level to analyze and make use of monitoring and evaluation date for management decision making

Technical support

a. provide technical support to the preparation of a health man-power policy, including manpower projections to enable development of a PHC manpower plan.
b. provide advocacy and support for the orientation of medical undergraduate education, and the education of other health professionals, towards PHC.
c. Organization of Health System
d. to identify orientation and continuing education needs of PHC manpower, including medical, organize programmes to meet these needs, using Schools *of* Health Technology as a resource.
e. to directly support the strengthening *of* the Schools *of* Health Technology.

Support to the village health system: In view *of* the importance *of* this level *of* the national health system in extending coverage, the Agency should:

a. Pay special attention and provide maximum support to the training deployment, logistic support and supervision *of* village health workers and TBAs: the relationship between these workers and their communities and the mechanisms which link these workers to the other levels *of* the health system.
b. Pay special attention to the involvement *of* women and grass-root t- women's organization in the village health system.

Health system research (HSR)

a. promotes and support problem oriented HSR as a tool for finding better ways for the provision *of* essential care as a component *of health for all,* in particular the introduction Of HSR in the LGA health system and the support of the other levels of this efforts.
b. to undertake or commission HSR operations research into the functionIng *of* PHC programmes;
c. to respond to request from government and other agencies in organizing special studies by mobilizing experts who will respond rapidly and in depth to guide legislative and administrative action.

Technical collaboration

a. 10 stimulate universities, NGOs, and international agencies to work with LGAs in nurturing their capacity for problem solving.
b. To develop LGA capacity to seek technical collaboration including from other LGAs in developing and implementing their PHC programmes;
c. To promote collaboration with other sectors at all levels in the development and support *of* LGA primary health care system.
d. To monitor the collaboration for PHC between the international agencies and government at all levels.
e. Promote and organize both the sharing *of* experience *of* the Agency with the world community (publications, reports, visitors, etc) and the collection *of* all relevant information from other countries and international organizations and disseminate it to all interested parties.
f. Promote maximum support to alJ its *efforts* by networking and creating formal and informal collaboration with relevant Nigeria-nand international institutions.

Promotion of PHC:

All activities carried out by the Agency will be promotin.g PHC. Specifically, however, the Agency should

a. carries out advocacy at the level of community leaders, mass media and NGGs, to promote PHC, making particular efforts to ensure that elected officials and party functionaries are continually oriented towards PHC and health for all;
b. re-oriented health professionals towards PHC by means of con-ferences, seminars, and other meetings.
c. support the documentation of PHC through commissioning of

case studies, reviews, books, articles, newsletters and other media productions as appropriate.

d. establish Resource centers to serve as national and zonal depositories of information on PHC implementation.
e. Organize seminars, reviews and other meeting to promote PHC and share experiences in implementation, with a view to strengthening LGA health systems.
f. Provide annual reports which are widely annual reports which are widely disseminated on the status of PHC implementation nation-wide.

Self-Assessment Exercises 4

i) List the eight (8) functions of the Agency

3.5.1 Organization of the Agency.

To be able to perform its functions effectively, the Agency will be an administratively autonomous Agency under the supervision of the Federal Ministry of Health., In addition: it will have a Board of Directors.

It will have an Executive Director who will head the team responsible for guiding the development of the PHC system. He/she must therefore have' considerable experience in this area.

There will also be a Scientific Committee in the Agency in which various experts with relevant skills will be represented. The composition and modalities for functioning of the Scientific committee will be prepared by the Executive Director and approved by the Board.

The board:

a. The agency will have a board to:

Receive reports on the state of development of the national PAC programme.

Approve the activities of the agency and its budget Have overall responsibilities for personnel matters; Assist with the mobilization of funds.

b. The board will consist of the following:

- ✓ A chairman, who will be a highly respected primary health care practitioner.
- ✓ The secretary, who will be the executive director of the agency, The federal director of primary health care.
- ✓ A representative of the conference of provosts of college of medicine; A representative of the conference of principals of community health officer's training institutions.
- ✓ A representative nominated by the National Association of Nigerian Nurses and Midwives.
- ✓ One State Ministry of Health representative from each PAC zone nominated by the National Council of Health in rotation to serve for a period of 3 years.
- ✓ One LGA representative from each PAC zone, nominated by the Conference of LGA chairmen, in rotation to serve for a period of 3 years.
- ✓ A representative of the National Planning Commission; A representative of NGOs working in PAC

Representative of the National Commission for Women.

Structure of **the agency at federal level.**

The Agency will have a small core of professional staff at the Federal Level. The Staff should follow the guiding principles of teamwork and polyvalence. Moreover, the Agency should have the ability to draw on outside expertise to the maximum extent possible. Further, it is understood that the structure of the Agency will be modified with experience.

Zonal level

The offices should collaborate with the State Ministries of Health to strengthen LGA PAC systems.

To be effective in providing LGAs with technical assistance, it is proposed that the zonal offices be organized along the same lines as the LGA PAC Departments are currently organized. The zonal offices, are therefore, proposed to be constituted.

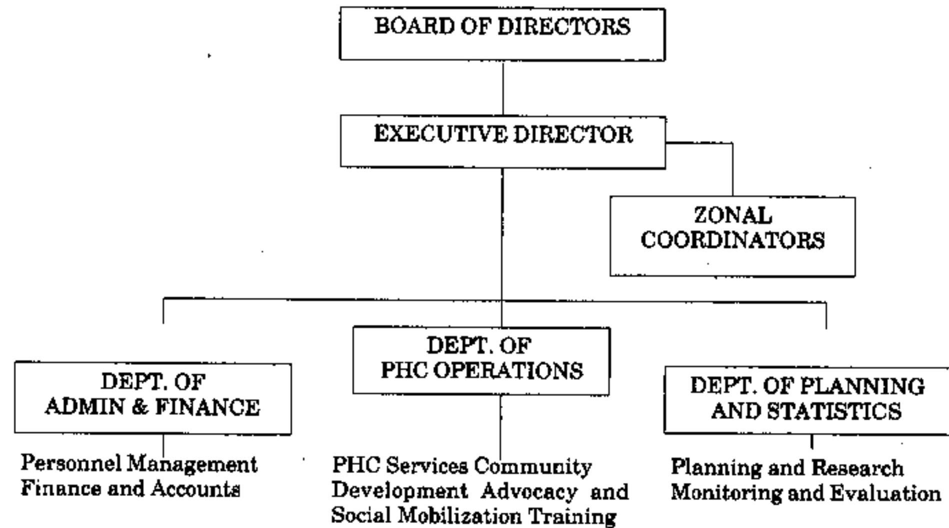


Fig. 4.1: Structure of the agency at federal level

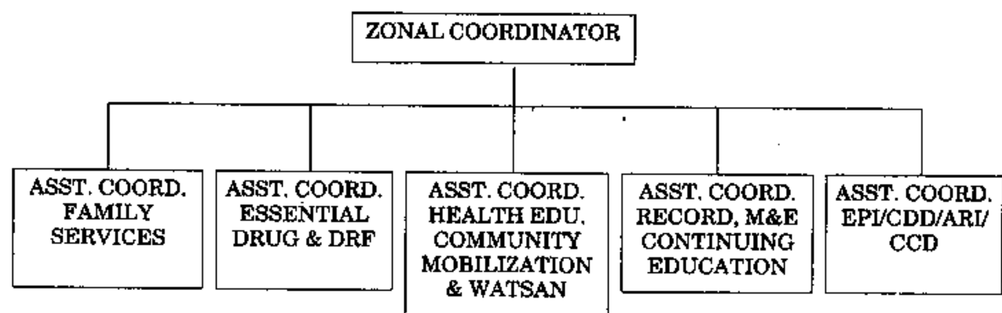


Fig. 4.2: Structure of the agency at zonal level

The assistant coordinators will oversee the functions allocated to them as follows:

- ✓ *-Family health services:* Maternal and child health services including family planning and nutrition/growth monitoring promotion.

- ✓ Essential drugs and drugs revolving fund, medical stores, essential drugs and drugs revolving fund promotion.

- ✓ Health education, community mobilization, water and sanitation.
- ✓ *-Promotion of health education:* Development of the managerial process through establishment of committee and training of committee members at all levels.
- ✓ Promotion of water and sanitation projects.

- ✓ Records, monitoring and evaluation collection, collation and analysis of monthly reports from all LGAs and States promotion of feedback to those levels.

- ✓ Development of capabilities at LGA level to analyze and make use of monitoring and evaluation data for management decision-making.

- ✓ Writing periodic zonal report and widely disseminating the same; establishment and maintenance of zonal resource centre;

- ✓ Serving as focal point support of PHC project formulation in LGAs in the zone.

- ✓ Coordination of the integration of EPI and diarrhea diseases, ARI and communicable diseases control programmes (guinea worm, TB and leprosy, onchocerciasis, schistosomiasis and AIDS) in the PHC systems in the zone.

The above organizational structure entails strengthening the zonal offices considerably. The resources needed at this level include personal, office accommodation, transportation and increased financial allocation to ensure that field work will go in the LGAs unhindered.

3.6 Summary

We have discussed about the organization of health system. Health system is defined as coherent whole of many interrelated components parts, both sectoral and intersectoral as well as community itself, which produces a combined effect on the health of the population. Health system is organized at three levels: federal, state and local level. At the federal level official organs are, Federal Ministry of Health and National Council of Health. The federal ministry is headed by a minister assisted administratively by the permanent secretary and has five departments

i. planning, research and statistics, personal management; finance and supplies, hospital services and primary health care/disease control. These departments are headed by directors.

At the state level, the health sector comprises of the State Ministry of Health and Health Management Board in some states. The State Ministries of Health are headed by commissioner assisted by permanent secretary and directors. At the local level, the head of department is the primary health coordinator with assistants overseeing other areas such as

immunization AIDS/HIV, measurement, and evaluation, PHC, and nutrition. Lastly, we discussed about the structural organization of health system based on national primary health care agency, which focuses on primary health care.

3.7 References / Further readings/Web Resources

Packard, Randall (2016). A History of Global Health. Baltimore: Johns Hopkins. pp. 227–229. ISBN 9781421420332.

World Health Organization. (1978) Declaration of Alma-Ata. Adopted at the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12

Starfield, Barbara (2011). "Politics, primary healthcare and health". J Epidemiol Community Health. **65** (8): 653–655. doi:10.1136/jech.2009.102780. PMID 21727176.

Public Health Agency of Canada. About Primary Health Care.

Marcos, Cueto (2004). "The ORIGINS of Primary Health Care and SELECTIVE Primary Health Care". Am J Public Health. 22. **94** (11): 1864–1874. doi:10.2105/ajph.94.11.1864. PMC 1448553. PMID 15514221.

White F. Primary health care and public health: foundations of universal health systems. Med Princ. Pract 2015 doi:10.1159/000370197

Secretariat, WHO. "International Conference on Primary Health Care, Alma-Ata: twenty-fifth anniversary" (PDF). Report by the Secretariat. WHO. Retrieved 28 March 2011.

Bulletin of the World Health Organization (October 2008). "Consensus during the Cold War: back to Alma-Ata". World Health Organization. Archived from the original on July 9, 2012.

Bulletin of the World Health Organization (December 2008). "China's village doctors take great strides". World Health Organization. Archived from the original on December 12, 2008.

"Health topics: Primary health care". World Health Organisation. Retrieved 28 March 2011.

Braveman, Paula; E. Tarimo (1994). Screening in Primary Health Care: Setting Priorities with Limited Resources. World Health Organization. p. 14. ISBN 9241544732. Retrieved 4 November 2012.

Walsh, Julia A., and Kenneth S. Warren. 1980. Selective primary health care:An interim strategy for disease control in developing countries. Social Science & Medicine. Part C: Medical Economics 14 (2):145-163

Rehydration Project. UNICEF's GOBI-FFF Programs. Accessed 16 June 2011.

World Health Organization. World Health Report 2005, Chapter 5: Choosing Interventions to Reduce Specific Risks. Geneva, WHO Press.

World Health Organization. Older people and Primary Health Care (PHC). Accessed 16 June 2011.

Department of Health, Provincial Government of the Western Cape. Mental Health Primary Health Care (PHC) Services. Accessed 16 June 2011.

"Meeting Report on Excess Mortality in Persons with Severe Mental Disorders" (PDF). World Health Organization. 18–20 November 2015.

Pfeiffer, J (2003). "International NGOs and primary health care in Mozambique: the need for a new model of collaboration". Social Science & Medicine. **56** (4): 725–738. doi:10.1016/s0277-9536(02)00068-0. PMID 12560007.

3.8 Possible Answers to Self-Assessment Exercises

Self-Assessment Exercises 1

i) a) interrelated intersectoral
b) delivering.
c) organizational '
d) Development

ii) Characteristics of health system.
- serves all -equality
- prime responsibility
- intersectoral action

- essential elements
- specialized

Self-Assessment Exercises 2

i) a) Federal Ministry of Health b) National Council of Health
ii) Department of Personnel Management
Department of Planning, Statistics & Research Department of Hospital Services Department of Primary Health Care & Disease Control Department of Finance & Supplier
iii) The Minister of Health (Chairman) and the Commissioners of Health (State).

Responsibilities: Advises the federal government. Advisory the Federal Government

. Development of national guidelines on health
. Implementation and administration of the National Health policy
. Various technical matters on the organization; delivery, and distribution of health services.

Self-Assessment Exercises 3

- Support to health policy
- Resources mobilization
- Support monitoring and evaluation
- Technical support,
- Support to the village health system
- Health system research
- Technical collaboration
- Promotion of primary health care.

3.9 Tutor-Marked Assignment

1. What is health systems? (2mark)
2. List the characteristics of health systems (4 marks)
3. What are the roles of Primary Health Care Agency? (4 marks)

UNIT 4 HEALTH CARE RESOURCES AND MONITORING AND EVALUATION OF HEALTH SERVICES

Unit Structure

4.1 Introduction
4.2 Intended Learning Outcomes
4.3 Human Resources Development
  4.3.1 Strategy and definition
  4.3.2 Sector-wise distribution
  4.3.3 Rural-urban distribution
  4.3.4 Planning and ratio in relation to population
  4.3.5 International action and role of WHO
4.4 Financial and material resources
  4.4.1 Financial resources and GNP
  4.4.2 Priority in financial allocation
  4.4.3 Review distribution and reallocation of health budget
  4.4.4 Estimate the fmancial needs and secure additional funds
  4.4.5 International action and the role of WHO
4.5 Monitoring and evaluation
  4.5.1 Definition and importance of monitoring
  4.5.2 Monitoring vs. surveillance
  4.5.3 Evaluation
  4.5.4 Elements of evaluation process
  4.5.5 General steps of evaluation
  4.5.6 Evaluation of health services
4.6 Indicators of health monitoring and evaluation
  4.6.1 Characteristics of indicators
  4.6.2 Broad classification of indicators in health measurement
  4.6.3 Details of indicator selected from monitoring progress towards health for all
4.7 Summary
4.8 References/Further Readings/Web Resources
4.9 Possible answers to SAEs

4.1 Introduction

In Unit 3 you have learnt the organization of health system based on primary health care and the action required to promote and support it, which are the main thrusts of the global strategy of Health For All. Inseparable parts of the strategy are the actions required to generate and mobilize all possible human and financial resources and development of suitable monitoring and evaluation process. Resources are needed to meet the many health needs of a community. No nation, however rich,

has enough resources to meet all the needs or all aspects of health care of its citizens. Therefore an assessment of the available resources, their proper allocation and efficient utilization are important considerations for providing efficient health care services. This basic resources for providing health care are Man, Money and Material which you will learn in the following broad categories:

i. Human Resources
ii. Money and Material Resources.

4.2 Intended Learning Outcomes

By the end of this unit, you will be able to:

- Describe the measures to develop human resources for health,
- Enumerate and explain ways of ensuring community involvement to be adopted by the ministry of health,
- Discuss the whole gamut of health manpower, including internal agencies engaged in delivery of national health care services,
- Analyse the action required to develop monitoring and evaluation process as part of managerial process for national health development.

4.3 Human resources development

The strategy seeks to involve not only the health personnel but also many other personnel from various sectors as human resources. Primary health care has to mobilize human potential of the entire community. This is possible on the condition that individuals and families accept greater responsibility for their own health. People need to be involved in deciding on the health system required by them and the health technology acceptable to them, in delivering a part of national health programme. This is to be achieved through *self-care and family care* and involvement in joint action for health.

Health manpower constitutes a major part in human resources, so it is explained in further details

4.3.1 Strategy and definition

The term "health manpower" includes both professional (doctor & nurse) and auxiliary health personnel (CHEWs, TBA, lab. techn. etc) who are needed to provide the health care. An auxiliary is defined by WHO as "technical worker in a certain field with less than full

professional training". Health manpower requirements of a country are based on

i. *Health needs and demands of the populations:* The health needs in turn are based on the health situation and health problems and aspirations of the people.
ii. *Desired outputs:* preventive, promotive, curative or rehabilitative, control or eradication.

4.3.2 Sector wise distribution

The health care system is intended to deliver the health care services. It constitutes the management sector and involves organizational matters. It operates in the context of the socio economic and political framework of the country. In Nigeria, it is represented by major sectors or agencies which differ from each other by the health technology applied and by the source of funds for operation. These are:

i. **Public sector**

a. Primary health centres
b. Hospitals/health centres Specialist hospitals Teaching hospitals
c. Health insurance scheme

ii. **Private sector**

a. Private hospitals, polytechnics, nursing homes, and dispensaries.
b. General practitioners and clinics

iii. **Indigenous system of medicine:**

- Homeopathy
- Unregistered practitioners (naturapathy)
- Herbal medicine practitioners.

iv. **Voluntary health agencies and non-governmental organizations.**

a. Nigerian Red Cross Society
b. Planned Parenthood Federation of Nigeria
c. The Leprosy Mission Nigeria
d. *Professional bodies:* The Nigerian Medical Association, National Association of Nigerian Nurses and Midwives, Pharmaceutical Society of Nigeria, National Association of Physiotherapist, Health Records Registration Board, Medical & Health Workers Union.

e. *Missionary bodies:* Christian Health Association of Nigeria, Islamic Organization.
f. *International agencies:* WHO, UNICEF, UNDP, UNFPA, USAID, Sight Savers International, Society for Family Health (SFH).

4.3.3 Rural urban distribution

You have now learned about the sector wise distribution of health manpower which does not give the real picture of available manpower according to geographical area. When we analyze them between rural and urban area we can observe the gross mal distribution of health manpower. Studies in Nigeria have shown that there is a concentration of doctors and nurses (up to 80 per -cent) in urban areas where only 20 per cent of population live. This maldis- tribution is chiefly attributed to absence of amenities in rural areas, lack of job satisfaction, professional isolation, lack of rural experience and inability to adjust to rural life by the professional doctors and nurses.

4.3.4 Planning and ratio in relation to population

Health manpower planning is an important aspect of community health planning. It is based on series of accepted ratios such as doctor population ratio, nurse-population ratio, bed-population ratio, etc.

4.3.5 International action and the role of WHO

International action will include the following:

i. Information will be collected and used internationally by the WHO regarding people and groups throughout the world who could provide individual or group support to countries on various aspects of their strategies.
ii. UNESCO, in its worldwide literacy programme will be requested to ~ use health information with a view to providing basic understanding of nutritional and health needs and of prevention and control of common health problems.
iii. WHO will engage in technical cooperation with its member states and promote such cooperation among them to ensure the maximum mobilization and development of personnel for health.
iv. WHO will ensure the involvement of other UN organizations like UNDP, UNFPA, International non-governmental and voluntary organizations by identifying specific tasks in which they can engage
v. WHO will promote dialogue between developing and developed coun- tries to prevent brain drain of health personnel

Self-Assessment Exercises 1

i) Outline the five major sectors where the health manpower are engaged.

a)

b)

C) d) e)

4.4 Financial and material resources

Financial and material resources are as essential as human resources for the successful implementation of the strategy. It involves efficient use of existing resources and making provision for the additional resources.

Table 1: National Health Development Plans in Nigeria

1st National Health Development Plan (10 years) 1946 -1956 2nd National Health Development Plan (5 years) 1970 -1974
3rd National Health Development Plan (6 years)1975 -1980
4th National Health Development Plan 1988 -Date
Source: National Health Policy (1989). Federal Ministry of Health

4.4.1 Financial resources and GNP

Money is an important resource for providing health services. Scarcity of money affects all parts of the health delivery system. In most developed countries, Government expenditure for health lies between 6 to 12 per cent of Gross National Product (GNP). In underdeveloped countries, it is less than I per cent of the GNP and it seldom exceeds 2 per cent of the GNP. To make matter worse, much of the spending is for services that reach only a small fraction of the population.

To achieve Health For All, WHO has set, as a goal, the expenditure of 5 per cent of each country's GNP on health care. At present, Nigeria is spending about 3 per cent of GNP on health and family welfare services. In Nigeria, 20% of the nation's budget is to be expended on health. The per capita health expenditure is not more than US$10 to 15. This is far less compared with Jamaica which expends US$100 and the United States of America with US$4,000. This accounts for the drop in the life-expectancy which is about 52 years. The greater part of the health expenditure goes to primary health care.
Infant mortality rate in Nigeria is about 80/ 1,000; Child mortality rate is

about 28.8/1,000 on the average (urban and rural populations) and maternal mortality rate is about 4/1,000.

The federal government has also directed that 12% of the State's budget should go for health.

4.4.2 Priority in financial allocation

Since money and material are always scarce resources they must be put to the most effective use, with an eye for maximum output of results on minimum investment. Since deaths from preventable diseases such as malaria, whooping cough, measles, tuberculosis, tetanus, diphtheria, malnutrition frequently occurs in developing countries, the case is strong for investing resources on preventing these diseases. Spending money on multiplying prestigious medical institutions and other high-cost medical establishments which cater for a small percentage of the sick citizens, absorbs a large portion of the national health budget. Management techniques such as cost effectiveness and cost-benefit analysis are now being used for allocation of resources in the field of community health.

4.4.3 Review distribution and reallocation of health budget

i. Review of the allocation of health budget to primary health care at peripheral, intermediate and central levels in urban and rural areas and to specific underserved groups.
ii. Reallocation of the existing resources or any additional resources for providing primary health care to underserved population groups.
iii. Analysis of the needs, in terms of costs and material, for appropriate health technology and establishment of health infrastructure.
iv. Consideration of cost effectiveness of different technologies, of 1 various health programmes, to find alternate ways of organizing the health system in relation to the cost.

4.4.4 Estimate the financial needs and secure additional funds

i. Estimation of the magnitude of total financial and material needs to implement the strategy.
ii. Consideration of alternative ways of financing the health system including the possible use of social security funds, e.g., ESI, CGHS;
iii. Identifying activities that might attract external grant or loans e.g. Leprosy control, child survival and Safe Motherhood, National Immunization Programme, AIDS control;

iv. Encouraging government (in developing countries) to request for grants and loans from other sources such as external banks, bilateral and multilateral agencies, e.g. World Bank; Rockefeller Foundation, i CARE, ODA of UK or Japan, Ford Foundation, UNDP, UNESCO;
v. In developed countries, to influence concerned agencies to provide grants and loans for the strategy, e.g. various religious organizations;
iv Presentation of their government a master plan which outlines the use of all financial and material resources including direct and indirect financing e.g. local community resources in terms of available manpower, material and money, individual payments for service and the use of external loans and grants.

4.4.5 International action and the role of WHO

To mobilize financial resources, WHO's action will consist of the following

i. Ensure the exchange of information on alternative ways of financing health systems.
ii. Estimate the order of magnitude of financial needs for the strategy.
iii. Promotion and development of methodology for and support cost benefit and cost-effectiveness studies on health systems and technology;
iv. Strengthen developing countries' capacities, on request, to prepare proposals for funding from external sources for health.
v. Use its mechanisms to identify needs and facilitate mobilization of funds as well as transfers between countries.
vi. Establishment and coordination of activities of 'global health for all', Resources group representation countries, intergovernmental, bilateral and multilateral agencies and foundations, as well as non-governmental organizations, working together to rationalize the transfer 1ofresources for 'Health For All' and to mobilize additional funds, if necessary.

Self-Assessment Exercises 2

i) Enter T or F (T = True; F = False) against the following statements:
National budget for health sector is:
a) mainly spent to build urban oriented prestigious curative institution
b) directed to supply wholesome water and sewage system to the rural population.
c) 5% of GNP which is recommended by WHO to achieve health for all

d) At present is only 3% of GNP.

ii) State in 5 lines regarding the international action for mobilizing financial and material resources:

4.5 Monitoring and evaluation

You have learnt all about health service resource in terms of Manpower, Money and Material distributed throughout the country from center to peripheral level. All these resources are allocated for *specified programme* or *task with definite goal.*

To know the progress in implementation of any strategy, and to evaluate the effectiveness in improving the health status of the people it is essential to set up a process of *monitoring and evaluation.* Success of any programme depends on constant monitoring of its different activities by guidance of an inbuilt predetermined systems of monitoring and evaluation right at the stage of its inception. Monitoring process as well as evaluation are complementary to each other to observe and assess the progress of a planned programme.

We will now explain the process of monitoring and evaluation in the following sub section.

4.5.1 Definition and importance of monitoring

Monitoring, we define as the day-to-day follow-up of activities during their implementation stage, to ensure that they are proceeding as planned and are on schedule. It is a continuous process of observing, recording, and reporting on the activities of the organization or project. Monitoring, thus, consists of keeping track of the course of activities and identifying

deviations and taking corrective action if deviations occur.

4.5.2 Monitoring vs surveillance

Definition of *monitoring* which you have learned is often taken as like that of surveillance. But in public health practice during the past 25 years, they have taken on a rather specific, somewhat different meaning.

i. ***Monitoring:*** **Monitoring** is "the performance and analysis of routine measurements aimed at detecting changes in the environment or health status of population". Thus, we have monitoring of an air pollution, water quality, growth and nutritional status of children etc. It also refers to the measurement of performance of an ongoing health service or a health professional, or of the extent to which patients comply with or adhere to advice from health professionals.

In management, monitoring refers to the continuous overseeing of activities to ensure that they are proceeding according to plan. It keeps track of performance of health staff, utilization of supplies and equipment, and the money spent in relation to the resources available so that if anything goes wrong immediate corrective measures can be taken.

ii. ***Surveillance:*** Surveillance is defined in many ways. According to one interpretation, surveillance means to watch over with great attention and authority of the minute details in a situation. Surveillance is also defined as the continuous scrutiny of the factors that determine the occurrence and distribution of disease and other conditions of ill health. Surveillance pro- grammes can assume any character and dimension - thus we have epidemiological surveillance, demographic surveillance, nutritional surveillance etc:

The main objectives of surveillance are:

a. to provide information about new and changing trends in the health status of a population, e.g. morbidity, mortality, nutritional status or other indicators of environmental hazards.
b. to provide feedback which may be expected to modify the policy and the system itself and lead to redefinition of objectives, and
c. to provide timely warning of public health disasters so that interventions can be mobilized.

According to the above definitions, monitoring becomes one specific and essential part of the broader concept embraced by surveillance. Monitoring requires careful planning and the use of standardized

procedures and methods of data collection, but can then be carried out over extended periods of time by technicians and automated instrumentation. Surveillance, in contrast, requires professional analysis and sophisticated judgement of data leading to recommendations for control activities.

4.5.3 Evaluation

It is worthy of note that both monitoring and surveillance processes are only to check the deviation of any programme or activity from its aim till it reaches to the goal in terms of its resources. These tools fail to assess the programme achievement at its different levels of implementation which is done by the process of evaluation.

The purpose of evaluation is to assess the achievement of the stated objectives of a programme, its adequacy, its efficiency and its acceptance by all parties involved. While monitoring is confined to day-to-day ongoing operations, evaluation is mostly concerned with the final outcome and with factors associated with it. Good planning will have a built-in evaluation to measure the performance and effectiveness and for feed-back to correct specific deficiencies.

Evaluation is the process by which results are compared with the intended objectives, or more simply the assessment of how well a programme is performing. Evaluation should always be considered during the planning and implementation stages of a programme or activity. Evaluation may be crucial in identifying the health benefits derived (impact on morbidity, mortality, squelae, patient satisfaction). Evaluation can be useful in identifying performance difficulties. Evaluation studies may also be carried out to generate information for other purposes, e.g. to attract attention to a problem, extension of control activities, training and patient management, etc.

The *reasons* for evaluation are as follows: Health services. have become complex. There has been a growing concern about their functioning both in the developed and developing countries. Questions are raised bout the quality of medical care, utilization and coverage of health services, benefits to community health in terms of morbidity and mortality reduction and im- provement in the health status of the recipients of care. An evaluation study addresses itself to these issues.

4.5.4 Elements of evaluation process

Evaluation is perhaps the most difficult task in the whole area of health services. The components of the evaluation process are:

a. *Relevance:* Relevance or requisiteness relates to the appropriateness I of the Service, whether it is needed at all. If there is no need, the I service can hardly be of any value. Example, vaccination against smallpox is now irrelevant because the disease no longer exists in the world.

b. *Adequacy:* It implies that sufficient attention has been paid to certain previously determined courses of action. For example, the staff allocated to a certain programme may be described as inadequate if sufficient attention was not paid to the quantum of work-loan and targets to be achieved.

c. *Accessibility:* It is the proportion of the given population that can be expected to use a specified, facility, service, etc. The barriers to accessibility may be physical (e.g. distance, travel, time): economic (e.g. travel cost, fee charged); or social and cultural (e.g. caste or language barrier).

d. *Acceptability:* The service provided may be accessible, but not acceptable to all, e.g. male sterilization, screening for cervical or rectal cancer, insertion of copper T if the professional worker is male/female as the case may be.

e. *Effectiveness:* It is the extent to which the underlying problem is prevented or alleviated. Thus, it measures the degree of attainment of the predetermined objectives and targets of the programme, service or institution-expressed, if possible, in terms of health benefits, problem reduction or an improvement of an unsatisfactory health situation. The ultimate measures of the effectiveness will be the reduction in morbidity and mortality rates.

f. *Efficiency:* It is a measure of how well resources, money, men, material and time are utilized to achieve a given effectiveness.

The following examples will illustrate: the number of immunizations provided in a year as compared with an accepted norm using cotton and gauze to clean the windows or chairs~ during personal work on project time, a medical officer who cannot speak the language of the client or a professional nurse who cannot insert copper T or health personnel proceeding on long. leave with no replacement.

g. *Impact:* It is an expression of the overall effect of a programme service or institution, on health status and socioeconomic development. For example, because of malaria control in Nigeria, not only has the incidence of malaria dropped down, but all aspects of life agricultural, industrial, and social-showed an improvement. If the target of 100 per cent immunization has been reached, it must also lead to reduction in the incidence or

elimination of vaccine preventable diseases. If the target of village water supply has been reached, it must also lead to a reduction in the incidence of diarrhea diseases.

Planning and evaluation must be viewed as a continuous interactive process, leading to continual modification both of objectives and plans. Successful evaluatibn may also depend upon whether the means of evaluation were built into the design of the programme before it was implemented.

4.5.5 General steps of evaluation the basic steps involved are as follows:

- Determine what is to be evaluated.
- Establish standards and criteria.
- Plan the methodology to be applied.
- Gather information.
- Analyse the results.
- Take action
- Re-evaluate

Determine what is to be evaluated:

Generally speaking; there are three types of evaluation:

a. Evaluation of "structure": This is evaluation of whether facilities, equipment, manpower and organization meet a standard accepted by experts as good.
b. Evaluation of "process": The processes of medical care include the problems of recognition, diagnostic procedures, treatment and clinical management, care, and prevention. The way in which the various activities of the programme is carried out is evaluated by comparing with a predetermined standard. An objective and systematic way of evaluating the physician (or nurse) performance is known as "Medical (or nursing) Audit"
c. Evaluation of "outcome": This is concerned with the end results, that is, whether persons using health services experience measurable benefits such as improved survival or reduce disability. The traditional outcome components are the "5 Ds" of ill health, viz. Disease, death, disability, discomfort, and dissatisfaction.

Establishment of standards and criteria: Standards and criteria must be established to determine how well the desired objectives have been attained. Naturally such standards are a prerequisite for evaluation., Standards and criteria must be developed in accordance with the focus

of evaluation-

i. Structural criteria: e.g., physical facilities and equipments

iii. Process criteria: e.g. every prenatal mother must receive 6 check-ups; every laboratory technician must examine 100 blood smears, etc;

iv. Outcome criteria: e.g. an alterations in patient health status (cured, dead, disabled): or a change in behaviour resulting from health care (satisfaction, dissatisfaction); or the educational process (e.g. cessation of smoking, acceptance of a small family norm), etc.

Planning the methodology: A format in keeping with the purpose of evaluation must be prepared for gathering information desired. Standards and criteria must be included at the planning state.

Gathering information: Evaluation requires collection of data or information. The type of information required may include political, cultural, economic, environmental, and administrative factors influencing the health situation as well as mortality and morbidity statistics. It may also concern health and related socioeconomic policies, plans and programmes as well as the extent, scope and use of health systems, services and institutions. The amount of data required will depend on the purpose and use of the evaluation.

Analysis of results: The analysis and interpretation of data and feedback to all individuals concerned should take place within the shortest time feasible, once information has been gathered. In addition, opportunities should be provided for discussing the evaluation results with all concerned.

Taking action: For evaluation to be truly productive, emphasis should be placed on actions-actions designed to support, strengthen or otherwise modify the services involved. This may also call for shifting priorities, revising objectives, or development of new programmes or services to meet previously unidentified needs.
Re-evaluation: Evaluation is an ongoing process aimed mainly at rendering health activities more relevant, more efficient, and more effective.

4.5.6 Evaluation of health services

Randomized controlled trials have been extended to assess the effectiveness and efficiency of health services. Often, choices must be made between alternative policies of health care delivery. The necessity of choice arises from the fact that resources are limited, and priorities must be set for the implementation of many activities, which could

contribute to the welfare of the society. An excellent example of such an evaluation is the controlled trials in the chemotherapy of tuberculosis in Nigeria, which demonstrated that "domiciliary treatment" of pulmonary tuberculosis was as effective as the costlier "hospital or sanatorium" treatment. The results of the study have gained international acceptance and ushered in a new era-the era of "domiciliary treatment" in the treatment of tuberculosis.

More recently, multiphasic screening which has achieved great popularity in some countries, was evaluated by a randomized vast outlay of resources required to mount a national programme of multiphasic screening in UK. Another example is that related to studies which have shown that many of the health care delivery tasks traditionally performed by physicians can be performed by nurses and other paramedical workers, thus saving physician's time f9r other essential tasks. These studies are also labeled as "health services research" studies.

Self-Assessment Exercises 3

i) Enter T or F (T = True; F = False) against the following statements: Monitoring of any programme is:
a) keeping track of course of activities
b) providing information about recent trends in disease pattern
c) identifying deviation and taking corrective action, if needed
d) day- to-day follow up activities during implementation
ii) List all the seven steps involved in evaluation process in chronological order.

4.6 Indicators of health monitoring and evaluation

Now you have imbibed all about the process of monitoring and evaluation of Health Services implemented to uplift the health of the people. The level of health must be measured in some units as kilogram for weight and meter for height. For this purpose, we have different health indicators to measure the qualitative and quantitative variables in health.

A question that is often raised is, how healthy is a given community? (Indicators are required not only to measure the health status of a community, but also to compare the health status of one country with that of another, for assessment of health care needs, for allocation of scarce resources and for monitoring and evaluation of health services, activities and programmes. Indicators help to measure the extent to which the objectives and targets of a programme are being attained.

As the name suggests, indicators are only an indication of a given situation or a reflection of that situation. In WHO's guidelines for health programme evaluation, indicators are defined as variables which help to measure change- s. Often they are used particularly when these changes cannot be measured sequentially over time, they can indicate direction and speed of change and serve to compare different areas or groups of people at the same moment in time.

4.6.1 Characteristics of indicators.

Indicators have been given scientific respectability; ideal indicators:

a. should be valid, i.e. they should actually measure what they are supposed to measure;
b.
c. should be reliable and objective, i.e. the answers should be the same if measured by different people in similar circumstances;
d. should be sensitive, i.e. they should be sensitive to changes in the situation concerned; and
e. should be specific. i.,e. they should reflect changes only in the situation concerned.

But in real life there are few indicators that comply with all these criteria. Measurement of health is far from simple.

4.6.2 Broad classification of indicators in health measurement

As all of you have learnt that health is multidimensional in nature and each dimension is influenced by numerous factors, some known and many unknown. Therefore, no single indicator can measure the health of people. It must be conceived in terms of a profile employing many indicators like:

- Mortality indicators
- Morbidity indicators
- Disability (rate) indicators
- Nutritional status indicators
- Health care delivery indicators
- Utilization (rate) indicators
- Indicators of social and mental health
- Environmental indicators
- Socio-economic indicators
- Health policy indicators.
- Indicators of quality of life
- Other indicators for specific situations

We shall now study the same in detail for better understanding.

Mortality indicators

There are many measurements involved such as –

a. *Crude death rate:* This is considered a fair indicator of the comparative health of the people. Crude death rate is defined as the number of deaths per 1000 population per year in a given community.
It indicates the rate at which people are dying. Strictly speaking, health should not be measured by the number of deaths that occur in a community. But in many countries, the crude death rate is the only available indicator of health. When used for international comparison, the usefulness of the crude death rate is restricted because it is influenced by the age-sex composition of the population. Although not a perfect measure of health status, a decrease in death rate provides a good tool for assessing the overall health improvement in a population. Reducing the number of deaths in the population is an obvious goal of medicine and health care, and success or failure to do so as a measure of a nation's commitment to better health. In 1991 the crude death rate (CDR) for Nigeria is 9.8 per thousand population.

b. *Expectation of life:* Life expectancy at birth is "the average number of years that will be lived by those born alive into a population if the current age-specific mortality rates persist". Life expectancy at birth is highly influenced by the infant mortality rate where that is high. Life expectancy at the age of 1 excludes the influence of infant mortality, and life expectancy at the age of 5 excludes the influence of child mortality. Life expectancy at birth is used most frequently. It is estimated for both sexes separately. It indicates an increase in the health status. Life expectancy is a good indicator of socio-economic development in general. As an indicator of long-term survival, it can be considered as a positive health indicator. It has been adopted; as a global health indicator. A minimum life expectancy at birth of 60 years is the goal of health for all by 2000 AD. For Nigeria life expectancy is 62.8 for urban and 53.7 in rural areas at present.

c. *Infant mortality rate:* Infant mortality rate (IMT) is the ratio of deaths under 1 year of age in a given year to the total number of live births in the same year, usually expressed as a rate per 1000 live births. It is one of the most universally accepted indicators of health status not only of infants, but also of whole populations and of the socioeconomic conditions under which they live. In addition, the infant mortality rate is a sensitive indicator of the availability, utilization and effectiveness of health care, particularly perinatal care. The global strategy of health for

all has suggested an infant mortality rate not more than 50 per 1000 live births by 2000 AD. In 1991 the IMR in Nigeria is 80 per thousand live births.

d. *Child mortality rate:* Another indicator related to the overall health status is the early childhood (1-4 years) mortality rate. It is defined as the number of deaths at ages 1-4 years in a given year, per 1000 children in that age group at the mid-point of the year concerned. It thus excludes infant mortality. In Nigeria the CMR is 18.2 for urban and 39.4 in rural area at present. Apart from its correlation with inadequate MCH services, it is also related to insufficient nutrition, low coverage by immunization and adverse environmental exposure and other exogenous agents.

Mortality indicators represent the traditional measures of health status. Even today they are probably the most often used indirect indicators of health. As infectious diseases have been brought under control, mortality rates have declined to very low levels in many countries. Consequently, mortality indicators are losing the sensitivity as health indicators in developed countries. However, mortality indicators continue to be used as the starting point in health status evaluation.

Morbidity indicators

To describe health in terms of mortality rates only is misleading. This is because; mortality indicators do not reveal the burden of ill health in a community, as for example mental illness, rheumatoid arthritis. Therefore, morbidity indicators are used to supplement mortality data to describe the developing countries than in the developed countries. The child mortality rate may be as much as 250 time higher. This indicates the magnitude of the gap and the room for improvement in the health status of developing and developed countries.

Maternal (puerperal) mortality rate: Maternal (puerperal) mortality accounts for the greatest proportion of deaths among women of reproductive age in most of the developing world, although its importance is not always evident from official statistics. There are enormous variations in maternal mortality according to country level of socioeconomic status. At present in Nigeria the MMR is 3-4. There are enormous variations in maternal mortality according to country level of socioeconomic status. At present in Nigeria the MMR is 3-4 per 10,000 deliveries against our national target of below 2 per 10,000 by 2000 AD.
Disease-specific mortality: Mortality rates can be computed for specific diseases. As countries begin to extricate themselves from the burden of communicable diseases, a number of other indicators such as deaths from cancer, cardiovascular diseases, accidents, diabetes etc. have

emerged as measures of specific disease problems. Mortality statistics have also their own drawback. They tend to overlook a large number of conditions which are sub clinics, in apparent, that is, the hidden part of the iceberg of disease.

The following morbidity rates are used for assessing ill health in community

i. incidence and prevalence
ii. notification rates
iii. Attendance rates at out-patient departments, health centers, etc.
iv. Admission, readmission and discharge rates
v. Duration of stay in hospital, and
vi. Spells of sickness or absence from work or school

Nutrition status indicators

Nutrition status is a positive health indicator. Three nutritional status indicators are considered important as indicators of health status. They are:

a. anthropometrics measurements of preschool children, e.g. weight and height, mid-arm circumference;
b. height (and sometimes weight) of children at school entry; and
c. prevalence of low birth weight (less than 2.5 kg.)

Health care delivery indicators

The frequently used indicators of health care delivery are:

a. Doctor population ratio
b. Nurse population ratio
c. Population bed ratio
d. Population per health center/subcenters
e. Population per traditional birth attendant (TBA)

These indicators reflect the equity of distribution of health resources in different parts of the country, and of the provision of health care.

Utilization rates

In order to obtain additional information on health status the extent of use of health services is often investigated. Utilization of services-or actual cover- age-is expressed as the proportion of people in need of a service who actually receive it in a given period, usually a year. It is argued that utilization rates give some indication of the care needed by a

population and therefore, the health status of the population. In other words, a relationship exists between utilization of health care services and health needs and status. Health care utilization is also affected by factors such as availability and accessibility of health services and the attitude of an individual towards his health and the health care system. A few examples of utilization rates are given below:

a. proportion of infants who are "fully immunized" against the 6 preventable disease through national programme of immunization (NPI)
b. proportion of pregnant women who receive antenatal care, or have their deliveries supervised by a trained birth attendant.
c. Percentage of the population using the various methods of family planning.
d. Bed-occupancy rate (i.e., average daily in-patient census/average number of beds).
e. Average number of patients using the health centre clinics.

The above list is neither exhaustive nor all inclusive. The list can be expanded depending upon the services provided. These indicators direct attention away from the biological aspects of disease in a population towards the discharge of social responsibility for the organization in delivery of health care services.

Indicators of social and mental health

As long as valid positive indicators of social and mental health are scarce, it is necessary to use indirect measures, viz, indicators of social and mental pathology. These include suicide, homicide, other acts of violence and other crime; road traffic accidents, juvenile delinquency, alcohol and drug abuse; smoking; consumption of tranquilizers; obesity, etc. To these may be added family violence, battered-baby and battered-wife syndromes and neglected and abandoned youth in the neighborhood. These social indicators provide a guide to social action for improving the health of the people.

Environmental indicators

Environmental indicators reflect the quality of physical and biological envi- ronment in which diseases occur and in which the people live. They include indicators relating to pollution of air and water, radiation, solid wastes, noise, exposure to toxic substances in food or drink. Among these, the most useful indicators are those measuring the proportion of population having access to safe water and sanitation facilities, as for example, percentage of households with safe water in the home or within 15 Minutes walking distance from a water standpoint

or protected well, adequate sanitary facilities in the home or immediate vicinity.

Socioeconomic indicators

These indicators do not directly measure health. Nevertheless, they are of great importance in the interpretation of the indicators of health care. These include:

a. rate of population increases
b. per capita GNP
c. level of unemployment
d. dependency ratio, literacy rates, especially female literacy rates f. family size
g. housing; the number of persons per room h. per capita "calorie" availability

Other indicator series

a. social indicators: Social indicators, as defined by the United Nations Statistical Office, have been divided into 12 categories: population, family formation, families and households, learning and educational services, earning activities, distribution of income, consumption, and accumulation, social security and welfare services, health services and nutrition, housing and its environment, public order and safety, time use, leisure and culture, social stratification and mobility.

c. *Basic needs indicators:* Basic needs indicators are used by ILO.

Those mentioned in "Basic needs performance" include calorie consump- tion; access to water; life expectancy; deaths due to disease; illiteracy, doctors, and nurses per population; rooms per person; GNP per capita.

d. *Health/or all indicators:* For monitoring progress towards the goal of health for all by 2000 AD, the WHO has listed the following four categories of indicators.

- Health policy indicators
- Social and economic indicators related to health
- Indication for the provision of health care
- Health status indicators.

4.6.3 Details of indicators selected for monitoring progress towards health for all

a. Health policy indicators

- political commitment to health for all
- resource allocation -the degree of equity of distribution of health services
- community involvement
- organizational framework and managerial process

b. Social and economic indicators related to health: -rate of population increase -GNP or GDP

- income distribution -work conditions
- adult literacy rate -housing
- food availability

c. Indicators for the provision of health care:

- availability
- accessibility
- utilization
- quality of care

d. Health status indicators

- low birth weight (percentage)
- nutritional status and psychosocial development of child -infant mortality rate
- child mortality rate (1-4 years) -life expectancy at birth
- maternal mortality rate
- disease specific mortality
- morbidity-incidence and prevalence
- disability prevalence

Self-Assessment Exercises 4

Situation: In the year 1992 an urban community' A' is inhabited by a group of people having birth rate of 40 per 1000 population have evidenced with 320 unfortunate children who could not see their 1st birthday.
i) Calculate the total number of live births in the community and calculate the infant mortality rate of the above community *'A'*.
ii) List five health care delivery indicators.
a) b) c) d) e).

4.7 Summary

Monitoring and evaluation are the essential parts of the strategy. To monitor progress during implementation and to evaluate its effect, a suitable monitoring and evaluation process will be set up. Indicators at the national level such as health indicators for the provision of health care and health status indicators will be used. At the global level evaluation will be based on the number of countries in which certain indicators comply with predetermined norms. These are: endorsement of policy at the highest official level, availa- bility of primary health to the whole population, equitable distribution of resources, life expectancy at birth over 60 years, literacy rate over 70%, and infant mortality rate below 50 per 1000 live births. At the international level, WHO's mechanisms will be used for reporting on progress and assessing the impact of the strategy.

4.8 References/Further Readings/Web Resources

Bates G, Jones L. *Monitoring and evaluation: A guide for community projects*. Liverpool: John Moores University Centre for Public Health; 2012. Available from: http://www.cph.org.uk/wp-content/uploads/2013/02/Monitoring-and-evaluation-a-guide-for-community-projects.pdf

Carter I, editor. Increasing our Impact. *Footsteps*. 2001; 50. Tearfund. Available from: http://tilz.tearfund.org/~/media/files/tilz/publications/footsteps/footsteps%2041-50/50/fs50.pdf
Community Sustainability Engagement Evaluation Toolbox. Available from: http://evaluationtoolbox.net.au/

Gosling L, Edwards M. *Toolkits: A practical guide to assessment, monitoring, review and evaluation*. London: Save the Children Fund; 1995. Available from: http://www.savethechildren.org.uk/resources/online-library/toolkits-practical-guide-planning-monitoring-evaluation-and-impact
International Federation of Red Cross and Red Crescent Societies. *Project/programme monitoring and evaluation (M&E) guide*. 2011. Available

from: http://www.ifrc.org/Global/Publications/monitoring/IFRC-ME-Guide-8-2011.pdf

WK Kellogg Foundation. *W.K. Kellogg Foundation Evaluation Handbook*. Battle Creek, MI: WK Kellogg Foundation; 2004. Available at: http://cyc.brandeis.edu/pdfs/reports/EvaluationHandbook.pdf *Participatory impact monitoring: Selected reading examples*. Eschborn: GATE; 1996. Available from: http://www.sswm.info/sites/default/files/reference_attachments/GTZ%20ny%20Participatory%20Impact%20Monitoring%20Selected%20Reading%20Examples.pdf

Rubin F. *A basic guide to evaluation for development workers*. Oxford: Oxfam; 1995. Available from: http://policy-practice.oxfam.org.uk/publications/a-basic-guide-to-evaluation-for-development-workers-121038

United Nations Development Group. *Monitoring and evaluation: UNDAF companion guidance*. New York: UNDG; 2005. Available online from: https://undg.org/wp-content/uploads/2017/06/UNDG-UNDAF-Companion-Pieces-6-Monitoring-And-Evaluation.pdf

U.S. Department of Health and Human Services Centers for Disease Control and Prevention. Office of the Director, Office of Strategy and Innovation. *Introduction to program evaluation for public health programs: A self-study guide.* Atlanta, GA: Centers for Disease Control and Prevention, 2011. Available at: https://www.cdc.gov/eval/guide/cdcevalmanual.pdf:

Valadez J, Weiss W, Leburg C, Davis R. *Assessing community health programmes: A trainer's guide*. Lusaka: TALC; 2007. A participant's manual and workbook are also available.

World Bank. *Sleeping on our own mats: An introductory guide to community-based monitoring and evaluation*. Washington, DC: World Bank; 2002

4.9 Possible answers to SAEs

Answer to SAE 1

i) a) Public sector
a) Private sector

b) Voluntary agencies
c) Indigenous medicine
d) International agencies.

ii) a) Engage in technical cooperation with its Member States to ensure the maximum mobilization and development of personnel for health
b) Organize the collation and international use of information regarding people and groups who can provide support to the strategy.
c) promote dialogues between developing and developed countries to prevent the brain-drain of health personnel.

Answer to SAEs 2

i) a) True b) False c) False d) True
ii) WHO will ensure exchange of information on alternate ways of financing health systems. It will estimate the order of magnitude of financial needs for the strategy. Support developing countries on request in preparing proposals for external funding for health and will work together with other multilateral and bilateral agencies, foundations and 'Health For All' Resources group to rationalize international transfer of resources.

Answer to SAEs 3

i) a) True b) False c) False d) True
ii) a) Identification of problem
b) Establishment of standard and criteria c) Plan the methodology to be applied
d) Gather information e) Analyse the results f) Take action g) Re-evaluate

Answer to SAEs 4

i) Total Live Birth of Community A = Birth Rate x Population

$$= \frac{40}{1000} \times 100,000 = 4,000 ,$$

$$IMR = \frac{\text{Deaths of children below 1 year}}{\text{Total live birth in the same year}} \times 1,000$$

$$IMR = \frac{320}{4000} \times 1000$$

= <u>80 per 1,000</u>

ii)
a) Doctor population ratio
b) Nurse population ratio

c) Population bed ratio
d) Population per health center/subcentre
e) Population per traditional birth attendant.

4.10 Tutor-Marked Assignment

1. What measures could be adopted to develop human resources (3 marks)
2. Monitoring and Evaluation are part of the managerial processes for national health development; what actions are required to achieve this (7 marks)

MODULE 3 FAMILY HEALTH CARE

Unit 1 Basic Concepts and Definitions of family and family health
Unit 2 Sustainable Development Goals
Unit 3 Maternal and Child Healthcare
Unit 4 Health Promotion

Glossary

Ethnography: has its roots in social anthropology which traditionally focuses in small scale communities that were thought to share culturally specific belief and practices.

Family: a group of persons united by blood, adoptive, marital, or equivalent ties, usually sharing the same dwelling unit. The **extended family** is multigenerational; the **nuclear family**, in contrast, is a single generation family, usually husband-wife-children, but is often headed by a single parent.

Germ theory: the theory that specific microorganisms cause characteristic infectious diseases. This in contrast to miasma theory which attributed disease to influences spread in the air as a result of decaying organic matter.

Globalization: is the process of increasing economic, political, and social interdependence that takes place as capital, traded goods, persons, concepts, images, and values diffuse across the state boundaries.

Health Economics: economics principles applied to the health field. One role of health economics is to provide a set of analytical techniques to assist decision-making, usually in the health care sector, to promote efficiency and equity.

Health Education: is a process with intellectual, psychological and social dimensions affecting their personal, family and community wellbeing.

Health Policy: is a set of statements and decisions defining health priorities and main directions for attaining health goals.

Health Promotion: a concept, set of activities, or process aimed at increasing people's ability to control and improve their health, and to reduce specific diseases and associated risk factors that reduce the health, wellbeing, and productive capacity of the individual and the society.

Health: a complete sate of mental, physical, social, and emotional well-being, not merely the absence of disease or infirmity.

Hygiene: means the science of health and embraces all factors which contribute to healthful living.

Immunization: protection of susceptible individuals from communicable diseases through administration of a living modified agent, a suspension of killed organisms (E.g., pertusis), a non-infective portion of an infective agent(e.g. ,hepatitis B), or an inactivated toxin(e.g. , tetanus toxoid) .

Intersectoral Collaboration is referred to the activities involving several sectors of the government, e.g., health, education, housing, industrial, etc., that, working together, can enhance health conditions more effectively than when working independently of one another.

Lifestyle: is the set of habits and customs that is influenced, modified, encouraged or constrained by the lifelong process of socialization. These habits and customs include use of substances such as alcohol, tobacco, tea, coffee; dietary habits, exercise, etc, which has important for health and are often the subject of epidemiological investigations.

Miasma Theory: the concept that epidemic disease transmission is due to “bad air” from decaying organic matter. Although proved to be scientifically unsound, it led to sanitary reforms that resulted in enormous progress in public health.

Occupation Health: is the specialized practice of medicine, public health, and ancillary health professions in an occupational setting.

Personal Hygiene: good personal hygiene means taking care of yourself everyday, from your hair to your feet, by following the rules of proper washing and grooming, healthful nutrition, and getting enough physical activity and rest.

Policy: a system that provides the logical framework and rationality of decision making for the achievement of intended objectives. It is the statements that guide and provide discretion within limited boundaries. Policy is a guide to action to change what would otherwise occur, a decision about and allocation of resources: the overall amount is a statement of commitment to certain areas of concern; the distribution of the amount shows the priorities of decision makers. Policy sets priorities and guides resources allocations.

Prevention is an intervention or intervention that interrupts the web of causality leading to one or more aspects of ill health.

Prevention: refers to the goals of medicine that are to promote health, to preserve health, to restore health when it is impaired, and to minimize suffering and distress.

Public Health: is defined as "organized community efforts aimed at the prevention of disease and promotion of health. It links many disciplines and rests up on the scientific core of epidemiology"; predominantly observational and committed to health of the populations. Ultimately, its many components must accommodate multiple causes acting in the dimensions of time, space, and structure, and thus at several relevant levels of organization (from molecules to the encompassing environment).

Rehabilitation: is the process of restoring a person's social identity by repossession of his/ her normal roles and functions in society.

Reproductive Health: World Health Organization (WHO) has defined reproductive health as follows: "within the framework of WHO's definition of health as a state of complete physical, mental, and social well being, and not merely the absence of disease or infirmity; reproductive health addresses the reproductive processes, functions and systems at all stages of life. Reproductive health therefore implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide, if when, and how often to do so. This definition focuses on right of men and women to be informed of and to have access to safe, effective, affordable, and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with best chance of having a healthy infant."

Strategy: is the determination of the basic long-term goals of an organization or government and the adoption of courses of an action and the allocation of resources necessary for carrying out these goals.

UNIT 1 BASIC CONCEPTS AND DEFINITIONS OF FAMILY AND FAMILY HEALTH

Unit Structure

1.1 Introduction
1.2 Intended Learning Outcomes
1.3 Concept of Family
 1.3.1 Family health
 1.3.2 Why focus on family health
 1.3.3 Components of Family health
1.4 Hygiene and Related concepts
 1.4.1 Importance of hygiene to the individual and community
1.5 Culture and health
 1.5.1 Relationship between culture and health
 1.5.2 Influence of culture on health
1.6 Summary
1.7 References/Further Readings/Web Resources
1.8 Possible answers to SAEs
1.9 Tutor-Marked Assignment

1.1 Introduction

Family is reckoned as the unit of society and living and therefore should be the unit of illness. Family has been variously treated as an independent, dependent, and intervening variable, as a participating, predisposing, and contributory factor in the aetiology, care, and treatment of both physical and mental illness, and also as a basic unit of interaction and transaction of healthcare. Family centered healthcare delivery could have a greater impact on addressing health and related issues and healthcare service utilization. It goes beyond providing care to individual patient to seeing them as being embedded in a family and providing services on that basis. PHC should adopt Family centered approach in an attempt to draw two areas normally considered only as part of the "social determinants of health" background, education, and family welfare into the foreground of primary healthcare practice. The core principles of family centered care are as follows:(i)treating clients and their families with dignity and respect,(ii)opening communication channels with clients and families,(iii)building up the strengths of client and family and promoting partnership between them,(iv)viewing client and family members as individuals and as members of a family and a community,(v)regarding family as a key source of information about their relatives' and their own needs,(vi)tailoring the services to fit family needs and preferences and also ensuring that services are apt for a family's culture and traditions.

1.2 Intended Learning Outcomes

By the end of this unit, you will be able to:

- Define Family and family health.
- Describe the reason why there is a focus on family health.
- Discuss components of Family health
- Explain the concept of Hygiene.
- Analyse the importance of hygiene to the individual and community
- Discuss the influence of culture on health.
- Describe the relationship between culture and health

1.3 Family

Family is a social unit composed of group of individuals who are related by blood or marriage or adoption, live under the same roof and share a common kitchen, and/or share common social responsibilities. Such social unit is defined primarily by reference to relationships which pertain to arise from reproductive process and which are regulated by law or custom, especially relationship established between a couple by marriage and those existing between a couple as parents and their children. However, it has to be differentiated from household. Household consists of a group of individuals who share living quarters, take their principal meal from the same kitchen, i.e. live under the same roof, and eat from the same kitchen. There are two types of households-private households (or family households) and institutional (or non-family) households like hostels, jail, etc.

Nuclear family

Nuclear family includes a male and female couple related by marriage or living together by common consent, with or without children.

Extended family

The extended family is multigenerational and consists of the nuclear family and relatives of both parties, whether or not living in close geographic proximity. The extended family provides a broader basis of mutual support.

1.3.1 Family Health

Family Health deals with problem of health of the whole family as a single and fundamental social unit. Special and great emphasis is given to family health since the problems of rapidly growing populations have important consequences at the family, community and the national level. Problems of maternal and child health, and human reproduction, including family planning, are now seen as aspects of the greater problem of the health of the whole family.

In developing countries like Ethiopia, families often consist of large numbers of children born to poorly educated parents living in poverty. The father or less commonly the mother may be absent for long periods while working in a distant place. This can create serious health hazards for all family members. In societies where death of adults occurs from civil wars, famine, or infectious diseases such as AIDS, raising of children by single parents, neighbors, or older siblings is common. Abandonment of children is also common in such situations.

1.3.2 Why do we focus on family health?

The family structure provides an important foundation for physical and emotional health of the individual and the community. A healthy family is a basis for a healthy society and healthy nation. Marital and family status and interaction among family members affect each person's health and the well being of the community and nations Family health mainly focuses on maternal (mother's) heath and child health. Both at the national level and internationally, maternal and child health are among the major priorities with special focus on primary health care, since women and children have health needs different from those of the general population. Public health must be sensitive to the special needs of the family by providing appropriate health promotion, disease prevention, medical care and support programs for each member of the family and the family as a whole.

Maternal health

Maternal health deals with insuring safe motherhood for all women of the world. This includes care for females starting from their conception through various stages of growth and development with special emphasis to women of childbearing age. Here pregnant mothers will get great emphasis towards care before delivery (prenatal care), care during labor and delivery (childbirth), and care after delivery (postnatal care) and family planning.

Women's health issues relate to their many roles: as individuals,

workers, wives, mothers, and daughters. This demand for lifelong responsibilities for knowledge, self-care, and family leadership in health-related issues, such as nutrition, hygiene, education, exercise, safety, fertility, child care, and care of the elderly. Changes in the social roles of women create extra demand and risks in health.

Family Planning

It is a conscious effort on the part of a couple in planning the size of the family and thus consists of the restrictions of births or limitation of births either temporarily to achieve the planned interval between successive births or permanently to prevent more births than planned by the usage of various contraceptive techniques. Family planning and spacing of pregnancy is a vital issue in developing countries, where the burden of frequent pregnancies contributes to high maternal and infant mortality rates. It enables women to determine the time, spacing, and frequency of pregnancy, as well as adoption of children. Accordingly, it prevents Too Early (e.g., Teenage), Too Soon (e.g. Short inter pregnancy interval), Too Many (e.g. Too many pregnancies and children) and Too Late (e.g. in older women >35 years) pregnancies. It includes a range of methods for preventing or terminating pregnancies, while maintaining a normal sex life. Male's involvement is of paramount importance in family planning especially in the decision making.

Child health

Public health has long played a major leadership role in improving the health of children by provision of care and regulation of conditions to prevent disease, provide early and adequate care of illness, and promote health.

Child health includes care for newborns, breast feeding and feeding practices, Immunization, growth monitoring and well-baby clinics, treatment of common childhood infections, school health activities and advocating for the rights of children.

Self-Assessment Exercises 1

i)What is family health and why is there a focus on family health in the health system?

1.4 Hygiene and Related Concepts

The concept of hygiene dates back to the time when the first man has moved in to the caves to protect himself from the forces of nature that

act against his survival. The known religious leaders, Prophet Moses and Prophet Mohammed have stated to their followers to wash their body before religious practices and even before meal. This practice is more probably true to the other religions and sects of the world.

Hygiene is a word derived from Hygeine the goddess of health in Greek mythology meaning the science of health and embraces all factors, which contribute to healthful living. Hygiene is also defined as the science that deals with the establishment and maintenance of health in the individual and the group, conditions, and practices conducive to health. Hygiene can be classified into community hygiene and personal hygiene. Community hygiene might include industrial hygiene, social hygiene, food hygiene, etc.

Personal Hygiene is part of hygiene, which tells us how an individual preserves, improves and maintains the health of his own mind and body. It is taking care of yourself every day, from your hair to your feet, by following the rules of proper washing and grooming, healthful nutrition, and getting enough physical activity and rest. Personal hygiene and health are greatly affected by heredity and environment; it can be discussed in terms of constitution, posture, habit, sunshine, rest and sleep, fatigue, exercise, emotions, cleanliness of the body, mental hygiene and nutrition.

Constitution means physical make-up of the body in relation to one's health vitality or condition of mind, which may greatly be influenced by the environment. The human body is constituted of several systems of organs. They work together although they perform a particular job to keep the human body alive and active.

Posture is attitude/ way of holding the body. Good posture is highly appreciable and a social asset because of its aesthetic value. Poor posture interferes with respiration and diaphragm movement, flow of blood, circulatory and digestive system. Congenital structure ill fitted footwear and high heels occupation which keeps body in incorrect posture for a long time and poor nutrition are some of the causes of incorrect posture.

Habit is settled or regular tendency or practice, especially one that is hard to give up. Habits grow out of our routines. Some habits are acquired from parents through unconscious imitation. Forming of good habits will determine a child's actions and thinking. Training in good habits both physical and mental have a definite effect on life.

Sunlight and fresh air have double beneficial action. They stimulate one's mind and produce important effects on skin, thus improving the

metabolism of the body.

Rest and sleep are needed for maintaining health. During sleep mind is set at rest. Repair and growth of the tissues take place during sleep because during working hours our tissues and nerves are constantly subjected to wear and tear. To take rest and have sufficient amount of sleep is necessary. Fatigue is the feeling of tiredness or weariness form muscular activity. It also means weariness resulting from either bodily or mental exertion in response of stimuli to any organs over activity.

Exercise is the basis for the healthy body for majority of people. It is important for maintaining health and vigor and to promote growth. Ability to think and perceive is enhanced by means of exercise. Without exercise, the whole body becomes sluggish.

Emotion is a "stirred up" state of the organism; it is a subjective feeling state, which can influence perception, thinking, and behavior; usually accompanied by facial and bodily expressions; an excited state of mind based on a physiological departure from homeostasis. It includes love, hate, fear, grief, angry or joy experienced unconsciously due to some drive.

Nutrition is defined as the series of processes by which an organism takes in and assimilates food for promoting growth and replacing worn out and injured tissues.

Cleanliness of the body includes both, care of hair, teeth, eyes, ears, nails, care of the feet, hand etc. Menstrual hygiene means taking care of the sanitary condition of the vulvae. Menstruation is a normal physiological process of a normal womanhood.

1.4.1 Role of Hygiene in the prevention of diseases

Keeping personal cleanliness costs very little when it is compared with its importance. In this case, everybody can practice it at home with available materials.

1. Hands and fingers nails: unclean hands considered important routes of transmission for diseases. Fingernails, if not properly cleaned and trimmed are suitable for accumulation of dirt and microorganisms. As a result, food can be contaminated during preparation and pathogens can directly transfer into the mouth when eating.

Control measure to prevent the transmission of diseases form hands and fingernails:

- Keep fingernails always clean and short
- Use detergent (soap) for the hand before food preparation and eating
- Use hand washing after eating and toilet visit including some other activities

NB. Improper hand washing is not better than hand washing not at all. Proper hand washing reduces the microbial load though it is not as remarkable as washing using soaps.

2. The skin: Sweat and oily secretions from the skin cause dust to stick on its surface. This clogs the skin pores and interferes with the natural function of the skin. Human skin serves as physical barrier and also has self-disinfectant power. The disinfectant power of skin increases when the skin is clean
   Moreover, the bacteria can readily breed on unclean surface of the skin to cause various diseases and undesirable odor. Therefore, proper skin cleanliness is very relevant to break the transmission of disease.
3. Clothes: help to protect our body from harsh weather conditions. However, unclean cloths contribute to the multiplication of pests and the spread of pests born disease like relapsing fever. To prevent such health problems regular day and night clothes washing and ironing is advisable.
4. The mouth and teeth: Can harbor microorganisms when food particles left between the teeth. The microorganism uses this food as a nutrient, multiplies in larger numbers, and can cause gum and tooth disease as well as bad breath. Therefore, to prevent the problem regular tooth brushing is relevant.
5. The head: unclean hair and scalp can harbor different microorganisms and pests, like lice, which can transmit disease. Therefore, to prevent the problem regular washing with soap and warm water is highly encouraged.
6. The nose: It contains hairs in the nostrils that filter dirt and microorganism from the air. Thus, the nose serves as a protecting devise against the entrance of harmful substances into lungs and circulatory system. For this reason, the nostrils should always be kept clean by using a clean handkerchief or blowing at intervals to remove the accumulated dusts and spores.
7. The eye: Dirty eyes attract common housefly. Microorganisms carried by the flies' legs can be deposited in or near the eyes and may cause disease like trachoma, which eventually lead to blindness. Regular face washing with soap can break the transmission of such diseases
8. The Genitalia: Shaving the hair is one of the main important parts for the genital hygiene. It helps to avoid the harborage of pests

and make cleaning of the genital organ easier. Cleaning of the genital areas can be done during general body cleaning or taking shower. However, there are conditions when one needs special cleaning of genital areas. These are before and after sexual intercourse, during menstruation period, before and after delivery.

Self-Assessment Exercises 2

I)	Discuss the role of hygiene in the prevention of diseases.

1.5 Culture and Health

Culture is that complex whole which includes knowledge, belief, art, morale, law, customs and other capabilities and habits acquired by man as a member of society.

Culture refers to the sum total of the life- ways of a group of people who share values, beliefs and practices that are passed on from generation to generation, and which change through time. Culture is the sum totals of the things that people do because of having been taught. For the perpetuation of human race, man depends on culture, which is a learned behavior.

Culture is peculiar to human beings. It separates man and the society from that of animals and insects, whose behavior is always only instinctual and therefore does not change. Man's culture or learned behavior makes possible to change continuously.

The three suggested levels of culture include:

- Concrete - the most visible tangible artifacts such as clothes, music, art, food and games. Festivals and celebration focus on these dimensions.
- Behavioral - practices reflect values and defined social and gender roles, languages spoken, and approaches to non-verbal communication. Behavioral aspects of culture include language, gender roles, family structure, political affiliation, and community organization.
- Symbolic - values and belief are often expressed in symbols and rituals. Although often abstract, symbolic meaning is key to how people define themselves in relation to each other, the world and the universe. Symbolic expression includes value systems, religion, worldview, customs, spirituality, morals, and ethics.

1.5.1 Relation of Culture and Health

Culture is one of the determinants of health among the environmental factors. An individual's culture influences his or her attitude toward various health issues, including perceptions of what is and is not a health problem, methods of disease prevention, treatment of illness, and use of health providers. In every culture, the care of the sick person is clearly dictated not only as to what care he/she is given, but also who will do it and how he/she should proceed. We learn from our own cultural and ethnic backgrounds how to be healthy, how to recognize illness, and how to be ill. Meanings attached to the notions of health and illnesses are related to basic, culture-bound values by which we define a given experience and perceptions. People around the world have beliefs and behaviors related to health and illness that stem from cultural forces and individual experience and perceptions.

To understand the cultural context of health, it is essential to work with several key concepts:

1. The concept of insider and outsider

Perspectives are useful for examining when we are seeing things from our point of view and when we are trying to understand some one else's view of things. Insider shows the culture as viewed from within. It refers to the meaning that people attach to things from their cultural perspective. For example, the view worms (ascaris) in children are normal and are caused by eating sweets in the perspective within some cultures. The outsider perspective refers to something as seen from the outside. Rather than meaning, it conveys a structural approach, or something as seen without understanding its meaning for a culture. It can also convey an outsider's meaning attached to the same phenomenon. For example, that ascaris is contracted through eggs ingested by contact with contaminated soil or foods contaminated by contact with that soil. .

The concept of insider and outsider perspective allows us to look at health, illness and prevention and treatment systems from several perspectives; to analyze the differences between these perspectives; and to develop approaches that will work within a cultural context.

The insider-outsider concept leads to other sets of concepts. Disease in the insider, usually the western biomedical definition refers to an undesirable deviation from a measurable norm. Example deviation in temperature, white cell counts, and many others are seen as indicators of disease.

Illness on the other hand, means "not feeling well." thus, it is subjective, insider view. This set ups some immediate dissonance between the two views. It is possible to have an undesirable deviation from a western biomedical norm and to feel fine. For example, hypertension, early stage of cancer. HIV infection and early stages of diabetes are all instances where people might feel well, in spite of having a disease. This means that health care providers to “fix” something that people may not realize are wrong. It is also possible for someone to feel ill and for the western biomedical system not to identify a disease.

2. Ethnocentrisms refer to seeing one’s own culture as "best". This is a natural tendency, because the survival and perpetuation of a culture depends on teaching children to accept it and on its members feeling that it is a good thing. Cultural relativism in anthropology refers to the idea that each culture has developed its own ways of solving problems of how to live together; how to obtain the essential of life, such as food and shelter; how to explain phenomena; and so on.

No one is "better" or "worse"; they are just different. This is a challenge, what if a behavior is "wrong" from and epidemiological perspective. How does one distinguish between a 'dangerous' behavior (example, using HIV contaminated needle) and behavior that are merely different and therefore, seem odd? For example, Bolivian peasants use very fine clay in a drink believed to be good for digestion and stomach ailments. Health workers succeeded in discouraging this practice in some communities because 'eating dirt' seemed like a bad thing. The health workers then found themselves faced with increased caries (tooth decay) and other symptoms of calcium deficiency. Upon analysis, the clay was a key source of calcium for these communities.

Thus, there is a delicate balance between being judgmental without good reason and introducing behavior change because there is a real harm from existing behaviors. In general, it is best to live harmless practices alone and focus on understanding and changing harmful behaviors.

3. The concept of holism is also useful in looking at health and disease cross culturally. Holism is an approach used by anthropologists that looks at broad context of whatever phenomenon is being studied. Holism involves staying alert for unexpected influences, because one never knows what a bearing on the program may have one is trying to implement. For public health, this is crucial because there may be diverse factors influencing health and health behavior.

Self-Assessment Exercises 3

i)How does culture affect health of a certain community?

1.6 Summary

Unit 1 conceptualises family as a social unit composed of group of individuals who are related by blood or marriage or adoption, live under the same roof and share a common kitchen, and/or share common social responsibilities. Family Health therefore deals with problem of health of the whole family as a single and fundamental social unit. Special and great emphasis is given to family health since the problems of rapidly growing populations have important consequences at the family, community, and the national level. There is focus on family health because the family structure provides an important foundation for physical and emotional health of the individual and the community. A healthy family is a basis for a healthy society and healthy nation. Culture is one of the determinants of health among the environmental factors. An individual's culture influences his or her attitude toward various health issues, including perceptions of what is and is not a health problem, methods of disease prevention, treatment of illness, and use of health providers.

1.7 References/Further Readings/Web Resources

Additional Cultural Competency Tools and Resources

Coverdell, Paul D. World wise schools: Culture matters workbook: Thirteen cultural categories; American and host country views compared. Peace Corps.

Juckett, Gregory. Cross cultural medicine. Am Fam Physician. 2005;72(11):2267-74.

SickKids Hospital (Toronto, Ontario), Centre for Innovation and Excellence in Child and Family-centred Care. The Clinical Cultural Competence E-Learning Modules Series.

Webinar: Mind the Gap! Developing Skills to Navigate Cultural Issues with Newcomer Children, Youth, and Families, September 24, 2014

University of Minnesota, Center for Advanced Research on Language Acquisition. What is culture?

Nova Scotia Department of Health, Primary Health Care Section, 2005. A cultural competence guide for primary health care professionals in Nova Scotia.

Kodjo, C. Cultural competence in clinician communication. Paediatri Rev 2009;30(2):57-64.

University of Washington Medical Centre. Communication Guide: All Cultures. Culture Clue for Clinicians, 2011.

1.8 Possible answers to SAEs

Answer to SAE 1

Family Health deals with problem of health of the whole family as a single and fundamental social unit. Special and great emphasis is given to family health since the problems of rapidly growing populations have important consequences at the family, community and the national level.

There is focus on family health because

The family structure provides an important foundation for physical and emotional health of the individual and the community. A healthy family is a basis for a healthy society and healthy nation. Marital and family status and interaction among family members affect each person's health and the well being of the community and nations Family health mainly focuses on maternal (mother's) heath and child health. Both at the national level and internationally, maternal and child health are among the major priorities with special focus on primary health care, since women and children have health needs different form those of the general population. Public health must be sensitive to the special needs of the family by providing appropriate health promotion, disease prevention, medical care and support programs for each member of the family and the family as a whole.

Answer to SAE 2

Keeping personal cleanliness costs very little when it is compared with its importance. In this case, everybody can practice it at home with available materials.

1. Hands and fingers nails: unclean hands considered important routes of transmission for diseases. Fingernails, if not properly cleaned and trimmed are suitable for accumulation of dirt and microorganisms. As a result, food can be contaminated during preparation and pathogens can directly transfer into the mouth when eating.

Control measure to prevent the transmission of diseases form hands and fingernails:

- Keep fingernails always clean and short
- Use detergent (soap) for the hand before food preparation and eating
- Use hand washing after eating and toilet visit including some other activities

NB. Improper hand washing is not better than hand washing not at all. Proper hand washing reduces the microbial load though it is not as remarkable as washing using soaps.

2. The skin: Sweat and oily secretions from the skin cause dust to stick on its surface. This clogs the skin pores and interferes with the natural function of the skin. Human skin serves as physical barrier and also has self-disinfectant power. The disinfectant power of skin increases when the skin is clean

Moreover, the bacteria can readily breed on unclean surface of the skin to cause various diseases and undesirable odor. Therefore, proper skin cleanliness is very relevant to break the transmission of disease.

3. Clothes: help to protect our body from harsh weather conditions. However, unclean cloths contribute to the multiplication of pests and the spread of pests born disease like relapsing fever. To prevent such health problems regular day and night clothes washing and ironing is advisable.
4. The mouth and teeth: Can harbor microorganisms when food particles left between the teeth. The microorganism uses this food as a nutrient, multiplies in larger numbers, and can cause gum and tooth disease as well as bad breath. Therefore, to prevent the problem regular tooth brushing is relevant.
5. The head: unclean hair and scalp can harbor different microorganisms and pests, like lice, which can transmit disease.

Therefore, to prevent the problem regular washing with soap and warm water is highly encouraged.

6. The nose: It contains hairs in the nostrils that filter dirt and microorganism from the air. Thus, the nose serves as a protecting devise against the entrance of harmful substances into lungs and circulatory system. For this reason, the nostrils should always be kept clean by using a clean handkerchief or blowing at intervals to remove the accumulated dusts and spores.
7. The eye: Dirty eyes attract common housefly. Microorganisms carried by the flies' legs can be deposited in or near the eyes and may cause disease like trachoma, which eventually lead to blindness. Regular face washing with soap can break the

transmission of such diseases

8. The Genitalia: Shaving the hair is one of the main important parts for the genital hygiene. It helps to avoid the harborage of pests and make cleaning of the genital organ easier. Cleaning of the genital areas can be done during general body cleaning or taking shower. However, there are conditions when one needs special cleaning of genital areas. These are before and after sexual intercourse, during menstruation period, before and after delivery.

Answer to SAE 3

Culture is one of the determinants of health among the environmental factors. An individual's culture influences his or her attitude toward various health issues, including perceptions of what is and is not a health problem, methods of disease prevention, treatment of illness, and use of health providers. In every culture, the care of the sick person is clearly dictated not only as to what care he/she is given, but also who will do it and how he/she should proceed. We learn from our own cultural and ethnic backgrounds how to be healthy, how to recognize illness, and how to be ill. Meanings attached to the notions of health and illnesses are related to basic, culture-bound values by which we define a given experience and perceptions. People around the world have beliefs and behaviors related to health and illness that stem from cultural forces and individual experience and perceptions.

1.9 Tutor-Marked Assignment

1. Justify the reasons for focus on family health (3 marks)
2. What are the components of family health (3 marks)
3. Discuss the influence of culture on health (4 marks)

UNIT 2 SUSTAINABLE DEVELOPMENT GOALS

Unit Structure

2.1 Introduction
2.2 Intended Learning Outcomes
2.3 Sustainable Development Goals
 2.3.1 History of SDGs
 2.3.2 Differences between MDGs and SGDs
2.4 The 17 SGDs
 2.4.1 Nine Targets Health Related SDGs
 2.4.2 Health -related SDGs
2.5 Universal Health Coverage UHC
2.6 Challenges of UHC
2.7 Role of the Nurse
2.8 Monitoring of the SDGs
2.9 Cross-cutting issues and synergies
 2.10 Sustainability and Barriers of SDGs
 2.10.1 Competing and too many goals
 2.10.2 Weakness and environmental sustainability
 2.10.3 Importance of technology and connectivity
 2.10.4 Implementation and Support
2.11 Challenges
2.12 Summary
2.13 References/Further Readings/Web Resources
2.14 Possible answers to SAEs

2.1 Introduction

The Sustainable Development Goals (SDGs), otherwise known as the Global Goals, are a set of objectives within a universal agreement to end poverty, protect all that makes the planet habitable, and ensure that all people enjoy peace and prosperity, now and in the future. The Goals were adopted by all member states of United Nations formally in 2015, for the period 2016–30 to address the over-whelming empirical and scientific evidence that the world needs a radically more sustainable approach. The goals provide a well consulted framework that is sufficiently scientifically robust, politically acceptable, and publicly intuitive. The goals provide us with our best chance of ensuring the necessary collaboration and alignment as we implement global approaches to securing a fair, healthy and prosperous future for ourselves, our children and grandchildren.

2.2 Intended Learning Outcomes

By the end of this unit, you will be able to:

- Define Sustainable Development Goals (SDGs)
- Distinguish between Millennium Development Goals & SDGs
- State the 17 SDGs
- Identify the health-related SDGs
- State the 9 targets of the health-related SDGs
- Define UHC
- Analyse challenges of SDGs
- Discuss the role of the Nurse in achieving the health -related SDG

2.3 Sustainable Development Goals

The Sustainable Development Goals (SDGs), also known as the Global Goals, were adopted by the United Nations in 2015 as a universal call to action to end poverty, protect the planet, and ensure that by 2030 all people enjoy peace and prosperity. The 17 SDGs are integrated—they recognize that action in one area will affect outcomes in others, and that development must balance social, economic and environmental sustainability. Countries have committed to prioritize progress for those who're furthest behind. The SDGs are designed to end poverty, hunger, AIDS, and discrimination against women and girls. The creativity, knowhow, technology and financial resources from all of society is necessary to achieve the SDGs in every context.

These 17 Goals build on the successes of the millennium development goals while including new areas such as climate change, economic inequality, innovation, sustainable consumption, peace and justice, among other priorities.

2.3.1 History

The 2030 Agenda for Sustainable Development, adopted by all United Nations Member States in 2015, provides a shared blueprint for peace and prosperity for people and the planet, now and into the future. At its heart are the 17 Sustainable Development Goals (SDGs), which are an urgent call for action by all countries - developed and developing - in a global partnership. They recognize that ending poverty and other deprivations must go hand-in-hand with strategies that improve health

and education, reduce inequality, and spur economic growth – all while tackling climate change and working to preserve our oceans and forests. The SDGs build on decades of work by countries and the UN, including the UN Department of Economic and Social Affairs

- In June 1992, at the Earth Summit in Rio de Janeiro, Brazil, more than 178 countries adopted Agenda 21, a comprehensive plan of action to build a global partnership for sustainable development to improve human lives and protect the environment.
- Member States unanimously adopted the Millennium Declaration at the Millennium Summit in September 2000 at UN Headquarters in New York. The Summit led to the elaboration of eight Millennium Development Goals (MDGs) to reduce extreme poverty by 2015.
- The Johannesburg Declaration on Sustainable Development and the Plan of Implementation, adopted at the World Summit on Sustainable Development in South Africa in 2002, reaffirmed the global community's commitments to poverty eradication and the environment, and built on Agenda 21 and the Millennium Declaration by including more emphasis on multilateral partnerships.
- At the United Nations Conference on Sustainable Development (Rio+20) in Rio de Janeiro, Brazil, in June 2012, Member States adopted the outcome document "The Future We Want" in which they decided, inter alia, to launch a process to develop a set of SDGs to build upon the MDGs and to establish the UN High-level Political Forum on Sustainable Development. The Rio +20 outcome also contained other measures for implementing sustainable development, including mandates for future programmes of work in development financing, small island developing states and more.
- In 2013, the General Assembly set up a 30-member Open Working Group to develop a proposal on the SDGs.
- In January 2015, the General Assembly began the negotiation process on the post-2015 development agenda. The process culminated in the subsequent adoption of the 2030 Agenda for Sustainable Development, with 17 SDGs at its core, at the UN Sustainable Development Summit in September 2015.
- 2015 was a landmark year for multilateralism and international policy shaping, with the adoption of several major agreements:
- Sendai Framework for Disaster Risk Reduction (March 2015)
- Addis Ababa Action Agenda on Financing for Development (July 2015)
- Transforming our world: the 2030 Agenda for Sustainable Development with its 17 SDGs was adopted at the UN

Sustainable Development Summit in New York in September 2015.
- Paris Agreement on Climate Change (December 2015)
- Now, the annual High-level Political Forum on Sustainable Development serves as the central UN platform for the follow-up and review of the SDGs.

Today, the Division for Sustainable Development Goals (DSDG) in the United Nations Department of Economic and Social Affairs (UNDESA) provides substantive support and capacity-building for the SDGs and their related thematic issues, including water, energy, climate, oceans, urbanization, transport, science and technology, the Global Sustainable Development Report (GSDR), partnerships and Small Island Developing States. DSDG plays a key role in the evaluation of UN systemwide implementation of the 2030 Agenda and on advocacy and outreach activities relating to the SDGs. In order to make the 2030 Agenda a reality, broad ownership of the SDGs must translate into a strong commitment by all stakeholders to implement the global goals. DSDG aims to help facilitate this engagement.

2.3.2 Differences between Millennium Development Goals and Sustainable Development Goals

SDGS ARE …

- A set of 17 goals for the world's future, until 2030
- Backed up by a set of 169 detailed Targets
- Negotiated over a two-year period at the United Nations
- Agreed to by nearly all the world's nations, on 25 Sept 2015

What is new and different about the 17 SDGs?

First, and most important, these Goals apply to *every* nation … and every sector. Cities, businesses, schools, organizations, *all* are challenged to act. This is called **Universality**

Second, it is recognized that the Goals are all inter-connected, in a system. We cannot aim to achieve just one Goal. We must achieve them all. This is called **Integration**

And finally, it is widely recognized that achieving these Goals involves making very big, fundamental changes in how we live on Earth. This is called **Transformation**

2.4 The 17 SDGs are:

(1) No Poverty,
(2) Zero Hunger,
(3) Good Health and Well-being,
(4) Quality Education
(5) Gender Equality
(6) Clean Water and Sanitation
(7) Affordable and Clean Energy
(8) Decent Work and Economic Growth
(9) Industry, Innovation and Infrastructure
(10) Reduced Inequality
(11) Sustainable Cities and Communities
(12) Responsible Consumption and Production
(13) Climate Action
(14) Life Below Water
(15) Life On Land
(16) Peace, Justice, and Strong Institutions
(17) Partnerships for the Goals.

Though the goals are broad and interdependent, two years later (6 July 2017) the SDGs were made more "actionable" by a UN Resolution adopted by the General Assembly. The resolution identifies specific targets for each goal, along with indicators that are being used to measure progress toward each target. The year by which the target is meant to be achieved is usually between 2020 and 2030. For some of the targets, no end date is given.

To facilitate monitoring, a variety of tools exist to track and visualize progress towards the goals. All intention is to make data more available and easily understood. For example, the online publication SDG Tracker, launched in June 2018, presents available data across all indicators. The SDGs pay attention to multiple cross-cutting issues, like gender equity, education, and culture cut across all of the SDGs. There were serious impacts and implications of the COVID-19 pandemic on all 17 SDGs in the year 2020.

2.4.1 Nine Target Health-related SDGs

Each goal is important in itself and they are all connected.

Goal3. Ensure healthy lives and promote wellbeing for all at all ages
3.1 By 2030 reduce the global maternal mortality ratio to less than 70 per 100,000 live births Nigeria 814 in 2015 [2nd highest in the world]
3.2 By 2030 end preventable deaths of newborns and under-five children 201/1000 in Nigeria

3.3 By 2030 end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases

3.4 By 2030 reduce by one third pre-mature mortality from non-communicable diseases (NCDs) through prevention and treatment, and promote mental health and wellbeing

3.5 Strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

3.6 By 2020 halve global deaths and injuries from road traffic accidents
3.7 By 2030 ensure universal access to sexual and reproductive health care services, including family planning information and education, & the integration of reproductive health into national strategies and programmes

3.8 Achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all

3.9 By 2030 substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination

3.9a Strengthen implementation n of the Framework Convention on Tobacco Control in all countries as appropriate GOAL

3.9b Support research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries

- Provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration which affirms the right of developing countries to use to the full the provisions in the
- TRIPS agreement regarding flexibilities to protect public health and provide access to medicines for all

2.4.2 GOAL 3: HEALTH RELATED

3.9c • Increase substantially health financing and the recruitment, development and training and retention of the health workforce in developing countries, especially in LDCs and SIDS

3.9d • Strengthen the capacity of all countries, particularly developing countries, for early warning, risk reduction, and management of national and global health risks

Self-Assessment Exercises 1

i) What is SDGs?

ii) What is different and new about the SDGs?

iii) List the 17 SDGs

2.5 Universal Health Coverage (UHC)

- On December 12, 2012, the United Nations unanimously affirmed Universal Health Coverage as
- Important pillar of sustainable development
- Urging countries, civil society and international organizations to make it part of the development agenda.
- The International Universal Health Coverage Day (UHCD) is observed every year on December 12 to mobilize diverse stakeholders to call for stronger, more equitable health systems to achieve universal health coverage, leaving no one behind.
- The first universal health coverage day was held in 2014 in Abuja, Nigeria.
- 400 million persons lack access to one or more essential health services
- Annually 100 million persons fall into poverty paying for health care services 40 % of the world's persons lack social protection
- 32 % of each country's health expenditure comes from out of pocket expenses
- Universal Health Coverage means all people receive the quality health services they need without suffering financial hardship (World Health Report, 2010).

UHC combines two key elements

1. People's use of the health services they need
2. Economic consequences of doing so.

Universal Health Coverage (UHC) addresses the vision of Health for All more than the original Alma Ata Declaration.

- It provides a more comprehensive approach to essential health services (more than just PHC) It considers the financial aspect to them as well.
- However, a major gap in UHC compared to the original Alma Ata declaration
- Lack of focus on the involvement of family and community in the decisions of health care.

Objectives of Universal Health Coverage

- Everybody should be able to access a full range of health services including promotion, prevention, treatment, rehabilitation and palliative care.
- These services should be of good quality. It is of no use having access to a scanner that is poorly calibrated or run by an untrained health worker.
- Because the emphasis here is on everybody getting the treatment they need, the objective includes an important equity dimension.
- To ensure protection from the financial risk associated with seeking care.
- The need to pay for care at the point of use (whether through explicit policies on user fees or informal payments) discourages people from using services, and can cause financial hardship for those that do seek care.
- The best way around this is to expand coverage with compulsory prepayment of some type – e.g. taxes and other government charges
- social insurance premiums – that are subsequently pooled to spread risks.
- Contributions should reflect people's ability to pay which means that there will always need to be subsidies for the poor and vulnerable.
- The quality of health services should be good enough to improve the health of those receiving

Benefits of Universal Health Coverage

- Economic growth and development is facilitated
- Improved Life Expectancy
- Improvement in Health and Wellbeing for All
- UHC is affordable for middle income countries
- Reduced Mortality rates due to communicable diseases
- Reduction in Child mortality

2.6 CHALLENGES OF UHC

- Lack of adequate funding the health system in developing countries (Health watch, 2018)
- Lack of political will
- Nursing challenges for universal health coverage are Education and training
- Better working conditions clear definition of nursing role in primary health care (Schveitzer, Zoboli, & Vieira, 2016).
- The global emphasis on universal health coverage has put the spotlight on the revitalization of primary health care (PHC), particularly in resource constrained settings (Munyewende, Rispel & Chirwa, 2014)

2.7 The Role of the Nurse

"Nurses and midwives are the backbone of every health system. They account for more than half of the global health workforce and are vital for realizing the vision of universal health coverage (Ghebreyesus, 2019).

As the largest health profession in the world, working in all areas where health care is provided, nursing has vast potential and value if appropriately harnessed to finally achieve the vision of Health for All,"(Catton, 2019).

Client-oriented roles 1

Caregiver Uses the nursing process to provide direct nursing intervention to individuals, families, or population groups Educator Facilitates learning for positive health behavior change Counselor Teaches and assists clients in the use of the problem-solving process

Client-oriented roles 2

Advocate The nurse often acts as an advocate for clients, pleading their cause or acting on their behalf: Clients may need someone to: - - Explain which services to expect, which services they ought to receive. - Make referrals as needed. -Write letters to agencies or health care providers for them. - Assure the satisfaction of their needs.

Client-oriented roles 3

Advocacy Goals: There are two underlying goals in client advocacy.

1. To help clients gain greater independence or selfadministration. by: - Showing them what services are available. -The ones to which they are entitled, and how to obtain them.
2. To make the system more responsive and relevant to the needs of clients, by calling attention to inadequate, inaccessible, or unjust care, community health nurses can influence change.

Client-oriented roles 4

Advocacy Actions The advocate role incorporate four characteristics actions: 1. Being assertive. 2. Taking risks. 3. Communicating and negating well. 4. Identifying options and getting results. Primary care provider Provides essential health services to promote health, prevent illness, and deal with existing health problems.

Client-oriented roles 5

Referral resource Links clients to services to meet identified health needs Role model Demonstrates desired health-related behaviors Case manager Coordinates and directs the selection and use of health care services to meet client needs in order to maximize resource use & cut cost

Delivery-oriented roles

Coordinator/Care manager Organizes and integrates services to best meet client needs in the most efficient manner possible Collaborator Engages in shared decision making regarding the nature of health problems and potential solutions to them

Delivery-oriented roles

Liaison Provides and maintains connections and communication between clients and health care providers or among providers

Population-oriented roles

Community developer

Mobilizes residents and other segments of the population to act regarding identified community health problems or issues.

Coalition builder

Promotes the development and maintenance of alliances of individuals or groups of people to address a specific health issue.

Researcher

Carry out studies to explain health-related issues and to assess the effectiveness / efficiency of interventions to control them

Case finder

The nurse identifies clients with specific health problems or conditions. This role focus on awareness of population-level problems

Change agent

Initiates and facilitates change in individual or client behaviors or conditions or those affecting population groups

As a leader, the nurse directs, influences, or persuades others to effect change so as to positively affect people's health and move them toward a goal. The leading function includes

1. persuading and motivating people,
2. directing activities,
3. ensuring effective two-way communication,
4. resolving conflicts and coordinating the plan.
5. Coordination means bringing people and activities together so that they function in harmony while pursuing desired objectives.

2.8 Monitoring of the SDGs

The UN High-Level Political Forum on Sustainable Development (HLPF) is the annual space for global monitoring of the SDGs, under the auspices of the United Nations economic and Social Council. In July 2020 the meeting took place online for the first time due to the COVID-19 pandemic. The theme was "Accelerated action and transformative pathways: realizing the decade of action and delivery

for sustainable development" and a ministerial declaration was adopted. High-level progress reports for all the SDGs are published in the form of reports by the United Nations Secretary General. The most recent one is from April 2020.

The online publication SDG-Tracker was launched in June 2018 and presents data across all available indicators. It relies on the Our World in Data database and is also based at the University of Oxford. The publication has global coverage and tracks whether the world is making progress towards the SDGs. It aims to make the data on the 17 goals available and understandable to a wide audience.

The website "allows people around the world to hold their governments accountable to achieving the agreed goals". The SDG-Tracker highlights that the world is currently (early 2019) very far away from achieving the goals. The Global "SDG Index and Dashboards Report" is the first publication to track countries' performance on all 17 Sustainable Development Goals. The annual publication, co-produced by Bertelsmann Stiftung and SDSN, includes a ranking and dashboards that show key challenges for each country in terms of implementing the SDGs. The publication features trend analysis to show how countries performing on key SDG metrics have changed over recent years in addition to an analysis of government efforts to implement the SDGs.

2.9 Cross-cutting Issues and Synergies

To achieve sustainable development, three aspects or dimensions need to come together: The economic, socio-political, and environmental dimensions are all critically important and interdependent. Progress will require multidisciplinary and trans-disciplinary research across all three sectors. This proves difficult when major governments fail to support it. Sustainable development can enhance sectoral integration and social inclusion (robust evidence, high agreement). Inclusion merits attention because equity within and across countries is critical to transitions that are not simply rapid but also sustainable and just. Resource shortages, social divisions, inequitable distributions of wealth, poor infrastructure and limited access to advanced technologies can constrain the options and capacities for developing countries to achieve sustainable and just transitions (medium evidence, high agreement)

According to the UN, the target is to reach the community farthest behind. Commitments should be transformed into effective actions requiring a correct perception of target populations. Data or information must address all vulnerable groups such as children, elderly folks, persons with disabilities, refugees, indigenous peoples, migrants, and internally-displaced persons.

Cross cutting issues include for example gender equality, education, culture and health. These are just some examples of various interlinkages inherent in the SDGs.

Gender equality

The widespread consensus is that progress on all of the SDGs will be stalled if women's empowerment and gender equality are not prioritized and treated holistically. The SDGs look to policy makers as well as private sector executives and board members to work toward gender equality.[96][97] Statements from diverse sources, such as the Organisation for Economic Cooperation and Development (OECD), UN Women and the World Pensions Forum, have noted that investments in women and girls have positive impacts on economies. National and global development investments in women and girls often exceed their initial scope.

Gender equality is mainstreamed throughout the SDG framework by ensuring that as much sex-disaggregated data as possible are collected.

Education

Main article: Education for sustainable development

Education for sustainable development (ESD) is explicitly recognized in the SDGs as part of Target 4.7 of the SDG on education. UNESCO promotes the Global Citizenship Education (GCED) as a complementary approach.[100] At the same time, it is important to emphasize ESD's importance for all the other 16 SDGs. With its overall aim to develop cross-cutting sustainability competencies in learners, ESD is an essential contribution to all efforts to achieve the SDGs. This would enable individuals to contribute to sustainable development by promoting societal, economic and political change as well as by transforming their own behavior.

Culture

Culture is explicitly referenced in SDG 11 Target 4 ("Strengthen efforts to protect and safeguard the world's cultural and natural heritage"). However, culture is seen as a cross-cutting theme because it impacts several SDGs. For example, culture plays a role in SDGs related to:

- environment and resilience (Targets 11.4 Cultural & natural heritage, 11.7 Inclusive public spaces, 12.b Sustainable tourism management, 16.4 Recovery of stolen assets),

- prosperity and livelihoods (Targets 8.3 Jobs, entrepreneurship & innovation; 8.9 Policies for sustainable tourism),
- knowledge and skills,
- inclusion and participation (Targets 11.7 Inclusive public spaces, 16.7 Participatory decision-making).

Health

SDGs 1 to 6 directly address health disparities, primarily in developing countries.[102] These six goals address key issues in Global Public Health, Poverty, Hunger and Food security, Health, Education, Gender equality and women's empowerment, and water and sanitation. Public health officials can use these goals to set their own agenda and plan for smaller scale initiatives for their organizations. These goals are designed to lessen the burden of disease and inequality faced by developing countries and lead to a healthier future.

The links between the various sustainable development goals and public health are numerous and well established:

- Living below the poverty line is attributed to poorer health outcomes and can be even worse for persons living in developing countries where extreme poverty is more common.[103] A child born into poverty is twice as likely to die before the age of five compared to a child from a wealthier family.
- The detrimental effects of hunger and malnutrition that can arise from systemic challenges with food security are enormous. The World Health Organization estimates that 12.9 percent of the population in developing countries is undernourished.
- Health challenges in the developing world are enormous, with "only half of the women in developing nations receiving the recommended amount of healthcare they need.
- Educational equity has yet to be reached in the world. Public health efforts are impeded by this, as a lack of education can lead to poorer health outcomes. This is shown by children of mothers who have no education having a lower survival rate compared to children born to mothers with primary or greater levels of education. Cultural differences in the role of women vary by country, many gender inequalities are found in developing nations. Combating these inequalities has shown to also lead to a better public health outcome.
- In studies done by the World Bank on populations in developing countries, it was found that when women had more control over household resources, the children benefit through better access to food, healthcare, and education.

- Basic sanitation resources and access to clean sources of water are a basic human right. However, 1.8 billion people globally use a source of drinking water that is contaminated by feces, and 2.4 billion people lack access to basic sanitation facilities like toilets or pit latrines. A lack of these resources is what causes approximately 1000 children a day to die from diarrheal diseases that could have been prevented from better water and sanitation infrastructure.

Synergies

Synergies amongst the SDGs are seen as "the good antagonists of trade-offs". With regards to SDG 13 on climate action, the IPCC sees robust synergies particularly for the SDGs 3 (health), 7 (clean energy), 11 (cities and communities), 12 (responsible consumption and production) and 14 (oceans).

2.10 Sustainability and Barriers of the SGDs

The SDGs have been criticized for setting contradictory goals and for trying to do everything first, instead of focusing on the most urgent or fundamental priorities. The SDGs were an outcome from a UN conference that was not criticized by any major non-governmental organization (NGO). Instead, the SDGs received broad support from many NGOs.

A commentary in *The Economist* in 2015 said that the SDGs are "a mess" compared to the eight Millennium Development Goals (MDGs) used previously. Others have pointed out that the SDGs mark a shift from the MDGs and emphasize the interconnected environmental, social and economic aspects of development, by putting sustainability at their centre.

The SDGs may simply maintain the *status quo* and fall short of delivering on the ambitious development agenda. The current status quo has been described as "separating human wellbeing and environmental sustainability, failing to change governance and to pay attention to trade-offs, root causes of poverty and environmental degradation, and social justice issues".

Regarding the targets of the SDGs, there is generally weak evidence linking the "means of implementation" to outcomes. The targets about "means of implementation" (those denoted with a letter, for example, Target 6.a) are imperfectly conceptualized and inconsistently formulated, and tracking their largely qualitative indicators will be difficult.

The “wedding-cake” model of the SDGs assigns each of the SDGs to one of the three dimensions of sustainability, i.e. environmental ("biosphere"), social and economic

Competing and too many goals

A commentary in 2015 argued that 169 targets for the SDGs is too many, describing them as "sprawling, misconceived" and "a mess". The goals are said to ignore local context. All other 16 goals might be contingent on achieving SDG 1, ending poverty, which should have been at the top of a very short list of goals.

The trade-offs among the 17 SDGs are a difficult barrier to sustainability and might even prevent their realization. For example these are three difficult trade-offs to consider: "How can ending hunger be reconciled with environmental sustainability? (SDG targets 2.3 and 15.2) How can economic growth be reconciled with environmental sustainability? (SDG targets 9.2 and 9.4) How can income inequality be reconciled with economic growth? (SDG targets 10.1 and 8.1)."

Weak on environmental sustainability

Continued global economic growth of 3 percent (Goal 8) may not be reconcilable with ecological sustainability goals, because the required rate of absolute global eco-economic decoupling is far higher than any country has achieved in the past. Anthropologists have suggested that, instead of targeting aggregate GDP growth, the goals could target resource use per capita, with "substantial reductions in high-income nations."

Environmental constraints and planetary boundaries are underrepresented within the SDGs. For instance, the paper "Making the Sustainable Development Goals Consistent with Sustainability" points out that the way the current SDGs are structured leads to a negative correlation between environmental sustainability and SDGs. This means, as the environmental sustainability side of the SDGs is underrepresented, the resource security for all, particularly for lower-income populations, is put at risk. This is not a criticism of the SDGs *per se*, but a recognition that their environmental conditions are still weak.

The SDGs have been criticized for their inability to protect biodiversity. They could unintentionally promote environmental destruction in the name of sustainable development.

Scientists have proposed several ways to address the weaknesses regarding environmental sustainability in the SDGs:

- The monitoring of essential variables to better capture the essence of coupled environmental and social systems that underpin sustainable development, helping to guide coordination and systems transformation.
- More attention to the context of the biophysical systems in different places (e.g., coastal river deltas, mountain areas)
- Better understanding of feedbacks across scales in space (e.g., through globalization) and time (e.g., affecting future generations) that could ultimately determine the success or failure of the SDGs.

Self-Assessment Exercises 2

i)What are the barriers to the sustainability of SDGs?

2.11 Implementation and support

Implementation of the SDGs started worldwide in 2016. This process can also be called "Localizing the SDGs". Individual people, universities, governments, institutions and organizations of all kinds are working separately on one or more goals at the same time. Individual governments must translate the goals into national legislation, develop a plan of action, and establish their own budget. However, at the same time, they must be open to and actively searching for partners. Coordination at the international level is crucial, making partnerships valuable. The SDGs note that countries with less access to financial resources need partnerships with more well-to-do countries.

The co-chairs of the SDG negotiations each produced a book to help people to understand the Sustainable Development Goals and how they evolved. The books are: "Negotiating the Sustainable Development Goals: A transformational agenda for an insecure world" by Ambassador David Donoghue, Felix Dodds and Jimena Leiva and "Transforming Multilateral Diplomacy: The Inside Story of the Sustainable Development Goals" by Macharia Kamau, David O'Connor and Pamela Chasek.

A 2018 study in the journal *Nature* found that while "nearly all African countries demonstrated improvements for children under 5 years old for stunting, wasting, and underweight... much, if not all of the continent will fail to meet the Sustainable Development Goal target—to end malnutrition by 2030".

To meet the long-term United Nations Sustainable Development Goals (SDGs), sustained long-term investment in green innovation is required: to decarbonize the physical capital stock – energy, industry, and transportation infrastructure – and ensure its resilience to a changing future climate; to preserve and enhance natural capital – forests, oceans, and wetlands; and to train people to work in a climate-neutral economy.

2.12 Summary

The Sustainable Development Goals (SDGs) are **a set of global goals for fair and sustainable health at every level: from planetary biosphere to local community**. The aim is to end poverty, protect the planet and ensure that all people enjoy peace and prosperity, now and in the future.

2.13 References/Further Readings/Web Resources

United Nations (2017) Resolution adopted by the General Assembly on 6 July 2017, Work of the Statistical Commission pertaining to the 2030 Agenda for Sustainable Development

"SDG Indicators - Global indicator framework for the Sustainable Development Goals and targets of the 2030 Agenda for Sustainable Development". *United Nations Statistics Division (UNSD)*. Retrieved 6 June 2022.

SDG Tracker". Our World in Data. Retrieved 6 June 2022.

Schveitzer, M. C., Zoboli, E. L. C. P., & Vieira, M. M. D. S. (2016). Nursing challenges for universal health coverage: a systematic review. Revista latino-americana de enfermagem, 24.

"SDGs". *Nordic Waves ENG*. Retrieved 3 June 2022.

United Nations Economic and Social Council (2020) Progress towards the Sustainable Development Goals Report of the Secretary-General Archived 30 December 2020 at the Wayback Machine, High-level political forum on sustainable development, convened under the auspices of the Economic and Social Council (E/2020/57), 28 April 2022

"World leaders adopt Sustainable Development Goals". *United Nations Development Programme*. Archived from the original on 30 December 2020. Retrieved 25 June 2022.

"Transforming our world: the 2030 Agenda for Sustainable Development". *United Nations – Sustainable Development knowledge platform*. Archived from the original on 5 December 2017. Retrieved 23 June 2022.

Bartram, Jamie; Brocklehurst, Clarissa; Bradley, David; Muller, Mike; Evans, Barbara (December 2018). "Policy review of the means of implementation targets and indicators for the sustainable development goal for water and sanitation". *NPJ Clean Water*. **1** (1): 3.

IAEG-SDGs 2020 Comprehensive Review Proposals Submitted to the 51st session of the United Nations Statistical Commission for its consideration". *United Nations, Department of Economic and Social Affairs, Statistics Division*. Archived from the original on 30 June 2022. Retrieved 1 June 2022.

"SDG Indicator changes (15 October 2018 and onward) - current to 17 April 2020" (PDF). *United Nations, Department of Economic and Social Affairs, Statistics Division*.

Winfried, Huck (2019). Iovane, Massimo; Palombino, Fulvio; Amoroso, Daniele; Zarra, Giovanni (eds.). *Measuring Sustainable Development Goals (SDGs) with Indicators: Is Legitimacy Lacking?. The Protection of General Interests in Contemporary International Law: A Theoretical and Empirical Inquiry*. Oxford University Press.

2.14 Possible answers to SAEs

Answer to SAE 1

i. The Sustainable Development Goals (SDGs), also known as the Global Goals, were adopted by the United Nations in 2015 as a universal call to action to end poverty, protect the planet, and ensure that by 2030 all people enjoy peace and prosperity. The 17 SDGs are integrated—they recognize that action in one area will affect outcomes in others, and that development must balance social, economic and environmental sustainability. Countries have committed to prioritize progress for those who're furthest behind. The SDGs are designed to end poverty, hunger, AIDS, and discrimination against women and girls. The creativity,

knowhow, technology and financial resources from all of society is necessary to achieve the SDGs in every context.

i. **Differences between Millennium Development Goals and Sustainable Development Goals**

First, and most important, these Goals apply to *every* nation … and every sector. Cities, businesses, schools, organizations, *all* are challenged to act. This is called **Universality**

Second, it is recognized that the Goals are all inter-connected, in a system. We cannot aim to achieve just one Goal. We must achieve them all. This is called **Integration**

And finally, it is widely recognized that achieving these Goals involves making very big, fundamental changes in how we live on Earth. This is called **Transformation**

iii. The 17 SDGs are:

(1) No Poverty,
(2) Zero Hunger,
(3) Good Health and Well-being,
(4) Quality Education
(5) Gender Equality
(6) Clean Water and Sanitation
(7) Affordable and Clean Energy
(8) Decent Work and Economic Growth
(9) Industry, Innovation and Infrastructure
(10) Reduced Inequality
(11) Sustainable Cities and Communities
(12) Responsible Consumption and Production
(13) Climate Action
(14) Life Below Water
(15) Life On Land
(16) Peace, Justice, and Strong Institutions
(17) Partnerships for the Goals.

Answers to SAE 2

Barriers to the sustainability of SDGs

- A commentary in *The Economist* in 2015 said that the SDGs are "a mess" compared to the eight Millennium Development Goals (MDGs) used previously.

- Others have pointed out that the SDGs mark a shift from the MDGs and emphasize the interconnected environmental, social and economic aspects of development, by putting sustainability at their centre.
- The SDGs may simply maintain the *status quo* and fall short of delivering on the ambitious development agenda. The current status quo has been described as "separating human wellbeing and environmental sustainability, failing to change governance and to pay attention to trade-offs, root causes of poverty and environmental degradation, and social justice issues".
- Regarding the targets of the SDGs, there is generally weak evidence linking the "means of implementation" to outcomes. The targets about "means of implementation" (those denoted with a letter, for example, Target 6.a) are imperfectly conceptualized and inconsistently formulated, and tracking their largely qualitative indicators will be difficult.
- Competing and too many goals: A commentary in 2015 argued that 169 targets for the SDGs is too many, describing them as "sprawling, misconceived" and "a mess". The goals are said to ignore local context. All other 16 goals might be contingent on achieving SDG 1, ending poverty, which should have been at the top of a very short list of goals.
- The trade-offs among the 17 SDGs are a difficult barrier to sustainability and might even prevent their realization. For example, these are three difficult trade-offs to consider: "How can ending hunger be reconciled with environmental sustainability? (SDG targets 2.3 and 15.2) How can economic growth be reconciled with environmental sustainability? (SDG targets 9.2 and 9.4) How can income inequality be reconciled with economic growth? (SDG targets 10.1 and 8.1)."
- Weak on environmental sustainability: Continued global economic growth of 3 percent (Goal 8) may not be reconcilable with ecological sustainability goals, because the required rate of absolute global eco-economic decoupling is far higher than any country has achieved in the past. Anthropologists have suggested that, instead of targeting aggregate GDP growth, the goals could target resource use per capita, with "substantial reductions in high-income nations."
- Environmental constraints and planetary boundaries are underrepresented within the SDGs. For instance, the paper "Making the Sustainable Development Goals Consistent with Sustainability" points out that the way the current SDGs are structured leads to a negative correlation between environmental sustainability and SDGs. This means, as the environmental sustainability side of the SDGs is underrepresented, the resource

security for all, particularly for lower-income populations, is put at risk.

- The SDGs have been criticized for their inability to protect biodiversity. They could unintentionally promote environmental destruction in the name of sustainable development.

2.15 Tutor-Marked Assignment

1. Define Sustainable Development Goals (1 mark)
2. State the 17 SDGs (3 marks)
3. Distinguish between MDGs and SDGs (2 marks)
4. What are the roles of the Nurse in achieving health-related SDGs 4 marks)

UNIT 3 MATERNAL, NEWBORN AND CHILD HEALTH AND FAMILY PLANNING SERVICES

Unit Structure

3.1 Introduction
3.2 Intended Learning Outcomes
3.3 Levels of service delivery
3.4 The current Models of ANC
3.5 Labour, Delivery, Puerperium and Post-Natal Care
  3.5.1 Using the Partograph
  3.5.2 Active management of 3rd stage of labour
  3.5.3 Initial Care of the Newborn
  3.5.4 Puerperium
  3.5.5 Care of the young child
  3.5.6 The School-Age Child and School Health Services
3.6 Family planning
3.7 Male involvement and participation in maternal Child Health/FP Services
3.8 Summary
3.9 References/Further Readings/Web Resources
3.10 Possible answers to SAEs

3.1 Introduction

Maternal, Newborn and Child Health services are provided at all levels of health care in Nigeria. However, the primary health care level is usually the first level of contact between women and children and the health care system (private or public) where basic elements of essential services are provided.

Of the three levels of care, Primary Health Care system is closer to the teaming rural population, where the burden of maternal and child morbidity and mortality are highest. The facilities at this level are more easily accessible, and service delivery cost effective, and therefore the most strategic for improving maternal health outcomes.

At Primary Health level, some facilities should be equipped to offer basic emergency obstetric and neonatal and childcare. These facilities should have at least 4-5 midwives with lifesaving skills and equipped to offer Basic Essential Obstetric & Newborn Care (BEOC) ie

- Monitor labour with partograph,
- Take normal delivery.
- Give immediate care for the newborn.
- Manage 3rd stage of labour

- Perform manual removal of placenta
- Identify abnormal deliveries and make referrals as appropriate
- Manage pre-eclampsia and eclampsia prior to referral as appropriate
- Perform and repair episiotomies
- Administer parenteral antibiotics, sedatives, oxytocin
- Provide 24 hours daily.
- These are the first level of referral for the other PHC facilities within ward.

Therefore, at this level, it is important that skilled care is provided with support from Community Resource Persons (CORPS). Primary health care must be able to deliver the essential package of MNCH services in full, which includes:

- Focused antenatal care including family planning, prevention of mother to child transmission of HIV, and early disease detection and treatment.
- Early detection and timely referral with minimal first- line management of women and newborns with pregnancy-related complications.
- Normal delivery including use of partograph and active management of third stage of labour.
- Care for mother and newborn in the postnatal period (warmth, cleanliness, resuscitation, and prevention and management of sepsis.
- Early initiation of exclusive breastfeeding.
- Continued breastfeeding with timely complementary feeding
- Full immunization and growth monitoring.
- Integrated Management of Childhood Illnesses

Every LGA must have at least one health facility equipped to provide a comprehensive emergency obstetric and newborn care as it is estimated that approximately 15% of all pregnant women will require access to specialized medical services for diagnosis and treatment of an underlying health problem or pregnancy and childbirth related complications. These women must be referred promptly from PHC level to a secondary level health facility that offers comprehensive essential obstetric and newborn care with the necessary drugs, equipment and skilled staff to manage such complications. Services provided at this level include:

- Surgical procedures including Caesarean section.
- In the absence of electric supply, appropriate technology to use solar / kerosene fridges for blood storage.
- Safe blood transfusion.

- Assisted vaginal delivery.

3.2 Intended Learning Outcomes

By the end of this unit, you will be able to:

- Explain the provision of Maternal, Newborn and Child Health services
- Analyse the levels of MNCH service delivery
- Discuss the current models of ANC
- Explain the Labour, Delivery, Puerperium and Post-Natal Care services at the village and facility levels
- Describe the us use of partograph
- Discuss the active management of 3rd stage of labour
- Discuss the care of the newborn and the young child
- Enumerate the components of school health services
- Explain the various methods of family planning
- Discuss the importance of Male involvement and participation in maternal Child Health/FP Services

3.3 Much Service Delivery

Ante-Natal Care

The Village level

The JCHEW and CORPS (VHW/TBA) are the cadre of health workers providing services at this level: It is important that at this level:

- Pregnant women are identified and encourage to register early for ante-natal care in the facility.
- Provide appropriate follow up on health tips during pregnancy, adequate diet, sleep/rest, personal hygiene, birth preparedness and keeping hospital appointment

The Facility level

Community Health Extension Workers, Community Health Officers, Nurses, Midwives and Physicians (in some places) are the cadres of health workers providing services at the health facility/wards level.
These cadres of health workers should perform all the tasks of the village health workers and the traditional birth attendants with all clinical duties

Maintain a good relationship with women in the clinic and community by:

- using appropriate communication techniques.
- explaining to the women in local language the services available in the clinic and the community.
- providing integrated and culturally acceptable services; and
- Review the following (briefly):
- anatomy and physiology of the male and female reproductive organs in relation to pregnancy, labour, delivery, puerperium and family planning.
- menstrual cycle in relation to conception and implantation.
- fertilization.
- signs and symptoms of pregnancy.
- the National Code of Ethics and professional standards for the marketing of breast milk substitutes.
- Decree No. 41 "Marketing Breast milk Substitutes of 1990"
- the 10 steps to successful breast-feeding

Self-Assessment Exercises 1

i)What are MNCH services provided at the facility level?

3.4 The current model for ANC: is **focused** antenatal care (FANC) model which has an overall goal of reduced visits and yet achieving the same outcome as in the traditional model. It saves cost and unnecessary visits by patient. Evidence indicates that there is no difference in outcome between a four-visit schedule of FANC and a twelve-visit schedule of the traditional method of antenatal care. Currently the trend is towards reducing the number of visits, while at the same time establishing clearly defined objectives to be achieved at each visit.

The focused antenatal care can therefore be defined as care offered based on evidence of optimal need rather than routine care. It is client-centred, goal-directed care provided by skilled health providers with emphasis on quality rather than quantity of visits

Objectives

The overall goal is to obtain the best possible outcome for the mother and the child within the minimum four antenatal visits.
The specific objectives include:

- To promote healthy behaviour in pregnancy
- Early detection and treatment of problems and complications
- Birth preparedness and complications readiness

- Use of interpersonal communications skills for ANC
- Evidenced-based best practices for ANC

3.4.1 Schedule of Visits

Previously, antenatal visits were: monthly until 28 weeks gestation; then fortnightly until 36 weeks; and weekly thereafter until delivery, resulting in up to 14 hospital visits during pregnancy. Currently the trend is towards reducing the number of visits, while at the same time establishing clearly defined objectives to be achieved at each visit. The schedule of visit is listed below.

1. 1st ANC visit - best before and not later than the 16th week
2. 2nd ANC visit - scheduled around the 24-28th week
3. 3rd ANC visit - scheduled around the 32nd week
4. 4th ANC visit - between the 36th and 38th week

1st Ante-natal Visit

TIMING	**First antenatal visit (Less than 16 weeks)**
GOALS	**Confirm pregnancy** and **EDD** **Classify woman** for basic or specialized care (if specialized, **refer**) Screen, treat and give preventive measures Develop a **birth and emergency plan** Advise and **counsel** **Should last** 30-40 minutes
ACTIVITIES	
Rapid assessment and management for emergency signs, give appropriate treatment and refer to hospital if needed	
History (ask, check records)	**Quick check** to assess significant **symptoms** Take identification, psychosocial, medical and obstetric **history Confirm pregnancy** (Check LMP and EDD) **Classify woman** (for basic or specialized care) - check test results if available
Examination (look, listen and feel)	Conduct **complete** general, obstetric and genital **examination**
Screening and tests	Hemoglobin/PCV VDRL for syphilis HIV test Urinalysis for proteinuria and glycosuria Urine for bacteriuria Blood/rhesus group Hemoglobin Genotype

Treatment	ARV if indicated, antibiotics for bacteria if indicated
Preventive measures	1st dose Tetanus toxoid, Iron/Fesolate tablets
Health education, advice and counseling	Self-care, alcohol and tobacco use, nutrition, safe sex, rest, sleeping under ITN,IPT, HIV counseling and birth and emergency plan

2nd ANC Visit

TIMING	**About the 24th - 28th week**
GOALS	Assess maternal and fetal wellbeing Exclude **PIH, anemia and other common prenatal medical disorders** Give preventive measures Review and modify **birth and emergency plan** Advice and **counsel** **Should last** 20 minutes
ACTIVITIES	
Rapid assessment and management for emergency signs, give appropriate treatment and refer to hospital if needed	
History (ask, check records)	**Quick check** to assess significant **symptoms** Check records for previous complications and treatment during the pregnancy **Re-classify woman** if needed
Examination (look, listen and feel)	Check BP, for anemia, fetal growth and wellbeing
Screening and tests	Urine for bacteriuria Urinalysis for proteinuria if parturient is a primigravida Hemoglobin/PCV if anemia is suspected
Treatment	ARV if indicated Antibiotics for bacteriuria if indicated Antihelminthics for worms
Preventive measures	**2nd dose tetanus toxoid** **Iron/folate** tablets 1st dose IPT (3 tabs of SP)
	ARV if indicated

Health education, advice and counseling	Birth and emergency plan Reinforcement of previous advice

3rd ANC visit

TIMING	**About the 32nd week**
GOALS	Assess maternal and fetal wellbeing Exclude **PIH, anemia, multiple pregnancy and other common prenatal medical disorders** Give preventive measures Review and modify **birth and emergency plan** Advice and **counsel** **Should last** 20 minutes
ACTIVITIES	
Rapid assessment and management for emergency signs, give appropriate treatment and refer to hospital if needed	
History (ask, check records)	**Quick check** to assess significant **symptoms** Check records for previous complications and treatment during the pregnancy Treatment during the pregnancy if indicated **Re-classify woman** if needed
Examination (look, listen and feel)	Check BP, for anemia, fetal growth, and wellbeing
Screening and tests	Urine for bacteriuria Urinalysis for proteinuria if parturient is a primigravida Hemoglobin/PCV if anemia is suspected
Treatment	ARV if indicated Antibiotics for bacteriuria if indicated
Preventive measures	**2nd dose tetanus toxoid** **Iron/folate** tablets 2nd dose IPT (3 tabs of SP) ARV if indicated

Health education, advice and counseling	Infant feeding Postpartum/postnatal care Pregnancy spacing/Family planning Birth and emergency plan Reinforcement of previous advice

4th ANC visit

Timing and Goals

- This is the final visit before labor or delivery
- It should take place about or between the 36th - 38th weeks
- Should last 20-30 minutes
- Exclude PIH, anemia, multiple pregnancy, malpresentation
- Continue to give preventive measures
- Review and modify birth and emergency plan
- Advice and counsel

Activities

Activities during the visit include.

Review history for any change & compliance with routine ANC drugs
Examination –

* General
* BP
* SFH
* Abdomen for fetal lie & presentation as well as for twins/breech

1. Review and modification of birth and emergency plan
2. Tests -
   - urine for proteinuria only in nullipara, hypertension, pre-eclampsia/eclampsia
3. Assess for referral (reclassification)
4. Interventions -

i. Preventive
a. iron,
b. folic acid,
c. malaria prophylaxis

ii. Treatment
a. ARV if indicated
b. Antibiotics for bacteriuria if indicated

Extra-attention to advice on;

- What to do if labor occurs - birth and emergency plan
- What to do in case membranes rupture
- Advise on the concept of prolonged pregnancy & the need to present if still not in labor by the 41st week
- Birth spacing & contraceptive counseling
- Infant feeding
- Postpartum/postnatal care

Advice, questions & answers, and scheduling next appointment
Maintain complete records - clinic records & ANC card records
explain the term antenatal care as care given to pregnant women from the period of conception to delivery.

identify the signs of pregnancy as follows:

- morning sickness;
- vomiting and/or nausea;
- absence of monthly period
- tender and enlarged breast.
- increase in womb size.
- weakness and drowsiness

State the benefits of antenatal care as:

- promotion and maintenance of good physical and mental health of the expectant mother and the unborn child.
- ensuring the delivery of a mature, live, healthy infant.
- preparing the women for labor, lactation, and care of her child.
- early detection of high-risk conditions and referral.
- Nutritional care during pregnancy and puerperium and use of supplements eg iron, calcium and folic acid; and provision Long Lasting Insecticide Treated Nets (LLINs) and intermittent 'prophylactic malaria treatment (IPT).

Provide ante-natal care by:

a. Taking history from the expectant mother by asking the following questions:
- last date of menstruation.
- number of children the woman has and sex distribution.
- average interval between each pregnancy.
- if any still births, abortion or miscarriages, neonatal jaundice.
- problems associated with previous pregnancies e.g. hypertension, bleeding, etc; and type of family planning device used after delivery of each child.
- eating pattern.

b. Calculating the expected date of delivery.

c. Carrying out the procedure for assessing the normal progress of pregnancy, which include:

- examination of head for cleanliness and lice;
- examination of the eyes, and fingers and nails for paleness;
- examination of the breast for lumps;
- examination of neck for swelling;
- examination of legs for oedema and varicose veins;
- examination of vagina for discharge and blood,
- palpation of abdomen to assess fundal height and lie of the baby;
- urine test to detect albumin by boiling and sugar by asking the woman to urinate in a container and observe if ants will gather round it or it foams excessively.

d. Giving advice on:

(i) Nutrition:

•	foods that promote growth of the unborn baby, maintain mother's tissues and supply adequate blood; for example, beans, snails, caterpillars, groundnuts, fermented locust beans, melon seeds, fish, meat as affordable;
•	foods that protect the body against infections e.g. fruits and green leafy vegetable;
•	foods that promote development of strong bones and teeth e.g. small fish, crayfish and crabs.
(ii)	Exercises, rest, personal hygiene, environmental sanitation, clothing, shoes and work schedule.
(iii) (iv)	regular attendance for ante-natal care; immunization as follows: - TT1 - at first contact or as early as possible. - TT2 - at least four weeks after TT1. - TT3 - at least 6 months after TT2 or during subsequent pregnancy. - TT4 - at least one year after TT3 or during subsequent pregnancy. - TT5 - at least one year after TT4 or during subsequent pregnancy;

e.	Preparing mother for lactation by educating her on care of the nipples, for example: - bathing at least once daily. - massaging nipples (if flat) by rolling them between fore finger and thumbs. - pulling them out gently, especially during the last two months. This helps to make nipples prominent and easier for baby to grip and suckle.
f.	Educating mother on the advantage of breast feeding. Breast milk: - contains protective substances for the baby (especially the colostrum); - contains correct proportions of nutrients; and it is easily digestible. - is cheap, clean and safe. - is readily available and at the correct temperature. - provides bonding between mother and child. - is traditionally and culturally acceptable. - Breastfeeding option for HIV positive clients.

g. Educating mother on harmful traditional practices, which affect the health of women and children e.g.

- food taboos and food faddism (i.e. likeness or hatred for certain foods);
- Female circumcision.
- early marriages.
- skin tattoos (skin scarification);
- child abuse.
- Importance of girl child education.
- Harmful effect of alcohol during pregnancy and after delivery.
- forced-feeding.
- use of cows' urine concoction.
- Gishiri cuts.
- hot baths after delivery.
- inappropriate emergency treatment practices e.g. putting the feet in fire as treatment for convulsions.

h. Giving routine drugs to pregnant women, using Standing Orders.

i. Managing common complaints in Pregnancy as stated below:

COMPLAINTS	ADVICE
Backache:	sit up straight and lie on flat and firm surface.
General	encourage rest, schedule work, and eat adequate diet.
Nausea & vomiting:	avoid eating oily foods or rushing out of bed in the morning; eat dry foods e.g. biscuits, bread, and boiled yam.
Heart burn:	avoid oily or spicy foods.
Varicose veins:	keep legs raised when resting or seated, avoid standing for too long; support the legs with crepe bandage.
Loss of appetite:	make food attractive and encourage eating of plenty of fruits and vegetables; encourage rest.
Constipation:	drink plenty of water and take fruits and vegetables.
Itching of the vulva:	wash vulva frequently with clean water and soap, keep dry with clean towel, then refer.

Cramps: take foods rich in calcium e.g. snails, green vegetables, milk, millet, sorghum and grapefruits. Immerse affected parts in cold water.

Haemorrhoids: drink plenty of fluids, eat vegetables and fruits. Take sitz baths (salt and water)

Itching of the skin: take regular baths and dry under creases and folds.
Excessive salivation: maintain oral hygiene.

Refer to standing orders for further treatment details.

j. Identify conditions that require immediate referral such as:
- vaginal bleeding during pregnancy.
- pallor (anaemia);
- excessive and offensive vaginal discharge during pregnancy.
- frequent headache.
- swollen feet, and hands.
- blurred vision.
- persistent cough.
- jaundice.
- fits.
- Massive protein in the urine (3+) or heavily foamy urine.

k. Identify "At Risk" mother during first visit to ante-natal clinics as stated below:
- women with first pregnancy irrespective of maternal age.
- women with previous multiple pregnancies.
- women aged below 16 years and above 35 years.
- short women (below 5 feet) with small feet.

- women with more than 4 children.
- women with bad obstetric history e.g. still birth, prolonged labour etc.
- women with deformity (hunch back)
- women with scars on the vulva.

SAE 2

i)What are the indicators for “at risk” pregnant women?

3.5 Labour, Delivery, Puerperium and Post-Natal Care

Labour: Labour is the process of expulsion of the fetus, placenta and membranes through the birth canal.

Established labour: onset of painful, regular and frequent uterine contractions of at least 1 in 10 minutes each lasting at least 20 seconds, resulting in progressive cervical dilatation, shortening of the cervix and descent of the presenting.

Normal labour:

- occurs spontaneously at term
- With regular, frequent uterine contractions •Producing cervical dilation of at least 1cm/hour
- Lasting not more than 12 hours
- Normal baby and mother without complications

At the village /community level, the CORPS (VHW/TBA) should recognise signs of labour and give timely support to woman, escort her to the facilty. Can be support to the woman during labour

At the facility level, health worker should:

• Recognize women in labour through:

i. history of - ‘show' (plug of mucus and blood)
frequent lower abdominal pain and backache.
ruptured bag of water

ii Perform a rapid evaluation of the woman including vital signs (pulse, blood pressure, respiration, temperature)

iii examination of women to determine:

frequency of pain.
baby movement.
baby's lie, and
the presenting part.

Iv assess foetal condtion

- listen to the foetal heart rate immediately after acontraction: Count the foetal heart rate for a full minute at least once every 30 minutes during the active phase and every 5 minutes during the second stage
- If there are foetal rate abnormalities (less than 100 or more than 180 beats per minute) suspect foetal distress. REFER to a facility with the capability of performing caesarean section inspection of the vulva and vagina to check for:

-. show.
- bulging bag of water, denoting second stage of labour;
- presenting parts i.e. head, leg, cord, arm or buttocks and
- gaping orifices.

iv. explain the stages of labour thus:

- Stage I - regular lower abdominal pain until full dilatation of cervix.
- Stage II- indicated by full dilatation of cervix and delivery of baby.

Stage III- indicated by separation and expulsion of the placenta (delivery of after birth)

Supportive Care During Labour and Childbirth

- Encourage the woman to have personal support from a person of her choice throughout labour and delivery, seats by her.
- Encourage companion to give adequate support (rub her back, wipe her face with wt clot, assist her to move around)
- Ensure goo communication and support
- Explain all procedures, seek permissions and discuss findings with the woman and treat with respect
- Ensure privacy and confidentiality

- Maintain cleanliness of the woman and her environment

- Encourage the woman wash herself or shower if she can
- Clean vulva and perineal areas berore each examination
- Wash hands with soap before and after each examination
- Maintain universal precaution
- Keep labouring and delivery areas clean

- Ensure mobility:
- Encourage the woman to move about freely
- Support the woman's choice of position during labour and birth
- Encourage the woman to empty her bladder regularly
- Encourage the woman to eat and drink freely
- If anxious, give her praise, encouragement, and reassurance
- Give her information on the process and progress of her labour
- Listen to the woman and be sensitive to her feelings

VAGINAL EXAMINATION

Vaginal examination should be carried out at least once in every four hours during the first stage of labour and after rupture of membranes. Plot findings on partograph

3.5.1 Using the Partograph

Partograph is a graphic record of all the events of labour. A managerial tool used to identify prolonged labour and proffer solution. WHO modified partograph is simpler to use as plotting now begins from the active stage when the cervix is 4cm dilated Record the following on the partograph:

Patient Information: Full name, gravidity, hospital number, date & time of admission, and time of ruptured membranes or time elapsed since rupture (in rupture occurred before charting on the partograph began)
Feotal heart rate: recorded every half hour

Amiotic fluid: Record colour of amniotic at every vaginal examination and recorded as:

- I: Membranes intact
- R: Membranes ruptured
- C: Membranes ruptured; clear fluid
  M: Meconium-stained fluid
- B: blood-stained fluid

Moulding is felt and recorded on the partograph with an "O"

for no moulding or + (mild)
++ (moderate), +++ (severe)

Cervical Dilatation: Assessed at every vaginal examination and marked with a cross (X) Begin plotting on the partograph from 4cm

The Maternal Condition

All observation on the mother's condition are recorded at the bottom of the partograph. All entries are made on the timeline at which the observations are made, Pulse, Blood Pressure and Temperature:
Take the blood pressure, temperature and pulse every 4 hours.

Urine

Ask the mother to pass urine every 2 hours. Look at urine for amount and concentration. Concentrated urine is a sign of dehydration. The urine should be tested for proteins, sugar and acetone on admission. Protein in the urine may be a sign of pregnancy induced hypertension. Acetone in the urine may be a sign of dehydration or diabetes.

Drugs and rehydration fluids -Chart these when you give them.

Oxytocin: This is recorded in a separate column above the column for fluids and drugs.

Delivery

Once the cervix is fully dilated and the woman is in the expulsive phase of the second stage, encourage her to assume the position she prefers and encourage her to push

NOTE Episiotomy is no longer recommended as routine procedure as there is no evidence that routine decreases perineal damage.

• Manage the second stage of labour by:

- washing hands with soap and water and putt on gloves.
- ensuring clean delivery
- recognizing when cervix is fully dilated.
- advising women to push with contractions as the baby's head deliver.
- Continuing to support the perineum as baby's head delivers.
- tying cord in two places after measuring the length of cord from

the baby's knee to hip.
- cutting in between the ligature, using a sterile scissors or new razor blade.
- wrapping the baby in a warm clean cloth; and making mother comfortable.

3.5.2 Active Management of Third Stage Of Labour

Active management of the third stage (active delivery of the placenta) helps to prevent postpartum haemorrhage. Active management of the third stage of labour includes:

- immediate oxytocin/Misoprostol tablet
- controlled cord traction; and uterine massage

- clamp the cord close to the perineum using one minute of delivery. Hold the clamed cord and the end of the forceps with one hand
- place the other hand just above the woman's pubic bone and stabilize the uterus by applying counter traction during controlled cord traction. This helps prevent inversion of the uterus
- keep slight tension on the cord and await a strong uterine contraction (2 to 3 minutes)
- when the cord becomes rounded or the cord lengthens, very gently pull downward to deliver the placenta. Continue to apply counter traction to the uterus with the other hand
- slowly pull to complete the delivery of the placenta
- look carefully at the placenta to be sure none of it is missing.

Deliver the placenta (the after birth) during third stage of labour using active management of third stage of labour

- clean the women and make her comfortable.
- check placenta and membranes for completeness.
- check woman carefully for tear; repair any tear to the cervix
- massage (rub) uterus to expel clots, immediately and every 15 minutes for 2 hours
- assess amount of blood loss; and make mother and baby comfortable.

- Recognize conditions requiring immediate referral such as:

- abnormal presentation e.g. buttocks (breech), foot; delay of the head.
- excessive bleeding before and after delivery of birth.

- deep tear or cut of the perineum; and
- mother too weak and tried to push baby or placenta out.
- cord prolapsed or cord presentation.
- Prolonged obstructed labour.

• Manage excessive bleeding by:

- encouraging the client to empty the bladder.
- massaging the abdomen.
- putting the baby to breast to assist in uterine contraction.
- prophylactic use of misoprostol (cytotec) and also use in management of PPH.

3.5.3 Initial Care of the newborn

Dry the baby thoroughly:

Wipe the mouth, skin and nose of mucous debris and meconium if present. If baby is crying it means it is breathing well and large amount of air is moving in and out of the lungs.

Provide Warmth:

Immediately remove the wet clothe and position the baby skin to skin on the mother’s abdomen and cover them both with another cloth or blanket. Cover the baby's head with a cap or head covering. Record first Apgar score. Postpone bathing and weighing as you maintain warmth

Check Breathing:

Assess baby's breathing, listen to the sounds of breathing and watch the baby's chest breathing movement (Crying)

Cut Cord:

Wait at least one minute and up to three minutes to clamp tie and cut the cord encourage (baby) mother to commence breast feeding. Leave the cut end of the cord open to air dry

- check the sex of the child;

Care of the newborn

• Clear the airway gently.
• Use mucus extractor if necessary.
• Dry and wrap the baby using two clean towels/cloths for keeping

the baby warm; one for drying and wrapping the baby initially, the other for covering the newborn to prevent heat loss. Further assessment of the baby should be done near a source of warmth e.g. a 200 watt bulb or under a radiant warmer.

- Weigh the baby and determine if LBW (low birth weight) or high risk.
- Check baby temperature: ensure skin-to skin contact with mother for warmth. Normal temperature of the baby is between 36.5 and 37 ^{0}C.
- Perform cord care by ensuring a clean cord tie and a clean cord stump. Use methylated spirit to clean the cord stump.
- Clean the eyes with a clean separate swab for each eye using clean. Each eye should be cleaned from inner end to the outer end of the eye.
- Examine the baby for any abnormalities and screen for any danger signs.
- Give vitamin k injection.
- Initiate exclusive breastfeeding as early as possible, usually within 30minutes of birth and ensure there is good attachment, and the baby is suckling well. If the mother is HIV positive, assist her to feed her baby with the chosen feeding option.

Note; ensure that during and after delivery, no fans are running in the delivery room and no windows are open to blow draughts into the room. If a newborn is high risk (preterm baby, low birth weight-less than 2.5kg), provide immediate care (warming, skin-to-skin, KMC etc). Assist in referral of the mother and newborn if necessary. Care of the newborn is directed to maintain asepsis and prevent infection of the newborn, prevent hypothermia and keep the airways patent

3.5 4 Puerperium

The Puerperium-This is a period of six weeks or forty-two days after delivery Characteristics of Normal Puerperium

- Reproductive organs return to their pre-pregnancy state
- Lactation is established and maintained
- The body recovers from the physical, hormonal and emotional change which occurred during pregnancy, labour and delivery
  Lochia-is the term given to the flow from uterus during the Puerperium

Characteristics and Types of Lochia

- The lochia encourages the growth of bacteria because it contains blood

- The quantity of lochia varies in different women, but it is generally more than what is lost during menstruation
- The colour of lochia progressively changes from red (lochia rubra) to pink (lochia serosa) within the first week of puerperum and becomes light cream (alba) in colour by the third week
- The odour may be heavy and unpleasant but not offensive
- The persistence of red lochia is an indication of infection or postpartum bleeding, however by the end of six weeks, the lochia should have stopped

Management in immediate Postpartum

- Allow the baby early contact with the mother by putting baby to breast within 30mins.of delivery
- Advice on:
- food items rich in protein, calcium and vitamins
- personal hygiene for mother and baby
- care of the umbilical cord and stump
- postpartum exercises
- Adequate rest
- Check the abdomen to ensure that the uterus is firmly contracted. Note the shape and size towards monitoring the process of involution
- Ensure bladder is empty
- Check the vital signs
- Offer the mother a drink of her choice as available and allow her to rest Within 48hours of delivery (Mother)

- Conduct general assessment
- Symptoms
- General examination
- Involution
- Lochia
- Check the vital signs
- Observe the mother's attitude towards the baby to assess her mental state -Advise on personal hygiene, adequate rest and nutrition.

Before Discharge

- Check the general health of the woman
- Check the progress of involution
- Ensure that lactation is established and adequate
- Discuss child spacing and provide suitable choice of contraception
- Health education on:

- personal hygiene
- environmental sanitation
- exclusive breastfeeding
- general care of the neonate
- immunization regime
- pap smear/ acetowhite test
- self breast examination

• Give appointment for postnatal visit

Baby (within 48hours)

• Provide warmth
• Prevent infection especially of the cord
• Check that the baby is suckling normally
• Exclude any abnormalities
• Observe vital signs

Before discharge

- Assess the general wellbeing of the baby
- Conduct general examination
- Exclude oral thrush, septic spots
- Assess the weight gain
- Immunize: BCG and OPV0

Advise mother on:

- danger signs that may appear few days after delivery.
- yellow eyes (jaundice);
- swelling and pus in the eye (infection);
- any problem with breathing.
- failure to suck.
- twitching.
- tiny watery or pustule rashes.

Reasons for Post Natal Care

To ensure:

• Continued good health of the client and the baby
• Maintenance of lactation
• Involution is complete
• Baby is thriving well

- Monitoring of immunization process
- Counseling on Pap Smear/Acetowhite test and self-breast examination
- Family planning counselling/services
- Examine the baby:

Fifty percent of deaths in the newborn period take place within 24 hours of birth and 75 percent by the end of the first week of life. The first six hours after delivery constitute the time interval of maximum change. WHO recommends visits/evaluation at six hours, six days, and six weeks after the childbirth. In view of this, after discharge, the health worker/CORPs should make a follow up check on mother and baby. This will be to check on mother/baby's wellbeing, encourage and support the mother, detect early and act promptly.

- check colour and odour of discharge.
- palpate the abdomen for the size of the uterus or any abdominal swellings or tenderness.
- observe the mother for pallor.
- interview mother on how she is coping at home with breast

feeding, and her own health. If there is any problem, treat as in Standing Orders.

- Assist the mother in putting the baby to breast with good attachment. The 4 signs of good attachment to the breast include:
  More areola is seen above than below the baby's mouth
  Baby's mouth is wide open

Lower lip is turned outwards and.

Chin is touching breast

- The baby should be taking slow deep sucks with pauses
- The mother should be in a comfortable position, supporting the breast with the palm of her hand, allowing the nipple to be properly placed in the baby's mouth.
- Avoid giving pre-lacteal feeds of water, glucose etc before or in between feeds
- Breastfeed baby on demand and from both breasts.
- Educate mother on importance of exclusive breastfeeding for 6months.
- Educate mother on preventing cracked nipples by.
  S Fixing the baby's mouth properly on the nipple
  S Drawing the nipples gently out from the baby's mouth.
  Care of the neonate/infant
- Examine the baby:

Check baby's mouth for thrush, body for general cleanliness
Check eyes, nose and ears for discharge
Assess the cord
Assess the child's general health

- Discuss family planning and encourage use
- Counsel mother on when to come to the health facility immediately by teaching her how to recognize danger signs. Danger signs include:
  Poor breastfeeding
  Convulsion or fitting
  Looks ill
  Develops fever or is cold to the touch
  Fast/difficult breathing
  Blood in the stool
  Yellow body
  Inactive baby
- Advice mother on immunization schedule

Post Natal Visit to Facility Six Weeks After Delivery

- Take history concerning mother (lactation, lochia general condition, resumption of sexual activity baby breastfeeding weight gain, immunization etc)
- Repeat physical examination of both mother and baby
- Check for signs of anaemia
- Check breast for tenderness, redness lumps, nipples for cracks and redness
- Check lactation
- Carry out vaginal examination as follows:

Check the vulva for discharge and lochia; vaginal should be pink, warm and moist

Check that cervix is firmly close with a transverse slit

Check uterus for full involution

- Test urine for acetone, sugar and protein
- Check haemoglobin (Hb) or PCV
- Provide the following information during post-natal visit:

- importance of exclusive breastfeeding
- compliance with immunization schedule with reasons
- the nearest primary health care clinic
- re-supply of routine drugs
- the need to report early at the health facility when complications arise
- Choice of family planning method

- discharge both mother and baby if everything is normal
- if any complication is noted, apply appropriate therapy and

reschedule another visit.

check the baby's mouth for thrush, baby for rashes and cleanliness.

- Check ears and nose for discharge.
- Check the cord;
- Assess child's growth by weighing and chart
- Assess child's general health;
- Discuss family planning and encourage use; IUCD can be inserted immediately.
- Advise on supplementary feeding for baby from 6 months e.g., fruits juice, home-made cereals, fortified pap; and
- Commence immunization and give appointment for subsequent ones

• Treat or Refer client presenting with the following:

-	heavy bleeding. offensive lochia. high temperature. incontinence of urine. urinary tract infection characterized by burning sensation; pain on passing urine; and psychiatric disorders. moderate to severe high blood pressure eg gestational proteinuria hypertension

• Give appropriate immunization/appointment and remind mother of immunization schedule

3.5.5 Care of the young child

Introducing Complimentary Diet 6 - 23 months

The health worker will be able to:

	• Explain the term complementary feeding as the gradual introduction of semi-solid foods to infants whilst breast feeding continues. • Advise mother to commence complementary feeding between 6 months of age by introducing cereal foods e.g. pap, guinea corn, millet, sorghum etc. enriched with red palm oil, and one of the following; ground roasted groundnuts, melon seeds, bean crayfish, edible insects and made palatable with the addition of a little sugar. • introduce other foods containing meat, fish, pulses, nuts, and vegetables. • Promote and monitor the growth of the child by: • Weighing monthly up till one year of age.

3.5.6 The School-Age child and School Health Services

At all levels (Village, Facility/Wards and LGA)

The Village/Community Health Worker should visit schools (Primary and Secondary Schools) and carry out the following:

- assess health needs of the school child.
- establish a working relationship with the school health personnel.
- conduct routine appraisal of the health status of school children at regular intervals.
- train the teachers to carry out daily inspection of children and report any abnormal findings to the health personnel.
- conduct daily inspection to include:
- general cleanliness.
- examination of the skull.
- appearance (Alertness, nutritional status); and any physical problems or defects.
- demonstrate to the teachers how to select relevant and high priority contents for teaching health topics appropriate to age and situations of school children (e.g. for adolescents: smoking, drugs, use of condoms)

- train school personnel to maintain own health and therefore act as "role models"
- visit homes to assess family, and follow-up school health instructions.
- explain the immunization needs of the school child to parents and schools personnel.
- give immunization to those school children who need them.
- organize school health inspection

• Organize food hygiene for the school food vendors to include:
- medical examination of food vendors.
- home assessment of food vendors (store, kitchen, water supply, toilet facilities);
- proper training in cooking of school meals.
- issuing of identity cards and certificates of attendance to vendors after training.

• Conduct health education classes for school personnel, parents-Association, and children. Discuss such topics as:

- personal and environmental hygiene - oral health
- accident prevention - immunization
- sex education.
- nutrition education.
- dangers of smoking and drug Abuse - HIV/AIDS/STI
- Advise the school authorities to provide an up to date First

Aid Box, which must be accessible at all, times;

- train teachers to provide emergency care to school children for specific minor ailments or accidents, e.g. fainting, fever, diarrhoea and vomiting;
- organize seminars/workshops for teacher and parents to enable them screen for underweight/or disabled children and refer to the clinic. Seminar topics can include:
- testing for visual acuity.
- testing for hearing.
- management of the epileptic child and other emergencies.
- growth monitoring and development.
- seek collaboration and cooperation of the children in carrying out simple surveys on health and hygiene matters within the community and encourage them to cooperate with activities to improve the school environment (e.g. school health scouts, peer counseling);
- review and evaluate school health needs and resources making use of such sources of information as:

  teachers and students

school attendance records; and health services/monitoring, evaluation and feedback.

3.6 Family Planning

The Village Level

Objectives of Family Planning Training

The Village Health Workers/Traditional Birth Attendants should:

- Identify women who should receive family planning counseling, such as:
  - pregnant women.
  - post-natal women.
  - women of childbearing age (15 - 49 years);
  - sexually active adolescents.
  - women older than 40 years.
  - women with chronic diseases such as heart disease, varicose veins, and hypertension etc and link them up with the facility

  At the Facility level, the health worker should.
- Counsel women on family planning by using effective communication techniques such as:
  - welcoming client and making her comfortable.
  - explaining the term, family planning as a way of having children by choice and not by chance, so that there is adequate spacing between children. It also assists infertile couples to have children.
  - discussing available family planning methods; and explaining the benefits of family planning thus:
  - good health for mother and child.
  - decreases maternal deaths and childhood deaths.
  - mother will be able to have smaller families, which will result in better and adequate nutrition for mother and other family members.
  - decreases adolescent pregnancies which may result to infection/ infertility or death (when miscarriage is induced);
  - increases women's economic and social status as women will be able to go out and work.
  - helps government to plan for adequate food, housing, health care, education, water supply, electricity supply and employment.

- Discuss different family planning methods such as:

1. **Abstinence and Coitus Interruptus:**
2. **Natural Family Planning (NFP) Fertility Awareness based Method (FAM) and Lactational Amenorrhoea Method (LAM)**

Calendar - Using calendar to determine the fertile days.

Ovulation -This is based on changes that take place in the quantity and quality of cervical mucus during the menstrual cycle

Symptom-thermal - This is a combination of the temperature, calendar and mucus methods to determine time of ovulation.

Fertility Awareness based Method (FAM) - Use of physical signs, symptoms and cycle data to determine when ovulation occurs. The same technique may be use to help couples became pregnant by detecting ovulation.

Lactational Amenorrhoea Method (LAM)

Breastfeeding delays the return of fertility in the postpartum period. However, LAM is a contraceptive method based on exclusive breastfeeding.

Is a natural method of birth control which involve observation of vaginal secretion and changes in temperature (Billing methods). Special training is required to know how to use the method. Better result could be obtained by the use of thermometer, beads and calendars.

3. **Barrier methods**

Male condoms and female condoms

Foaming Tablets - Chemical agents that can destroy male sperm (egg). It is inserted in the women's private part five minutes before sexual intercourse. If the women want to have another sexual intercourse, she has to insert another tablet and wait for it to dissolve.

4. **Hormonal Methods**

Oral pills: (re-supply only) taken by women once daily by mouth; it prevents the body from producing eggs. Clients referred are re-supplied with the pills monthly.

Emergency contraceptive pills (ECPs) –

I. **U.C.D:** A small plastic device placed in the womb, which prevents the man's sperm from joining the woman's eggs. The procedure is performed in special Family Planning Clinics.

Implants: These are progestin-only contraceptives inserted under the skin of women's upper arm by minor surgical procedure.

Injectables: These are long lasting contraceptives containing combined estrogen and progestogen only and are given by intramuscular injection.

5. **Voluntary Surgical Contraception (VSC):**

This is a permanent method of contraception which involves a minor surgical procedure to prevent pregnancy eg Vasectomy for males and tubal ligation for women.

• Advice clients to report whenever there is any problem such as:

- severe abdominal pain.
- severe headache.
- severe leg pain.
- blurred vision.
- severe bleeding;
- getting too fat;
- severe vomiting; and
- problem with breast feeding.

SAE 3

i) Discuss various method of family planning

3.7 Male involvement and participation in Maternal and Child Health/FP Services

Men constitute approximately half of the population. Taking cognizance of their gender stereotypes as leaders and decision makers at household, community and policy levels, they have an important role to play in the promotion and success of their own reproductive health as well as the reproductive health/MNCH their female partners/wives and young people. They also require information and knowledge to deal with their own reproductive health issues. Often marginalized by traditional health services e.g. MCH clinics, there is a need for health workers and CORPs

at PHC level to play a critical role in empowerment through the provision of information and services targeted at boys, youths and men within the home, communities and place of work.

To strengthen individual, family and community capacity to take necessary MNCH actions at home and to seek health care appropriately male involvement must be continuously encouraged. Utilization of MNCH/FP services should be a shared responsibility and collective action to improve household healthcare seeking behaviour and other Key Household Practices (KHHP). Women should be encouraged to bring their partners to the facility.

3.8 Summary

Primary health care is a strategy that was adopted and endorsed in an international conference in Alma Ata, Russia in 1978 with the purpose of attaining equitable access to basic health care services including both prevention and treatment of locally endemic diseases. The ultimate aim of primary health care is to ensure that, health care services are available, affordable, accessible and acceptable to all the various groups in the population with a greater emphasis on community involvement and participation. The primary health care approach is the best option to health care delivery that would satisfy the greater percentage of the health care needs of the mothers and children in the population. The foundational principles of primary health care, when properly adopted would significantly address the problem of inequality and inequitable distribution of health and health services among members of the various segments, thereby reducing maternal and child mortality in the communities.

3.9 References/Further Readings/Web Resources

Ogbonaya, R. & Aminu, M. (2009, April 7). Nigeria: north-west battling malnutrition, child maternal mortality. *THISDAY*. PP 18 – 21.

Ogunjimi, L.O, Ibe, R.T., & Ikorok, M.M. (2012). Curbing material and child mortality: the nigerian experience. *International Journal of Nursing and Midwifery, 4*(3), 33 – 39.

Omoleke, I.I. (2005). Primary health care services in Nigeria: constraints to optimal performance. *Nigeria Journal of Medicine, 14(*2), 206 – 212.

Saraki, T. (2008). *Nigeria of Community Medicine, maternal health – more that than just reproductive health.* Retrieved from Allafrica.com.

Shehu, M. (2003, December, 17). Revitalizing primary health care in nigeria. *The Road, 6*(3), 8 – 9.

Sridhar Rao, B. (2006). *Community health nursing*. New Delhi, India: AITBS Publishers.

Udofia, I., & Okonofua, F. (2008). Preventing primary post-partum hemorrhage in unskilled births in Africa. *Africa Journal on Reproductive Health, 12(*1), 8 – 10.

United Nations Children Fund (2010). *The children – material and child health*. Abuja. UNICEF.

World Bank (2005). *Nigeria health, nutrition, and population countrystatus report.* Abuja: World Bank.

World Health Organization (2015, February, 25). At the world health assembly. Nigeria confronts challenges of health care financing, MDGs. *THISDAY LIVE,* PP 11 – 14.

World health Organization and United Nations Children Fund (1978). *Declaration of Alma-Ata, international conference on primary health*. Geneva: WHO maternal.

Wotorufa, A.E. (2017, July 10). Bayelsa worst maternal mortality in south-south. *TRIBUNE*

3.10 Possible answers to SAEs

Answer to SAE 1

The MNCH Facility level Services

Community Health Extension Workers, Community Health Officers, Nurses, Midwives and Physicians (in some places) are the cadres of health workers providing services at the health facility/wards level.
These cadres of health workers should perform all the tasks of the village health workers and the traditional birth attendants with all clinical duties

Maintain a good relationship with women in the clinic and community by:

- using appropriate communication techniques;
- explaining to the women in local language the services available in the clinic and the community;
- providing integrated and culturally acceptable services; and Review the following (briefly):
- anatomy and physiology of the male and female reproductive organs in relation to pregnancy, labour, delivery, puerperium and family planning;
- menstrual cycle in relation to conception and implantation;
- fertilization;
- signs and symptoms of pregnancy.
- the National Code of Ethics and professional standards for the marketing of breast milk substitutes.
- Decree No. 41 “Marketing Breast milk Substitutes of 1990”
- the 10 steps to successful breast-feeding

Answer to SAE 2

- women with first pregnancy irrespective of maternal age;
- women with previous multiple pregnancies;
- women aged below 16 years and above 35 years;
- short women (below 5 feet) with small feet;
- women with more than 4 children;
- women with bad obstetric history e.g. still birth, prolonged labour etc.
- women with deformity (hunch back)
- women with scars on the vulva

Answer to SAE 3

Abstinence and Coitus Interruptus:

Natural Family Planning (NFP) Fertility Awareness based Method (FAM) and Lactational Amenorrhoea Method (LAM)

Calendar - Using calendar to determine the fertile days.
Ovulation -This is based on changes that take place in the quantity and quality of cervical mucus during the menstrual cycle
Symptom-thermal - This is a combination of the temperature, calendar and mucus methods to determine time of ovulation.
Fertility Awareness based Method (FAM) - Use of physical signs, symptoms and cycle data to determine when ovulation occurs. The same technique may be use to help couples became pregnant by detecting

ovulation.

Lactational Amenorrhoea Method (LAM)

Breastfeeding delays the return of fertility in the postpartum period. However, LAM is a contraceptive method based on exclusive breastfeeding.

Is a natural method of birth control which involve observation of vaginal secretion and changes in temperature (Billing methods). Special training is required to know how to use the method. Better result could be obtained by the use of thermometer, beads and calendars.

Barrier methods

Male condoms and female condoms

Foaming Tablets - Chemical agents that can destroy male sperm (egg). It is inserted in the women's private part five minutes before sexual intercourse. If the women want to have another sexual intercourse, she has to insert another tablet and wait for it to dissolve.

Hormonal Methods

- **Oral pills**: (re-supply only) taken by women once daily by mouth; it prevents the body from producing eggs. Clients referred are re-supplied with the pills monthly.
- **Emergency contraceptive pills (ECPs)** -
- **U.C.D:** A small plastic device placed in the womb, which prevents the man's sperm from joining the woman's eggs. The procedure is performed in special Family Planning Clinics.
- **Implants:** These are progestin-only contraceptives inserted under the skin of women's upper arm by minor surgical procedure.
- . **Injectables:** These are long lasting contraceptives containing combined estrogen and progestogen only and are given by intramuscular injection.

Voluntary Surgical Contraception (VSC):

This is a permanent method of contraception which involves a minor surgical procedure to prevent pregnancy eg Vasectomy for males and tubal ligation for women.

UNIT 4 HEALTH PROMOTION

Unit Structure

4.1 Introduction
4.2 Intended Learning Outcomes
4.3 Concepts and Elements of Health Promotion
4.4 Components of Health Promotion
4.5 Principles guiding Health Promotion
4.6 Critical Issues concerning Health Promotion
4.7 Roles and Responsibilities in Health Promotion
4.8 Information, Education and Communication (IEC) in PHC
4.8.1 Objectives of IEC
4.8.2 Examples of IEC
4.8.3 Types of IEC Media
4.8.4 Conditions for Effective Communication
4.8.5 Barriers to effective communication
4.8.6 Caution in use of IEC Strategies in PHC
4.9 Roles of PHC workers in Material Development
4.10 Advocacy meeting/Activities with LGA Functionaries and Community Leaders
4.10.1 Community Level Health Promotion
4.10.2 Local Government Level Health Promotion
4.10.3 State Level Health Promotion
4.10.4 National Level Health Promotion
4.11 Summary
4.12 References/Further Readings/Web Resources
4.13 Possible answers to SAEs

4.1 Introduction

Health promotion is the process of improving and protecting the health of the public, including individuals, populations, and communities. Health promotion and disease prevention can be achieved through planned activities and programs that are designed to improve population health outcomes. Health promotion and disease prevention programs can empower individuals to make healthier choices and reduce their risk of disease and disability. At the population level, they can eliminate health disparities, improve quality of life, and improve the availability of healthcare and related services. In this unit, the concepts, elements and components of Health Promotion will be discussed. Principles and the critical issues as well as the roles at different levels of health promotion will be analysed.

4.2 Intended Learning Outcomes

By the end of this unit, you will be able to:

- Define the concept of Health Promotion
- Enumerate the elements of Health Promotion
- State the components of Health Promotion
- Explain the principles of Health Promotion
- Analyse the critical issues of Health Promotion
- Discuss the roles at the different levels of Health Promotion
- Describe the processes of Information, Education and Communication (IEC) in PHC

4.3 Concept of Health Promotion

The concept of Health Promotion is broader than health education. There has been growing realization that health education can influence knowledge, but on its own may not result in behavior change. The concept of Health Promotion was defined at the landmark First Global Conference on Health Promotion in Ottawa 1986. The Ottawa Charter defined Health Promotion as consisting of five elements:

- Development of health public policy.
- Creation of supportive environment for health.
- Strengthening of community action.
- Development of personal skills.
- Reorientation of health services.

These five elements can also be simplified into three basic components.

1. Health Education with individuals and communities.

2. Reorientation of health services to improve their accessibility, acceptability and appropriateness.
3. Advocacy to influence policy makers to adopt healthy public policies and enact/enforce laws that promote health and consumer rights.
4. Health promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve their health. It is a core function of public health and contributes to the work of tackling communicable and non communicable diseases and other threats to health.
5. Health Promotion therefore involves a multidisciplinary

application of skills in psychology, anthropology, economics, political theory, consumer rights/law, communication, media design, epidemiology, management, community mobilization and the application of research, planning and evaluation skills.

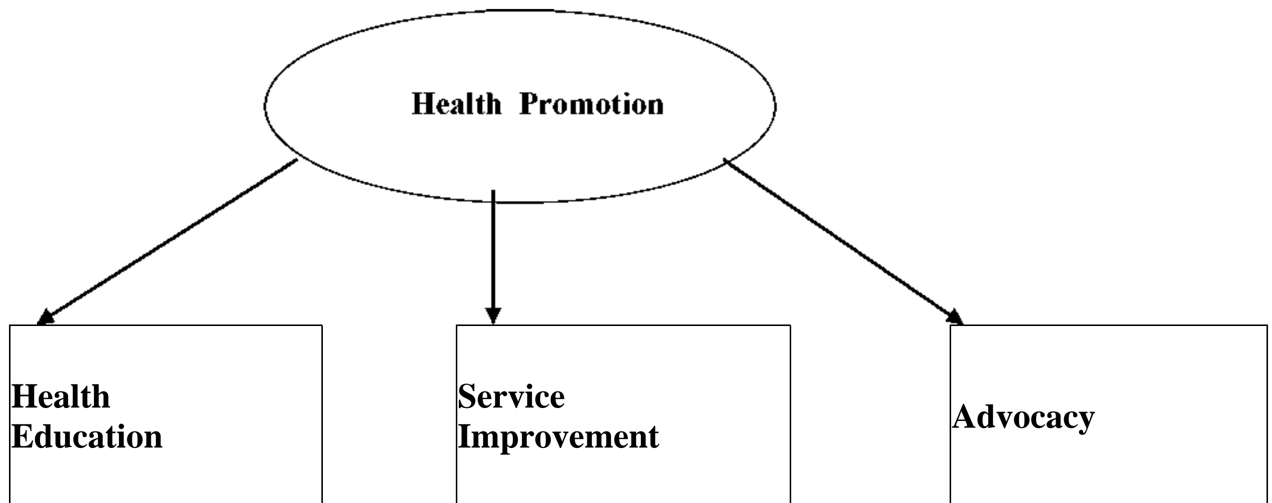
SAE 1

i)State the five elements of Health Promotion

4.4 Who does Health Promotion?

Health Promotion is part of the role of a wide range of field staff within health and other services e.g. nurses, doctors, teachers, agricultural workers etc.

Figure 1: Three Components of Health Promotion



Communication directed at families & communities to influence:

Awareness/Knowledge

Decision-making

Beliefs/attitudes

Employment

Individual and community

Action/ behaviour change

Community participation

Improvement in quality & quantity of services:

Accessibility

Case Management

Counselling

Patient Education

Outreach

Social Marketing

Agenda setting & individual, advocacy for healthy public policy:

Policies for health

Income generation

Removal of obstacles
Discrimination

Inequalities

Gender barriers

Health Promotion Specialists: These are persons who have received specialist training in Health Promotion, whose task is to act as resource persons for the planning, evaluation, training and support of Health Promotion. Accordingly, the term Health Promotion Specialist will apply to this specific cadre whose function is to complement and support the Health Promotion role of the Ministry of Health and LGA Health Team.

The Private Sector

In this policy, the term private sector refers to private health care providers and private-for-profit organizations.

4.5 Five Key Principles Guiding Health Promotion

Context Driven

Promoting health requires advanced knowledge about the interface between health and its determinants, social epidemiological skills for analyzing socio-economic, gender and ethnic gaps in health and disease patterns in populations, as well as effective mechanisms to maintain and improve good health for all, taking into account different historical, religious and societal values and practices.

Integrates the Three Dimensions of the WHO Health Definition

Promoting health means addressing the multi-dimensional nature of health, its physical, social, and mental dimensions. For many countries and communities it has also been evident to include a fourth dimension, spiritual health, given their cultural context.

Underpins the Overall Responsibility of the State in Promoting Health

All levels of government have a responsibility and accountability for protecting, maintaining and improving the health of its citizens, and need to include health as a health as a major component in all undertakings, i.e. policy development and service delivery. People have a right to equal opportunities to good health and well-being. In countries, or system, with a weak role of the government and a diminished public health sector, voluntary organizations and parts of the private sectors are significantly contributing to people's health.

Champions Good Health as a Public Good

Good health is beneficial to the society as a whole, its social and its

economic development. In this view health becomes a public good and a key component of modern citizenship. Being aware of health becoming increasingly inter-dependent, there is a need to ensure that health also is viewed as a global public good.

Participation as a Core Principle in Promoting Health

The participation of people and their communities in improving and controlling the conditions for health is a core principle in promoting health. Improved health literacy fostered by modern means of health education will make people better equipped in giving voice and contributing in participatory processes.

4.6 Critical Issues Concerning Health Promotion

Major Weaknesses

Various studies have highlighted a number of weaknesses that could limit the capacity of the Nigerian health system to effectively carry out Health promotion. These include:

Little understanding of concepts of Health Promotion, consumer rights, the need for multi-sectoral action and the promotion of supportive environments for health behavior change.

- Implementation of health education/Health Promotion at the three tiers of government is minimal, ad hoc and inconsistent.
- Poor communication design process: Analysis is rarely conducted before embarking on health communication activities and educational materials are not always pre-tested. Most health educators are not qualified and lack key skills in communication.
- Few health programmes directed at building capacity at the community level. Community participation is limited to mobilizing communities to attend health talks, meetings or other specific events. Most health educators lack key skills in communication and community participation.
- Lack of frameworks or guidelines that ensure systematic planning and management of health education interventions. The Health Education Unit is not adequately involved in the design of Health Promotion activities done within and outside the Ministry of Health.
- No clear mechanisms for monitoring and evaluating health communication activities.
- Health Education/Health Promotion is seen to be an activity for the Ministry of Health only and there has been a failure to mobilize the Health Promotion potential from other line ministries.
- Lack of coordination of the different organizations carrying out

Health Promotion.

- Health Education Branch/Units at the federal, state or local government levels do not have a consistent relationship with the numerous Nigerian NGOs and the private sector that work in the area of health.
- Lack of resources from Government for Health Promotion activities.

SAE 2

i)Explain major weaknesses of Health Promotion

Major Strengths

Despite the above weaknesses, there is also much strength that can be built upon to enable the Health System to effectively undertake health promotion activities. They include:

- Government commitment to Health Sector Reform, new Health Policy and health bill all include Health Promotion amongst designated actions.
- There is growing concern about state of health services and the need to promote consumer rights for healthcare.
- There are many NGOs in Nigeria active in health communication with skills and expertise.
- Evidence from other countries and also Nigeria demonstrate that well-planned Health Promotion can promote behavior change and improve health.
- A lively press that provides extensive coverage of health issues.
- National and State level mass media networks which are already being used extensively for Health Promotion.
- Involvement of Nigeria in International Health Promotion activities e.g. Framework Convention on Tobacco Control.
- Structures exist at all levels that can be built upon for health promotion including training institutions.
- Interest by donors and international agencies in supporting Health Promotion.
- Interest by Federal Government to prepare and implement a Health Promotion.

4.7 Roles and Responsibilities in Health Promotion

At the LGA, State and National levels of activity, two bodies will operate. The first body will be a committee bringing together key persons from all sectors at a level to provide the coordination and strategic planning for Health Promotion. With the exception of the national level, where a new body is proposed, these are to be based on existing multisectoral primary health care committees but with an expanded membership and defined Health Promotion and Consumer Rights responsibilities.

Role of Stakeholders In Health Promotion

The National Policy on Health Promotion recognizes the positive roles and immense contributions of the community, the private sector, Non-Governmental Organizations (NGOs), international organizations and all other donor agencies in the nation's drive towards achieving Health for all in accordance with the National Health Policy.

Line Ministries

- **Ministry of Education**

Collaborate with the Health Promotion Division/Unit at various levels in the implementation, monitoring and evaluation of school health activities including school health education, school health services, screening and improvements in the school environments including water and sanitation. Facilitate the incorporation of Health Promotion into school curriculum and teaching. Assist in the distribution and use of relevant IEC materials as well as promote Human Resource Development in Health Promotion. Advocate for policies to support girl and boy child education.

- **Ministry of Agriculture**

Collaborate with the Health Promotion Division/Unit at various levels in the promotion of nutrition education. Assist in the distribution of IEC materials through Agricultural Extension Workers. Contribute to the achievement of food security in Nigeria.

- **Ministry of Information**

Collaboration with the Health Promotion Division/Unit at various levels in the development and production of publicity/advocacy packages on Health Promotion. Foster collaboration between the various media bodies within the Ministry of Information and the various levels of

Health Promotion divisions/units. Assist in the distribution of IEC material. Coordinate activities between public and private media houses.

- **Ministry of Environment**

Collaborate with the Health Promotion Division/Unit at various levels in the development of messages/materials on environmental health issues. Advocacy on environmental protection issues such as environmental degradation, pollution, etc. advocate for policies on environmental protection. Assist in the development and distribution of IEC materials.

- **Ministry of Women Affairs**

Collaborate with the Health Promotion Division/Unit at various levels in the development of messages/materials on the health of women and children. Assist in the distribution of IEC materials. Advocate on issues relating to the rights of women, girl-child education, FGM, gender inequality, etc. Advocate for policies that affect women and children.

- **Ministry of Water Resources**

Collaborate with the Health Promotion Division/Unit at various levels in the development of messages/materials on water. Contribute to a supportive environment that ensures the availability and quality of water resources.

- **Ministry of Finance**

Ensure health is accorded a central place in the development and planning of national programmes. Ensure adequate budgetary provision and prompt budgetary disbursement for health. Collaborate with the Federal and State ministries of Health on matters relating to Health Promotion.

- **Ministry of Local Government**

Liaise between State and LGA on all matters relating to health. Ensure effective implementation of Health Promotion activities at the LGA level. Collaborate with the Federal and State Ministries of Health-on-Health Promotion.

- **Ministry of Science and Technology**

Provide scientific and technological support towards achieving the realisation of the health goals of Nigeria. Collaborate with the Federal and State Ministries of Health-on-Health Promotion issues.

- **Ministry of Housing**

Provide enabling supportive environment for the development of housing schemes which safeguard and protect human life. Collaborate with the Federal and State Ministries of Health-on-Health Promotion issues.

- **Other Line Ministries (involved in Health Promotion)**

Provide enabling supportive environment for Health Promotion activities. Collaborate with Federal and State Ministries of Health-on-Health Promotion issues.

Private Sector

- Private Health Service Providers

Create awareness on healthy lifestyles and practices. Disseminate information on consumer rights and responsibilities. Prompt referral of consumer to secondary and tertiary healthcare facilities. Carry out Health Promotion activities to patients. Collaborate with the Federal and State Ministries of Health in Health Promotion activities.

Others

- Professional Bodies

Regulate activities and practices of their members. Advocate for healthy lifestyles and consumer rights for members and clients. Collaborate with the Federal and State Ministries of Health in Health Promotion activities.

- **Civil Society Organizations**

Promote healthy lifestyles and practices among members. Collaborate with the Federal and State Ministries of Health in Health Promotion activities. Promote consumer rights and the protection/enforcements of such rights.

- **NGOs and CBOs**

Plan and implement sustainable Health Promotion activities at the community level. Liaise with the Federal and State Ministries of Health and Health Departments of Local Government Areas on matters relating to Health Promotion. Promote human resource development on Health Promotion.

- **Donors/International Organizations**

Provide financial and technical support for Health Promotion activities. Provide capacity building for health practitioners, CBOs, NGOs, Informal Health Service Providers, etc. collaborate with the Federal and State Ministries of Health in Health Promotion activities.

- **Faith Based Organizations**

Mobilize followers and community members for Health Promotion activities. Collaborate with the Federal and State Ministries of Health in Health Promotion activities.

- **Informal Health Service Providers**

Mobilize community members for Health Promotion activities. Collaborate with the Federal and State Ministries of Health and LGAs in Health Promotion activities.

- **Private Organizations/Companies**

Provide a healthy work environment for all employees. Disseminate information on healthy lifestyles and practices. Address issues related to occupational health.

Address Health Promotion needs of surrounding communities. Collaborate with the Federal and State Ministries of Health in Health Promotion.

- **Private Media Companies/Organizations**

Provide information of healthy lifestyles and practices. Create enabling environment for the adoption of healthy behaviours. Advocate for the enactment of legislation to support health promotion activities. Set an Agenda for Health Promotion nationwide. Collaborate with the Health Promotion/Education divisions of the Federal and State Ministries of Health in the development and dissemination of Health Promotion messages.

- **Private Research Companies/ Institutions**

Collaborate with the Federal and State Ministries of Health Promotion activities. Disseminate findings on best practices and lessons learned from evaluated Health Promotion interventions to stakeholders.

4.8 Information, Education and Communication (IEC) in Primary Health Care

Information, Education and Communication (IEC) is the planned process of deciding how to get educational messages most effectively across to the target audience, and this includes decision about what to say, to whom, and about the channel of communication. In most cases, needed communication material are unavailable and when available may not be culturally appropriate or relevant to the local situation. Therefore, a deliberate effort should be made to produce, develop or adapt needed information, education and communication materials which will meet the needs of target audience.

Producing material for health education locally is itself a process in which every community health worker should be involved.

This process requires that all concerned should think about:

(a) the target audience.
(b) the target behaviour;
(c) the message design.
(d) the credibility and source of the message; and
(e) the delivery channel.

The use of Information, Education and Communication (IEC) skills in Primary Health Care (PHC) involves the direct or indirect application of basic health education principles and theories for the purpose of promoting positive health behaviour which brings about the attainment of optimum level of wellbeing among individuals, families, communities and the nation.

IEC is the strategy through which the highly valued involvement and participation of people and communities in identification and solution of their problems in PHC can be effectively realized. Thus, it is the most widely applied of the basic elements of PHC.

4.8.1 Objectives

i) To increase awareness and improve knowledge on health issues.
ii) To effect attitudes, change that would create support for individuals or bring about collective action.
iii) To demonstrate or illustrate skills
iv) To create and increase demand for health services
v) To foster desirable changes on knowledge, attitudes, and behaviour.

A person's behaviour or the living conditions of a community may be the main cause of a health problem but can also be the main solution. Therefore, health workers can use IEC successfully by:

- Listening to the people and talking to them about their health problems.
- Identifying the behaviour or action of the people that could cause, cure or prevent these problems.
- Finding reasons for people's behaviour (beliefs, practices, ideas and others).
- Helping people to understand the relationship between their actions and health problems.
- Asking people to offer their own ideas for solving the problems.
- Helping people to examine their ideas so that they could decide which are the most useful and the simplest to put into practice.
- Encouraging people to choose the idea that best suits their circumstances.

But then, for the health worker to communicate in the most effective way with the people, relevant IEC methods, media and techniques (such as direct person to person, indirect or combination of approaches), have to be developed and applied. Often, many different presentations of the same facts and ideas are needed. The better you know the local people, the more likely you are to develop the best ways of communicating with them. Therefore, the methods, media or techniques chosen must suit the situation and the problem of the people concerned.

4.8.2The Examples of IEC methods from which a health worker may choose include:

- Health Talk/Lecture
- Counseling
- Stories
- Dance
- Songs
- Meeting
- Drama
- Town criers gong/drum
- Discussion
- Role playing
- Community meetings

4.8.3 Types of IEC Media

IEC Media include:

- Interpersonal channel (media) i.e. yourself and people around you. For instance, the use of stories, songs, role-playing, group discussions and community meetings rely on this type of IEC medium of communication.
- Print Media (using materials or teaching aids) such as posters, leaflets, pictures, pamphlets, brochures, newspapers, stickers, out-door panels (billboards), flip charts etc.
- Electronic Media (using machines), such as tape recorders, films or slide projectors etc. But it should be noted that machines usually need electricity. Machines and materials cost money. Try to look for methods that are inexpensive.

4.8.4 Conditions for effective Communication

Certain conditions are required for effective communication to take place. These include:

- A credible source
- Appropriate language
- Appropriate time
- Knowledge of characteristics of the target group
- Convenient place
- Involvement of people
- Pre-tested and appropriately designed educational materials.
- active listening.
- clear message.
- credibility on the part of the communicator
- keen interest in the subject matter
- good knowledge of subject matter
- conducive environment (lighting, no noise, sitting arrangement)
- appropriate audio-visual aids.

4.8.5 Barriers to effective communication

Certain factors can hinder effective communication. These include:

- Personality.
- Socio-economic differences.
- Differences in attitudes and perception.

. Emotion
. Ability to listen - may be a poor listener.
. Inadequate knowledge.
. Use of wrong medium.
. Too many messages in a shorttime.
. Disregard for normal attention span; and
. Non conducive environment

4.8.6 Caution in use of IEC strategies in PHC:

i) compensate for a lack of health care services
ii) produce behaviour changes without effective combinations or integration of supportive programme components.
iii) be equally effective in addressing all issues or relaying all messages.

In addition, any properly thought-out IEC policy in support of PHC should take cognizance of the following principles:

- Awareness and knowledge do not necessarily lead to change in behaviour
- Maintenance of desirable behaviour requires appropriate and constant motivation.

SAE 3

i)Enumerate the barriers to effective communication

4.9 Roles of PHC workers in Material Development

Although material design and development is a specialized area for IEC experts, it requires the participation of PHC workers at all levels of implementation. While certain material development roles are common for PHC workers at all levels, others are specific to each level of PHC implementation.

Roles of PHC Workers at all Levels

1. Contact the resource person for the material development e.g. graphic artists, trained health educator etc.
2. Make suggestions and decisions on problem areas for which educational materials would need to be developed.
3. Help in identification of target audience that will be using the developed material.
   ie. mothers, market women etc.
4. Assist in testing the developed materials with resource persons.

5. Participate in the review of field-tested materials before final production.
6. Use the produced materials in support of drama, songs, role-play, demonstration, discussion, storytelling to educate community members etc.
7. Monitor and evaluate the use of the materials after health education activity.

4.9.1 Specific Roles for PHC Workers: Village/Community Level

1. Liaise with the health facility to collect materials for use at community level.
2. Arrange for working area, putting poster, pamphlet, films at health post, etc.

Health Facility/Ward Level

In addition to the village level activities, the Community Health Worker will be able to:

1. liaise with the Wards Supervisor to collect educational materials.
2. supervise the use of these materials at the Wards and Facilities.
3. train the village level workers in the use and/distribution of the materials.

Local Government Area Level

1. Identify local media of information and NGOs as partners in Information, Education and Communication activities.
2. Identify local artists, media capabilities for usage of health education materials.
3. Motivate other service providers to use and distribute health education materials.
4. Liaise with mass media organizations such as radio, TV and newspaper to negotiate time to suit the target audience.
5. Identify local and external resources for printing and binding educational material.
6. Assess cost estimate for material development/printing and prepare budget.
7. Specify work outline for identified staff who have responsibility for material development.
8. Work with the Health Facility, Ward, and Village/Community levels in the development, pre-testing and adaptation of educational materials to meet local needs.
9. Collaborate with other health sector/NGOs within the LGA as

partners in development of educational materials:

10. Supervise procurement schedules of communication and audio-visual equipment.
11. Ensure that development, pre-testing, revision and production of I.E.C. Materials are done before organizing training session of field staff so that the produced IEC materials can be used.

4.10 Advocacy Meeting/Activities with LGA Functionaries and Community Leaders

Advocacy activities are designed for the purpose of seeking acceptance, commitment and support for PHC activities. In order to make a successful entry into an LGA, for example, contact should be with the Chairman and the functionaries of the LGA.

STEPS

- make initial visit to the LGA
- discuss with the LGA functionaries and community leaders, the following:
- objectives
- the responsibilities of the LGA, NGOs, communities and individuals
- the national health policy as it relates to PHC programme, and the target community
- the need to relaunch PHC in the LGA.

- Plan when, how, where to relaunch the programme with the PHC Coordinators as follows:
- Create awareness on the launching of the programme through appropriate and available channels
- Arranging for Radio/TV and traditional coverage etc;
- Allowing policy makers to talk briefly about the philosophy, principles, elements, strategies of PHC, stressing the roles of LGA and different groups in the community.
- Allowing the chairman to pronounce the commitment of the LGA to PHC programme;
- Formation and announcement of the LGA PHC Management Committee.

Advocacy is a dynamic process, and every health worker should be involved.

4.10.1 Community Level Health Promotion

- Community Level Committee

A Health Promotion Committee will be set up at the community level. The Ward Health Committee or Village Health Committee established in the National Health Bill/National Health Policy shall be expanded to include community members from the following areas of interest:

- Traditional Rulers
- Councillors
- Women's Associations
- NGO/CBO/CSOs
- Age Grade Associations
- Youth Associations
- Informal Health Providers
- Health Providers including TBAs/VHWs
- Teachers
- Town Unions
- Faith Based Organizations

The Committee will meet at least quarterly and will undertake the following responsibilities:

- Identify and prioritize Health Promotion and Consumer Rights needs in the Ward/village and develop action plans for health promotion.
- Implement, monitor and evaluate Health Promotion and Consumer Rights activities.
- Coordinate the Health Promotion activities of different stakeholders to ensure that Health Promotion messages are consistent and do not contradict each other.
- Advocate with local stakeholders to increase their involvement in Health Promotion.
- Liaise with Health Promotion staff in the LGAs.
- Mobilize resources for Health Promotion from the local community and the LGA. The Health Promotion unit at the LGA will provide support to the Health Promotion and Consumer Rights at Ward/village level.

4.10.2 LGA Level Health Promotion

- LGA Level Committee

The existing LGA Primary Health Care Management Committee shall be expanded to include representation from the following:

- Members of the Finance and General-Purpose Committee of the LGA.
- Traditional Rulers
- Women's Association
- NGO/CBO/CSOs
- Youths
- Media
- Donor Community
- Private Sector
- Transport Unions/Okadas
- Informal Health Providers
- Faith Based Organizations

The Committee's functions shall include the following:

- Identify Health Promotion and Consumer Rights needs of the LGA and develop action plans for Health Promotion responding to needs.
- Provide Health Promotion support for all components of PHC within the L.G.A.
- Liaise with the State and Federal Ministries of Health on Health Promotion and Consumer Rights issues.
- Coordinate, monitor and evaluate Health Promotion activities by the various organizations within the LGA area.
- Coordinate the Health Promotion activities of different stakeholders to ensure that Health Promotion messages are consistent and do not contradict.
- Mobilize resources for Health Promotion at the community and LGA level.
- Ensure adequate support and funding for the work of the LGA Health Promotion unit.

LGA Health Promotion Division

The Health Education Service at the LGA level will be regarded to a Health Promotion Unit within the Primary Health Care Department with the following responsibilities.

- Adapt National/state Health Promotions guidelines for local use.
- Liaise with Health Promotion divisions at State and Federal levels.
- Develop/adapt and distribute IEC materials to suit local requirements.
- Conduct training in Health Promotion and Consumer Rights for other field staff workers in the local government.

- Carry out Health Promotion activities in communities including community mobilization.
- Monitoring and evaluation of all Health Promotion activities at the LGA level.
- Assist Federal, State and other stakeholders conducting research on Health Promotion in the LGA.

4.10.3 State Level Health Promotion

State Level Committee

The existing State Primary Health Care Management Committee will be expanded. The membership of this committee shall include representatives from the following bodies operation at a State level:

- State House of Assembly
- Women's Association
- NGO/CBO/CSOs
- Relevant line ministries
- Youth organizations
- Media
- Donors
- Private sectors
- Traditional Rulers
- Informal Health Providers
- Faith Based Organizations
- Professional Associations
- Parastatals /Government Agencies

The committee will meet quarterly. Its functions shall include:

- Adapt national policies and guidelines on Health Promotion activities at the state level.
- Coordinate, monitor and evaluate all Health Promotion activities at the State level.
- Coordinate Health Promotion activities of different Stakeholders to ensure that Health Promotion messages are consistent and do not contradict.
- Advocate for Health Promotion and Consumer Rights within the State.

Strengthen Health Promotion components of Primary Health Care.

- Liaise between the Federal and Local Government on Health Promotion matters.
- Mobilize resources for Health Promotion activities.

State Health Promotion Division

The Health Education service at the State level shall be upgraded to a Health Promotion Division within the Primary Health Care Department with the following responsibilities:

- Provide technical support to LGAs in the development and implementation of Health Promotion activities.
- Approve all developed Health Promotion messages and materials for all vertical programmes and line departments within the State.
- Develop appropriate Health Promotion activities for implementation in the State.
- Promote human resource development in Health Promotion at State and LGA levels.
- Conduct and promote in Health Promotion at the State and LGA levels and document/disseminate the findings.
- Develop/adapt and distribute I.E.C materials on health and related issues.
- Collaborate with local NGOs, CBOs and other relevant on stakeholders on Health Promotion and Consumer Rights matters.
- Produce an annual report on Health Promotion activities within the state.
- Establish an electronic and paper-based documentation centre which includes both general resources on Health Promotion and details of previous and on-going Health Promotion activities in Nigeria. Make information from the documentation centre available to all interested groups through a web site.

4.10.5 National Level Health Promotion

National Health Promotion Committee

At the national level a National Health Level Promotion Committee will be formed with representatives from the following bodies:

- National Assembly
- Women's Associations
- NGO/CBO/CSOs
- Uniformed Services
- Youth Organizations
- Labour Organizations
- Media
- Donor's Community
- Private sector
- Traditional Rulers
- Informal Health Providers
- Faith Based Organizations

- Professional Associations
- Parastatals/Government
- Academia/ Research Institutions

The Committee will meet quarterly. Its functions will include the following:

- Advocate for Health Promotion and Consumer Rights at all levels
- Identify Health Promotion and consumer rights needs for Nigeria.
- Develop appropriate policies and strategies to promote health and protect consumer rights.
- Initiate, implement, monitor and evaluate mechanisms to protect consumer rights.
- Coordinate Health Promotion activities at all levels.
- Provide a forum for information exchange /sharing /networking on Health Promotion
- Promotion through quarterly meetings and an annual conference of Health Promotion.
- Monitor and evaluate the implementation of Health Promotion policy in Nigeria.
- Mobilize resources for Health Promotion
- National Health Promotion Division

The National Health Education Branch will be recognized and strengthened to become a division to carry out the following roles:

- Act as secretariat for Health Promotion Committee
- Act as national focal point for Health Promotion and Consumer Rights.
- Approve all Health Promotion messages and materials from vertical programmes and line departments at the Federal level.
- Provide technical assistance at Federal and State levels in planning, implementation, monitoring and evaluation of Health Promotion activities.
- Act as a focal point for international movements to develop Health Promotion within specific settings e.g. health-promoting schools, healthy cities, health promoting hospitals, healthy villages, healthy workplaces provide technical assistance to line ministries, NGOs, CBOs and private sector organizations working in these and other important settings.
- Conduct and promote research into various aspects of Health Promotion and disseminate the findings.
- Act as a focal point for actions to promote consumer rights within health care settings.
- Promote human resource development in Health Promotion at the three tiers of government and relevant stakeholders.

- Develop guidelines and prototype information (IEC) materials on health and related issues.
- Collaborate informally and through partnership agreements with National and international Agencies and NGOs on Health Promotion matters.
- Establish an electronic and paper-based documentation centre which includes both general resources on Health Promotion and details of previous and on-going Health Promotion activities in Nigeria. Make information available from the documentation centre available to all interested groups through a web site.

4.11 Summary

In this unit, you have learnt about the concepts and elements of Health Promotion, principles guiding Health Promotion as well as critical issues concerning Health Promotion. Objectives, examples and types of Information, Education and Communication in PHC was also highlighted. Conditions, barriers to effective communication was also unfolded. Advocacy meeting towards Health Promotion at Various levels were also discussed. However, the principal motivation for the development of Health Promotion has been the widespread realization of the limited ability of personal healthcare to solve all the health problems faced by populations.

4.12 References/Further reasons

Baum, F. E., Legge, D. G., Freeman, T., Lawless, A., Labonté, R., & Jolley, G. M. (2013). The potential for multi-disciplinary primary health care services to take action on the social determinants of health: actions and constraints. BMC public health, 13(1), 1-13.

Baum, F., Freeman, T., Jolley, G., Lawless, A., Bentley, M., Värttö, K., ... & Sanders, D. (2014). Health promotion in Australian multi-disciplinary primary health care services: case studies from South Australia and the Northern Territory. Health Promotion International, 29(4), 705-719.

Cohen Committee (1964) Health Education, Report of a Joint Committee of the Central and Scottish Health Services Councils. London: Health Management Service Organization

Hatch, S., & Kickbusch, I. (1983). Self-Help and Health in Europe. New Approaches in Health Care. World Health Organization

Publications Centre USA, New York

Katz A. H., Bender E. (1976) The Strength in Us: Self Help Groups in the Modern World. New York: Franklin Watts

Labonté, R. (1994). Death of program, birth of metaphor: the development of health promotion in Canada. Health promotion in Canada. Toronto: WH Saunders

Labonte R, Penfold S. (1981) Canadian perspectives on health promotion: A critique, Health Education 19 (3/4): 4–9

Lalonde M. (1974) A New Perspective on the Health of Canadians. Ottawa: Ministry of Supply and Services

McKeown T. (1979) The Role of Medicine: Dream, Mirage or Nemesis. Princeton, NJ: Princeton University Press

Means, R., Richards, S., & Smith, R. (2008). Community care: policy and practice. Macmillan International Higher Education.

Nutbeam D., Wise M. (1996) International experiences in health goal and target setting, Health Promotion International 11: 219–26

4.13 Possible answers to SAEs

Answer to SAE 1

1. Health Education with individuals and communities.
2. Reorientation of health services to improve their accessibility, acceptability and appropriateness.
3. Advocacy to influence policy makers to adopt healthy public policies and enact/enforce laws that promote health and consumer rights.
4. It is a core function of public health and contributes to the work of tackling communicable and non-communicable diseases and other threats to health.
5. Health Promotion therefore involves a multidisciplinary application of skills in psychology, anthropology, economics, political theory, consumer rights/law, communication, media design, epidemiology, management, community mobilization and the application of research, planning and evaluation skills.

Answer to SAE2

Major weaknesses to health Promotion

- Implementation of health education/Health Promotion at the three tiers of government is minimal, ad hoc and inconsistent.
- Poor communication design process: Analysis is rarely conducted before embarking on health communication activities and educational materials are not always pre-tested. Most health educators are not qualified and lack key skills in communication.
- Few health programmes directed at building capacity at the community level. Community participation is limited to mobilizing communities to attend health talks, meetings or other specific events. Most health educators lack key skills in communication and community participation.
- Lack of frameworks or guidelines that ensure systematic planning and management of health education interventions. The Health Education Unit is not adequately involved in the design of Health Promotion activities done within and outside the Ministry of Health.
- No clear mechanisms for monitoring and evaluating health communication activities.
- Health Education/Health Promotion is seen to be an activity for the Ministry of Health only and there has been a failure to mobilize the Health Promotion potential from other line ministries.
- Lack of coordination of the different organizations carrying out Health Promotion.
- Health Education Branch/Units at the federal, state or local government levels do not have a consistent relationship with the numerous Nigerian NGOs and the private sector that work in the area of health.
- Lack of resources from Government for Health Promotion activities.

Answer to SAE 3

Barriers to effective communication

Certain factors can hinder effective communication. These include:

- Personality.
- Socio-economic differences.
- Differences in attitudes and perception.
- Emotion
- Ability to listen - may be a poor listener.
- Inadequate knowledge.
- Use of wrong medium.
- Too many messages in a short time.

- Disregard for normal attention span; and
- Non conducive environment.

4.14 Tutor-Marked Assignment

1. Define Health Promotion (2 marks)
2. State the components of Health promotion (4 marks)
3. What are the critical issues in Health Promotion? (4 marks)