COURSE GUIDE

PHS 322
COMMUNITY MOBILISATION AND PARTICIPATION

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INTRODUCTION

PHS 322: Community Mobilisation and Participation is a 3-credit unit course for BSc. Public Health Science and related disciplines. The course is broken into four modules. It introduces you to the importance of community mobilisation and participation in a community, LGA, State and Federal Government Projects.

It equips you with concept of community mobilisation, rationale for community mobilisation and steps involved in community mobilisation. It emphasises on community participation, rationale for community, participation, formation and organisation of development committees, community diagnosis, situation analysis and advocacy.

At the end of this course, it is expected that you will be adequately equipped on issues concerning community mobilisation and participation.

The course guide, therefore, tells you briefly what the course is all about, the types of course materials to be used, what you are expected to know in each unit, and how to work through the course material. It suggests the general guidelines and also emphasizes the need for self-assessment and tutor-marked assignments (TMA). There are also tutorial classes that are linked to this course and you are advised to always be in attendance.

WHAT YOU WILL LEARN IN THIS COURSE

The overall aim of this course, PHS 322, is to introduce you to the variables associated with community mobilisation and participation. During this course, you will learn about community mobilisation, rationale for community mobilisation and steps involved in community mobilisation, community participation, rationale for community, participation, formation and organisation of development committees, community diagnosis, situation analysis and advocacy.

COURSE AIMS

This course aims at giving you an in-depth understanding of issues concerning Community Mobilisation and Participation.

COURSE OBJECTIVES

Note that each unit has specific objectives. You should read them carefully before going through the unit. You may want to refer to them during your study of the unit to check on your progress. You should always look at the unit objectives after completing a unit. In this way, you can be sure that you have done what is required of you by the unit.

However, below are the overall objectives of this course. On successful completion of this course, you will be able to:

- discuss rationale for community mobilisation
- list steps involved in community mobilisation
- be able to mobilise community participation
- discuss rationale for community participation
- describe formation and organisation of development committees
- carry out community diagnosis
- describe concept of community diagnosis
- discuss rationale for community diagnosis
- list steps in community diagnosis
- describe methods for community diagnosis
- discuss information sought during community diagnosis
- table concept of situation analysis
- list rationale for situation analysis
- list steps in situation analysis
- state instruments used in situation analysis
- discuss the role of situation analysis
- discuss concept of advocacy
- state rationale for advocacy
- identify steps in advocacy
- describe processes and methods for the design of advocacy messages
- illustrate the use of advocacy materials.

WORKING THROUGH THIS COURSE

To complete this course, you are required to read the units, the recommended textbooks, and other relevant materials. Each unit contains some self-assessment exercises and Tutor-Marked Assignments (TMA), and at some point in this course, you are required to submit the tutor marked assignments. There is also a final examination at the end of this course. Stated below are the components of this course and what you have to do.

COURSE MATERIALS

The major components of the course are:

1. Course guide
2. Study units
3. Textbooks and references
4. Assignment file
5. Presentation schedule

STUDY UNITS

There are 21 study units and four modules in this course. They are:

Module1 Community Mobilisation

Unit 1 Concept of Community Mobilisation
Unit 2 Rationale for Community Mobilisation
Unit 3 Steps involved in Community Mobilisation
Unit 4 Community Participation
Unit 5 Rationale for Community Participation
Unit 6 Formation and Organisation of Development Committees

Module2 Community Diagnosis

Unit 1 Concept of Community Diagnosis
Unit 2 Rationale for Community Diagnosis
Unit 3 Steps in Community Diagnosis
Unit 4 Methods for Community Diagnosis
Unit 5 Information Sought During Community Diagnosis

Module3 Situation Analysis

Unit 1 Concept of Situation Analysis
Unit 2 Rationale for Situation Analysis
Unit 3 Steps in Situation Analysis
Unit 4 Instruments used in Situation Analysis
Unit 5 Role of Situation Analysis

Module 4 Advocacy

Unit 1 Concept of Advocacy
Unit 2 Rationale for Advocacy
Unit 3 Steps in Advocacy
Unit 4 Processes and Methods for the Design of Advocacy Messages

Unit 5 Use of Advocacy Materials

TEXTBOOKS AND REFERENCES

These texts will be of immense benefit to you:

Kyari, U. M. U. (2002). Introduction to Primary Health Care for Beginners in Community Health Nigerian Experience, Zaria, SankoreEducational Publishers.

Gbefwi, N. B. (2004). Health Education and Communication Strategies: A Practical Approach for Community Based Health practitioners and rural health workers, Lagos. West African Publisher

Federal Ministry of Health (2004) .Operational Training Manual and Guidelines for the Development of Primary Health Care System in Nigeria, Abuja.

Olise, P. (2007). Primary Health Care for Sustainable Development. Abuja: Ozege Publications

Onuzulike, N. M. (2004). Health Care Delivery Systems. Owerri: Achugo
Publishers.

WHO/UNICEF (1978). Primary Health Care Report of theInternational Conference on Primary Health Care Alma Ata USSR,6-12September1978.

ASSIGNMENT FILE

The assignment file will be given to you in due course. In this file, you will find all the details of the work you must submit to your tutor for marking. The marks you obtain for these assignments will count towards the final mark for the course. Altogether, there are 21 tutor-marked assignments for this course.

PRESENTATION SCHEDULE

The presentation schedule included in this course guide provides you with important dates for completion of each tutor marked assignment. You should therefore try to meet the deadlines.

ASSESSMENT

There are two aspects to the assessment of this course. First, there are tutor- marked assignments; and second, the written examination.

You are thus expected to apply the knowledge, comprehension, information and problem solving gathered during the course. The tutor-marked assignments must be submitted to your tutor for formal assessment, in accordance with the deadline given. The work submitted will count for 30% of your total course mark.

At the end of the course, you will sit for a final written examination.
This examination will account for 70% of your total score.

TUTOR-MARKED ASSIGNMENT

There are 21 TMAs in this course. You need to submit all the TMAs. The best three out of four will therefore be counted. When you have completed each assignment, send them to your tutor as soon as possible and make sure that it gets to your tutor on or before the stated deadline. If for any reason you cannot complete your assignment on time, contact your tutor before the assignment is due to discuss the possibility of extension.

Extension will not be granted after the deadline, unless on exceptional cases.

FINAL EXAMINATION AND GRADING

The final examination of will be a two (2) hour duration and have a value of 70% of the total course grade. The examination will consist of questions which reflect the self-assessment exercise and e-tutor marked assignments that you have previously encountered. Furthermore, all areas of the course will be examined. It is also better to use the time between finishing the last unit and sitting for the examination, to revise the entire course. You might find it useful to review your TMAs and comment on them before the examination. The final examination covers information from all parts of the course.

COURSE MARKING SCHEME

The following table includes the course marking scheme:

Table 1 Course Marking Scheme

Assessment	Marks
Assignment 1-21	21 assignments, 30% for the best 3
	Total = 10% x 3 = 30%
Final Examination	70% of overall course marks
Total	100% of Course Marks

COURSE OVERVIEW

This table indicates the units, the number of weeks required to complete them and the assignments.

Table 2 Course Organisation

Unit	**Title of Work**	**Weeks Activity**	**Assessment (End of Unit)**
	Course Guide	**Week 1**	
1	Rationale for community mobilisation	Week 1	Assignment 1
2	Steps involved in community mobilisation	Week 2	Assignment 2
3	Mobilise community participation	Week 3	Assignment 3
4	Rationale for community participation	Week 4	Assignment 4
5	Formation and organisation of development committees	Week 5	Assignment 5
6	Community diagnosis	Week 6	Assignment 6
7	Concept of community diagnosis	Week 7	Assignment 7
8	Rationale for community diagnosis	Week 8	Assignment 8
9	Steps in community diagnosis	Week 9	Assignment 9
10	Methods for community diagnosis	Week 10	Assignment 10
11	Information sought during community diagnosis	Week 11	Assignment 11
12	Concept of situation analysis	Week 12	Assignment 12
13	Rationale for situation analysis	Week 13	Assignment 13
14	Steps in situation analysis	Week 14	Assignment 14

15	Instruments used in situation analysis	Week 15	Assignment 15
16	Role of situation analysis	Week 16	Assignment 16
17	Concept of advocacy	Week 17	Assignment 17
18	Rationale for advocacy	Week 18	Assignment 18
19	Steps in advocacy	Week 19	Assignment 19
20	Processes and methods for the design of advocacy messages	Week 20	Assignment 20
21	Use of advocacy materials	Week 21	Assignment 21

HOW TO GET THE MOST OUT OF THIS COURSE

In distance learning, the study units replace the university lecturer. This is one of the huge 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. Think of it as reading from the teacher, the study guide tells you what to read, when to read and the relevant texts to consult. You are provided exercises at appropriate points, just as a lecturer might give you an in-class exercise.

Each of the study units 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 as a whole. Next to this is a set of learning objectives. These learning objectives are meant to guide your studies. The moment a unit is finished, you must go back and check whether you have achieved the objectives. If this is made a habit, then you will significantly improve your chances of passing the course.

The main body of the units also guides you through the required readings from other sources. This will usually be either from a set book 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.

The following are practical strategies for working through this course;

1. Read the Course Guide thoroughly.
2. Organise a study schedule. Refer to the course overview for more details.
   Note the time you are expected to spend on each unit and how the assignment relates to the units. Important details, e.g. details of your tutorials and the date of the first day of the semester are available. You need to gather together all these information in one place such as a diary, a wall chart calendar or an organiser. Whatever method you choose, you should decide on and write in your own dates for working on each unit.

3. Once you have created your own study schedule, do everything you can to stick to it. The major reason that students fail is that they get behind with their course works. If you get into difficulties with your schedule, please let your tutor know before it is too late for help.

4. Turn to Unit 1 and read the introduction and the objectives for the unit.

5. Assemble the study materials. Information about what you need for a unit is given in the table of contents at the beginning of each unit. You will almost always need both the study unit you are working on and one of the materials recommended for further readings, on your desk at the same time.

6. Work through the unit, the content of the unit itself has been arranged to provide a sequence for you to follow. As you work through the unit, you will be encouraged to read from your set books.

7. Keep in mind that you will learn a lot by doing all your assignments carefully. They have been designed to help you meet the objectives of the course and will help you pass the examination.

8. Review the objectives of each study unit to confirm that you have achieved them. If you are not certain about any of the objectives, review the study material and consult your tutor.

9. When you are confident that you have achieved a unit's objectives, you can start on the next unit. Proceed unit by unit through the course and try to pace your study so that you can keep yourself on schedule.

10. When you have submitted an assignment to your tutor for marking, do not wait for its return before starting on the next unit. Keep to your schedule. When the assignment is returned, pay particular attention to your tutor's comments, both on the tutor-marked assignment form and also that written on the assignment. Consult you tutor as soon as possible if you have any questions or problems.

11. After completing the last unit, review the course and prepare yourself for the final examination. Check that you have achieved the unit objectives (listed at the beginning of each unit) and the course objectives (listed in this course guide).

FACILITATORS/TUTORS AND TUTORIALS

There are 12 hours of tutorials provided in support of this course. You will be notified of the dates, time and location together with the name and phone number of your tutor as soon as you are allocated a tutorial group.

Your tutor will mark and comment on your assignments, keep a close watch on your progress and on any difficulties you might encounter and provide assistance to you during the course. You must mail your e-tutor-marked assignment to your tutor well before the due date. At least two working days are required for this purpose. They will be marked by your tutor and returned to you as soon as possible.

Do not hesitate to contact your tutor by telephone, e-mail or discussion board if you need help. The following might be circumstances in which you would find help necessary: contact your tutor if:

- You do not understand any part of the study units or the assigned readings.
- You have difficulty with the self-test or exercise.
- You have questions or problems with an assignment, with your tutor's comments on an assignment or with the grading of an assignment.

You should try your best to attend the tutorials. This is the only chance to have face to face contact with your tutor and ask questions which are answered instantly. You can raise any problem encountered in the course of your study. To gain the maximum benefit from the course tutorials, prepare a question list before attending them. You will learn a lot from participating in discussion actively.

Good luck.

MAIN COURSE

CONTENTS **PAGE**

MODULE 1 COMMUNITY MOBILISATION

UNIT 1 CONCEPT OF COMMUNITY MOBILISATION

CONTENTS

1.0 INTRODUCTION

Community Mobilisation has been defined as a capacity building process through which community individuals, groups, or organisations plan, carry out and evaluate activities on a participatory and sustained basis to improve health and other needs on their own initiative or stimulated by others. This process must involve the whole community, not just the specific actors who are directly involved in the intervention programme.

A community could be considered “mobilised” when all members feel as though the issue is important to them and worthy of action and support. Community mobilisation inherently involves community engagement and partnership which are the universally-identified key components to success. These key components include recruiting community members to participate in needs assessments, convening advisory boards comprised of multiple constituencies within a community, empowering community members to carry out chosen

intervention strategies and evaluation endeavors, and recruiting community members to occupy leadership positions within the prevention effort.

Community mobilisation is important because the community itself is ultimately responsible for and affected by situations of safety or insecurity.
Government resources are insufficient to meet the entire health needs of all the people. But even where Government has all the resources available, the appreciation of the people and their willingness to use the seresources must be aroused for the fullest exploitation of and benefit from deployed resources. Community mobilisation is directed at stimulating people to be aware of what they can do by and for themselves to improve their health and solve some of their health problems. In any case, we should take a look at the objectives as indicated below.

2.0 OBJECTIVES

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

- define a community
- describe the organisational structure of a community
- describe the leadership composition of a community.

3.0 MAIN CONTENT

3.1 Definition of a Community

The World Health Organisation (1978) stated that a community consists of people living together in some form of social organisation and cohesion. Its members share in varying degree political, economic, social and cultural characteristics, as well as interests and aspirations including health. Communities vary widely in size and socio-economic profile, ranging from clusters of isolated homesteads to more organised villages, towns and cities. Olise (2007) defined a community as a group of people living in a defined area and sharing some common interest. Examples are towns and villages.

A community can be homogenous that is consisting of people sharing the same culture e.g villages or heterogeneous that is consisting of people sharing different culture e.g urban cities.

You can see the different ways a community is defined. Each of these definitions expresses the idea of living together in a specified area and sharing things in common.

"Community" is important within a public health context. Research demonstrates that:

- Prevention and intervention take place at the community level.
- Community context is an important determinant of health outcomes.

However, the lack of a commonly accepted definition of community results in different collaborators forming contradictory or incompatible assumptions about community. This often undermines their ability to evaluate the contribution of the community in achieving in December 2001; the American Journal of Public Health published the results of research to define community within a public health context (MacQueen *et al*. 2001).

Researchers identified core dimensions of "community," as defined by people from diverse groups. Five core elements emerged:

- locus
- sharing
- action
- ties, and
- diversity

A common definition of community emerged:
A group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or setting (MacQueen *et al*. 2001).

3.2 Description of the Organisational Structure of a Community

Organisational structure of a community refers to how a community is made up as well as who is at what position otherwise known as the leadership structure.

The structure is as follows:

1. Village Head (Paramount Ruler)
2. Village Council (Chiefs)
3. President/Chairman (Community Development Committee)
4. Influential leaders
5. Members of the Community (the people)

This structure enables community mobilises to know where to start from in the communities in their mobilisation processes.

3.3 Description of the Leadership Composition of a Community

There are different group of leaders in the community. They include:

Formal Leaders
These are the first class individuals otherwise knowna s ceremonial leaders in the community who are elected, appointed or chosen to rule the community e.g. traditional rulers namely Chiefs, Ezes, Obas, Emirs, Districts heads and village heads. They are entitled to remuneration from government.

Informal Leaders
These leaders are unofficially installed but nominated and recognised by members of the community to lead them in their day to day activities. For example women leaders, market women leaders, youth leaders, men leaders etc.

Opinion L e a d e r s

These are persons authorised a n d recognised b y constituted authorities to give opinions on various matters concerning the community. They are appointed to hold offices especially in public bodies and organisations. For example; chairmen of councils, councilors, pastors, Imams etc. Opinion leaders constitute the leadership composition of a community. They represent a cross-section of the community in matters of decision making.

SELF-ASSESSMENT EXERCISE

List the types of leaders in the community

4.0 CONCLUSION

In this unit you have learned that a community is a group of people living in an area and that the organisational structure of the community starts from the traditional rulers downwards. You also know the leadership composition of the community. This unit also defined community mobilisation as a process of creating awareness on the community on health issues.

5.0 SUMMARY

This unit has focused on the definition of a community, its organisational structure and leadership composition. It also emphasised on definition of community mobilisation as a process of creating awareness. Unit two will discuss the rationale for community mobilisation.

6.0 TUTOR-MARKED ASSIGNMENT

1 a. Define the term community.
b. Describe the organisational structure of a community.

7.0 REFERENCES/FURTHER READING

Kyari, U. M. U. (2002). *Introduction to Primary Health Care for Beginners in Community Health Nigerian Experience.* Zaria: Sankore Educational Publishers.

Gbefwi, N. B. (2004). Health Education and Communication Strategies: A Practical Approach for Community Based Health practitioners and Rural HealthWorkers. Lagos: West African Publisher.

Federal Ministry of Health (2004). Operational Training Manual and Guidelines for the Development of Primary Health Care System in Nigeria. Abuja.

Olise, P. (2007). Primary Health Care for Sustainable Development. Abuja: Ozege Publications.

Onuzulike, N. M. (2004). Health Care Delivery Systems. Owerri: Achugo
Publishers.

WHO/UNICEF (1978). Primary Health Care Report of the International Conference on Primary Health Care AlmaAta USSR, 6-12 September 1978.

UNIT 2 RATIONALE FOR COMMUNITY MOBILISATION

CONTENTS

1.0 INTRODUCTION

Rationale for community mobilisation simply means the fundamental reasons or ideas behind community mobilisation. Since community mobilisation is an important activity in health care delivery it must have some rationale behind it. In this unit, we are going to be discussing the importance of community mobilisation and its key elements.

2.0 OBJECTIVES

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

- define community mobilisation
- state the goals of community mobilisation
- discuss the rationale for community mobilisation
- discuss the key tasks involved in community mobilisation.

3.0 MAIN CONTENT

3.1 Definition of Community Mobilisation

Federal Ministry of Health (FMOH) (2004) defined community mobilisation as a means of encouraging, influencing and arousing interest of people to make them actively involved in finding solutions to some of their own problems. Community Mobilisation is getting people involved and committed to achieving goal. Onuzuluike (2004) defined community mobilisation as process of assisting people to become more

aware of their community, take an in-depth look at that community, identify the felt needs as well as their needs, have belief or faith that something can be done to relieve these needs and that most of there sources to achieve these are within the competence of the community, possess a desire and a willingness to use such resources to ensure the continued existence and improvement of their community. Gbefwi (2004) stated that community mobilisation involves creating awareness on health conditions and allowing for a common solution in the community.

It is an ideal method for developing decision-making skills, communication, co-operation and self reliance. Community mobilisation simply implies putting a community in a state of readiness for action. It requires time, patience and understanding on the part of the health workers in order to achieve success. This is not a one time activity, but rather, a continuous exercise, which should constitute an integral aspect of efforts, aimed at initiating health action by the people them selves. You will observe thatin the different definitions of community mobilisation the focus has been on creating awareness for the community to take decision involving some of their health problems.

Community mobilisation has been defined as a capacity building process through which community individuals, groups, or organisations plan, carry out and evaluate activities on a participatory and sustained basis to improve health and other needs on their own initiative or stimulated by others (Howard-Graham, 2005). Mobilisation increases the participatory decision-making processes by bringing diverse stakeholders to the table. It enables those people who may not normally be involved in the decision making process to be a part of the project. Mobilisation also fosters strong relationships between Federal governments, local governments, businesses and community members.

Community mobilisation strengthens and enhances the ability of communities to work together to achieve goals that are important for that community. Community mobilisation is not something that is done over night, but it is a process that requires time and commitment from all parties involved. The key to successful mobilisation efforts is making sure that communities are in the driver's seat during the process. Mobilisation is not something that happens to the community rather it is something that the community does. One of the primary goals of mobilisation is to make sure mobilisation efforts are community driven. This allows a community to solve its problems through its own efforts which is the key to having sustained outcomes within a community.

3.2 Goals of Community Mobilisation

- Increase community, individual, and group capacity to identify and satisfy needs
- Increase community level decision-making
- Increase community ownership of programs
- Bring additional resources to the community
- Build on social networks to spread support, commitment and changes in social norms and behaviours

3.3 Rationale for Community Mobilisation

A community mobilisation approach is valuable because it empowers people's rights to participate and to determine their own future. It enables groups to create local solutions to local problems. These local solutions will be more sustainable than external solutions that do not fit well with the local situation, culture and practices. When communities define the problem, set common goals and work together on their own programs, to achieve the goals, the communities change in ways that will last after the project ends (Florida Department of Health, 2016).

The discussions on the rationale for community mobilisation are as follows:

The rationale is that when people are actively mobilised and committed in taking part in matters concerning them and their health right from the planning stage, they will take part in the implementation and evaluation processes.

It has been proved that when health projects are initiated from outside, nobody is interested in taking good care of such facilities but when the people are involved in such projects greater care is taken by the community.

It is known that mobilisation activity depends on sensitisation through adequate flow of information. Therefore, instead of any Health Agency to present the community with ready-made solutions on all the health problems, the community is encouraged to take a look at its own problems and find solutions to some of them using its own resources and local organisation. However, outside assistance may be provided through advice, materials and finance.

It is observed that rural or community development/health programmes that do not recognise the initiatives and the ingenuity of the people are unlikely to achieve its stated objectives. Thus, community mobilisation

is therefore expedient for the stated objectives of any health programmes in the community to be achieved.

One of the rationales for community mobilisation is that it establishes cordial relationship and understanding between the health workers and the community in areas of traditional beliefs and cultural values.

Community mobilisation enables the community to develop link with different organisations. This inter-sectoral collaboration assists the community in times of need. The rationale for community mobilisation also include the idea of teaching the community how to solve some of their health development programmes within themselves and not always waiting for Government to do everything for them.

From the above stated facts you can understand the rationale or the idea behind community mobilisation in health care delivery as it is pre-requisite for community involvement and commitment towards health programmes in the community.

3.4 Key Tasks Involved in Community Mobilisation

- Developing an ongoing dialogue with community members regarding health issues

- Creating or strengthening community organisations aimed at improving health

- Assisting in creating an environment in which individuals can empower themselves to address their own and their community's health needs

- Promoting community members' participation in ways that recognise diversity and equity, particularly of those who are most affected by the health issue

- Working in partnership with community members in all phases of a project to create locally appropriate responses to health needs

- Identifying and supporting the creative potential of communities to develop a variety of strategies and approaches to improve health status

- Assisting in linking communities with external resources to aid them in their efforts to improve health

- Committing enough time to work with communities or with a partner who works with them.

SELF-ASSESSMENT EXERCISE

Define community mobilisation.

4.0 CONCLUSION

In this unit you have learned what the rationale for community mobilisation is in the promotion of community health. Community mobilisation enables the community members to be aware of the problems, know the impact and take part in strategies drafted out in the intervention. It makes them willing to change and allow the sustainability of the interventions provided.

5.0 SUMMARY

This unit focused on the rationale for community mobilisation and that when people are involved in health programmes there is commitment, objectives are achieved, facilities are protected and the people become self-reliant in initiation and problem solving.

6.0 TUTOR-MARKED ASSIGNMENT

State, at least, three rationales for community mobilisation.

7.0 REFERENCES/FURTHER READING

Akinsola, H. A. (1993). A-Z of Community Health and Social Medicine in
Medical and Nursing Practice with special reference to Nigeria.Ibadan: 3 AM communications.

Federal Ministry of Health, (1996). Curriculum for Community Health Officers, Lagos.

Federal Ministry of Health. (2004). Operational Training Manual and Guidelines for the Development of Primary Health Care System in Nigeria, Abuja.

Forida Department of Health, (2016). What is Mobilisation? https://www.myctb.org/wst/floridacommunityprevention/Mobilisation/default.aspx. Accessed 13/01/17

Gbefwi, N. B. (2004). Health Education and Communication Strategies: A practical Approach for Community Based Health practitioners and Rural Health Workers. Lagos: West African Publisher.

Howard-Graham, L. (2005). Demystifying Community Mobilisation: An Effective Strategy to Improve Maternal and Newborn Health. Storti C. (ed.) Pp. 1-32.

Kyari, U. M. U. (2002). *Introduction to Primary Health Care for Beginners in Community Health Nigerian Experience.* Zaria: Sankore Educational Publishers.

Olise P. (2007). Primary Health Care for Sustainable Development: Abuja: Ozege Publications.

Onuzulike, N. M. (2004). Health Care Delivery Systems. Owerri: Achugo Publishers.

Peter O. (2006). Principles and Practice of Primary Health Care. Onitsha: Noble Publishers.

UNIT 3 STEPS IN COMMUNITY MOBILISATION

CONTENTS

1.0 INTRODUCTION

You must have at this juncture understood theconcept of community Mobilisation. Consequently, in order to mobilise communities there are steps that should be taken togain entry into a community. It should be noted that no one can develop a model of community Mobilisation steps that would have rigid application in all parts of a country as large and diverse as Nigeria. However, the following steps represent a minimum that could be adapted for communities irrespective of whatever setting one finds oneself.

2.0 OBJECTIVES

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

- describe the steps involved in community mobilisation
- graphically illustrate community mobilisation
- describe the information to be provided before the community mobilisation
- discuss the success factors
- recount the dos and don'ts for community mobilisation.

3.0 MAIN CONTENT

3.1 Steps Involved in Community Mobilisation

In order to mobilise a community, the following steps are necessary:

i) Know the community
ii) Make initial contact with the community leaders
iii) Communicate intentions to the leaders
iv) Acquaint yourself with the cultura land social protocols of the community
v) Arrange meetings with the community leaders and community representatives.
vi) Develop an agenda for the meeting with the other health workers
vii) Attend the meeting
viii) Explain purpose of the meeting in a nacceptable language
ix) Request them to convey the message to other community members and bring feed back to subsequent meetings.
x) Encourage questions and participation from the audience to clarify all issues before meeting disperses, including actions to be taken before the next meeting;
xi) Decide with participants the time, date and venue of next meeting.
xii) Have as many meetings as necessary until a consensus is arrived at.

Minkler and Wallenstein, (eds.) (2003) summarised the steps for community Mobilisation as follows:

i. stakeholder recruitment
ii. identifying underlying conditions, as identified by community stakeholders
iii. community assessment
iv. development of a community plan (along with outcome measurements)
v. development of an evaluation
vi. plan implementation
vii. evaluate
viii. repeat!

3.2 Graphical Representation of The Community Mobilisation Cycle

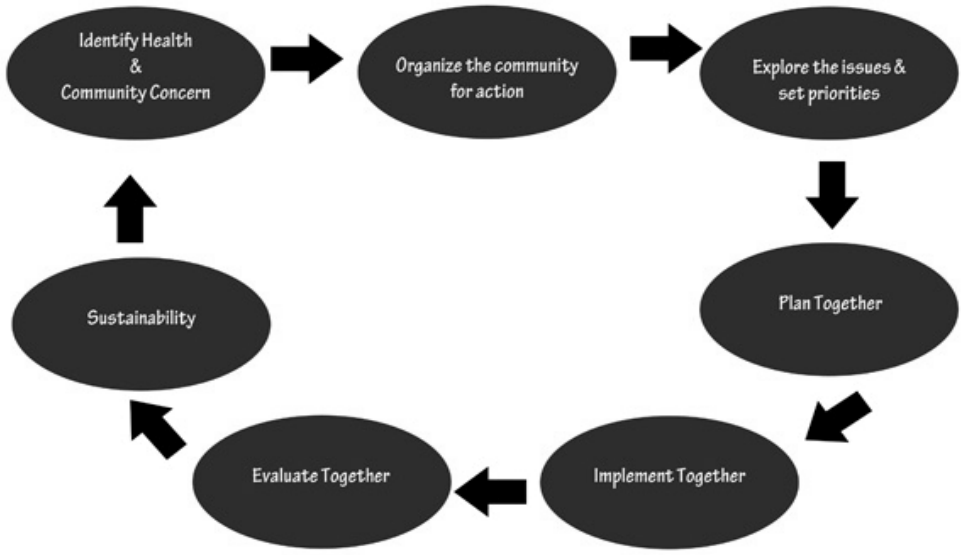

Fig. 3.1 *Source: Florida Department of Health, (2016)*

3.3 Information to be Provided before Community Mobilisation

There are some critical questions about the community mobilisation strategy that need to be answered (based on the results of the formative research) before proceeding with a mobilisation effort. Planning and implementing successful community mobilisation initiatives requires answering some important questions: These questions include:

I. What is the goal? (Described in terms that motivate citizens)
ii. Who is the community? (Those most affected by and interested in the issue)
iii. Where is the community now? What resources does it have? What needs or issues are pressing?
iv. Where does the community want to go? What needs and opportunities does the community most want to pursue? When the

community gets where it wants to be, how will the community be measurably better?

v. What strategies and activities will move the community from where it is to where it wants to be? What resources can be Mobilised to address these priorities?

vi. How will results be assessed?

vii. Who is stimulating the process? (Outside of or inside the community)

viii. Who will be facilitating the process? (Community member? Community Based Organisation (CBO) staff/volunteer? Health system worker?Local NGO staff?InternationalPrivate Voluntary Organisation (PVO) staff?Government worker outside health system?)

ix. What support structure exists for facilitators? (Training, facilitation materials, monitoring/supervision, logistics and transport)

x. What external and internal resources are potentially available to contribute to the effort?

xi. What laws, policies, and governance structures are in place to support or limit CM efforts?

xii. To what extent do people have experience participating in community action? Who is included? Who is left out? Why?

xiii. If the effort is externally supported, how long is the donor's timeframe? Is it realistic? What is the potential for longer-term community ownership and sustainability?

Without answers to these strategic questions, community mobilisation is likely to involve many activities, but not meet community needs or achieve important results.

3.4 Success Factors

A review of the programs that have been implemented to date suggests that the primary ingredients of a successful community mobilisation program using maternal and newborn health as an example consist of the following:

i. program staff including: a program manager, team of facilitators (one or two selected from a community, or, more likely, a team of two to cover approximately 10 communities);
ii. trainer(s)
iii. transport budget, depending on where facilitators and managers are based and may include means of transport (e.g., bicycles or motorcycles) if facilitators need to travel longer distances
iv. budget for developing training and educational materials (e.g., training manuals, picture cards, booklets, audio-video aids)
v. media budget (for radio shows, street drama, and other media)

vi. training budget (depends on distance to training site, number of days, and number of participants and existing skills/knowledge of trainees); and
vii. Other direct costs associated with office expenses.

These success factors can still be applied to other areas in health.

3.5 The Dos and Don'ts for Community Mobilisation

The Dos
i. Do it with the community help
ii. Use community expertise
iii. Understand ethnic and cultural differences of communities and build on ethnic and cultural diversities
iv. Include others in the planning process
v. Develop community partnerships

The Don'ts
i. Do it all for the community
ii. See professionals as the experts
iii. Deny ethnic and cultural differences of a community
iv. Plan mobilisation efforts alone
v. Focus solely on individual efforts

SELF-ASSESSMENT EXERCISE

Minkler and Wallenstein (2003) summarised community mobilisation in _____ number of steps?

4.0 CONCLUSION

In this unit, you have learned the steps to be taken before entering a community to mobilise the people towards health actions. At this point you should be able to enumerate the steps.

5.0 SUMMARY

This unit has brought to bear the steps necessary for community mobilisation which include knowing the community, establishing contacts with leaders and holding meetings to arrive at consensus on how to tackle health issues in the community. Unit four will deal with community participation

6.0 TUTOR-MARKED ASSIGNMENT

List the steps involved in community mobilisation.

7.0 REFERENCES/FURTHER READING

Ibet-Iragumina, M. W. (2010). *Fundamentals of Primary Health Care*. (Rev.ed.) Port Harcourt: Minson Publishers.

Onuzulike, N. M. (2004). Health Care Delivery Systems. Owerri: Achugo Publishers.

FMOH. (1996). Curriculum for Community Health Officers. Lagos.

Federa lMinistry of Health (2004). Operational Training Manual and Guidelines for the Development of Primary Health Care System in Nigeria. Abuja.

Florida Department of Health, (2016). What is Mobilisation? https://www.myctb.org/wst/floridacommunityprevention/mobilisation/default.aspx. Accessed 13/01/17

Kyari, U. M. U. (2002). *Introduction to Primary Health Care for Beginners in Community Health Nigerian Experience.* Zaria: Sankore Educational Publishers.

Gbefwi, N. B. (2004). Health Education and Communication Strategies: A practical Approach for Community Based Health Practitioners and rural health workers, Lagos: West African Publisher.

Olise, P. (2007).Primary Health Care for Sustainable Development Abuja: Ozege Publications.

Peter, O. (2006). Principles and Practice of Primary Health Care. Onitsha: Noble Publishers.

Egwu, I. N. (2000). Primary Health Care System in Nigeria. Theory, Practice and Perspectives. Lagos: Elmore Publishers.

Onuzulike, N. M. (2004). Health Care Delivery System. Owerri: Achugo Publishers.

Peter O. (2006). Principles and Practice of Primary Health Care. Onitsha: Noble Publishers.

Cheetham, N. (2002). Community Participation. What is it? Transitions: Community Participation vol. 14, No. 3:1-10.

UNIT 4 COMMUNITY PARTICIPATION

CONTENTS

1.0 INTRODUCTION

Community participation is a proven approach to addressing health care issues and has been very useful in HIV prevention in the United States and in development globally, in projects ranging from sanitation to child survival, clean water, and health infrastructure. However, the quality of participation varies from project to project. Moreover, despite the failure of many health programs designed *without* the participation of target communities, some professionals continue to question the value of community members' participating in program design, implementation, and evaluation. The next unit will discuss the importance of community participation in addressing the reproductive and sexual health of adolescents *(Cheetham, 2002).*

One of the fundamental Principles of Primary Health Care is the participation of the community at all stages of development. For communities to be intelligently involved, they need to have easy access to the right kind of information concerning their health situation and how they themselves can help to improve some of them. below.

2.0 OBJECTIVES

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

- explain the concept of community participation
- define community participation
- describe the beneficiaries of community participation approach

- enumerate major characteristics and skills necessary to facilitate a community participation approach
- discuss the major challenges of community participation programs.

3.0 MAIN CONTENT

3.1 Explanation of the Concept of Community Participation

Fig.4.1

Community participation differs from community mobilisation but could be interwoven with community involvement. A WHO study (WHO, 1991) suggested that participation can be interpreted in three ways:

- Participation as contribution,
- As organisation and
- As empowerment.

When a community participates in programs by contributing labour, cash or materials, this is contributive participation. Participation as organisation means creation of appropriate structure which facilitates participation. Empowering participation occurs when people develop the capability to solve their problems without waiting for help from outside. However, in order not to make this concept cumbersome, community

participation maybe used interchangeably with community involvement. Furthermore, the definition of community participation will make the concept more explicit.

3.2 What is Community Participation?

WHO (1978) defined community participation as “the process by which individuals and families assume responsibility for their own health and welfare and for those of the and develop the capacity to contribute to their and community’s development” By knowing (understanding) their circumstances better, they are then motivated to solve their common problems because they will therefore become agents (participants) of their own development. The role of the Health Agencies therefore is to explain relevant health issues, advice and provide necessary information and technology to find solutions to the problems.

You will realise that this definition is quite explicit because that a lot of components that make community participation expedient and a necessary tool for health development in the community.

However, there is no single definition of participation by communities but an agglomeration of definitions varying mostly by the degree of participation. The continuum on the next page provides a helpful framework for understanding community participation. In this continuum, "participation" ranges from negligible or "co-opted"—in which community members serve as token representatives with no part in making decisions—to "collective action"—in which local people initiate action, set the agenda, and work towards a commonly defined goal (Macqueen et al. 2001).

Community participation occurs when a community organises itself and takes responsibility for managing its problems. Taking responsibility includes identifying the problems, developing actions, putting them into place, and following through (Advocates for Youth, 2001).

3.3 Beneficiaries of Community Participation Approach

Community participation has many direct beneficiaries when carried out with a high degree of community input and responsibility. Everyone benefits when participating in the activities. For example, adults and youth might participate in village committees to improve services. Everyone might watch a play or video and learn from presentations about local programs. Youth benefit from improved knowledge about contraception and HIV/AIDS or from increased skill in negotiating condom use, and other community members’ benefit, too. A truly participatory program involves and benefits the entire community,

including youth, young children, parents, teachers and schools, community leaders, health care providers, local government officials, and agency administrators. Programs also benefit because trends in many nations towards decentralisation and democratisation also require increased decision making at the community level.

3.4 Major Characteristics and Skills Necessary to Facilitate a Community Participation Approach

Promoters of community participation need to be able to facilitate a process, rather than to direct it. Facilitators need to have trust the community's members, their knowledge and resources. A facilitator should be willing to seek out local expertise and build on it while bolstering knowledge and skills as needed.

According to Cheetham (2002), key characteristics and skills required to Mobilise community participation include:

i. Commitment to community-derived solutions to community-based problems
ii. Political, cultural, and gender sensitivity
iii. Ability to apply learning and behaviour change principles and theories
iv. Ability to assess, support, and build capacities in the community
v. Confidence in the community's expertise
vi. Technical knowledge of the health or other issue(s) the project will address
vii. Ability to communicate well, especially by actively listening
viii. Ability to facilitate group meetings
ix. Programmatic and managerial strengths
x. Organisational development expertise
xi. Ability to advocate for and defend community-based solutions and approaches (NIH, 1995; Howard-Grabman and Snetro…).

3.5 Major Challenges of Community Participation Programs

Community participation also poses important challenges. The two major challenges are as follows:

i. Evaluating Participation
ii. Scaling up Participatory Models

i. Evaluating Participation

A challenge for program planners is how to evaluate community participation. For example, what should be evaluated (health outcomes,

participation levels, improved capacities, or some combination of these) and how will they be evaluated? While measuring health outcomes (such as birth rates or sexual health knowledge, attitudes, and behaviors in a particular age group) may be fairly straight forward, it will be important for community participation programs also to identify and measure indicators of participation (Cheetham, 2002).

One of the goals is to achieve participation. Whether planners want to measure changes in community self-efficacy or changes in local capacity to identify and solve problems, it is important to define these objectives clearly and to develop appropriate tools for measuring progress toward the objectives. Qualitative tools (or some combination of qualitative and quantitative) may be most appropriate to assess the subjective quality of "participation," but indicators of participation and ways of assessing it should be defined by the community, and community members should decide and carry out the evaluation (Cheetham, 2002).

ii. Scaling Up Participatory Models

Funding bodies often indicate interest in programs that have potential for "scaling up." Community participation programs present some obstacles to "scaling up" due to their deliberately and intensely local nature. As a program develops and matures, program planners may face the challenge of "scaling down" the intensity of community participation in order to "scale up" the project without compromising its participatory nature and results (Cheetham, 2002).

SELF-ASSESSEMENT EXERCISE

List one of the objectives of the Primary Health Care.

4.0 CONCLUSION

In this unit, we discussed the concept and definition of community participation. I hope you had fun! Community participation is a very important strategy in efforts to work with youth to improve their sexual and reproductive health. Community participation is a strategy that respects the rights and ability of youths and other community members in designing and implementing programs within their community. Community participation opens the way for community members including youths to act responsibly. Whether a participatory approach is the primary strategy or a complementary one, it will greatly enrich and strengthen programs and help achieve more sustainable, appropriate, and effective programs in the field (Cheetham, 2002).

You should at this point be able to discuss the relationship between community involvement and participation (considering that they are interwoven).The concept differs from community mobilisation in some direction. Also you should be able by now to define comfortably, the term community participation.

5.0 SUMMARY

This unit has emphasised on community participation as an organised means of empowering the community with increasing control over project activities such that it develops the collective capacity for their implementation and management for better healthcare for the people. It is advisable that every community must participate in any form towards adequate healthcare delivery in the community. Community Participation encourages community members to solve some of their health problems on their own.

6.0 TUTOR-MARKED ASSIGNMENT

1. Explain the concept of community participation.
2. Define the term community participation according to WHO.

7.0 REFERENCES/FURTHER READING

Ibet-Iragumina, M. W. (2010). *Fundamentals of Primary Health Care.* (Rev.ed.) Port Harcourt: Minson Publishers.

Minkler, M. & Waller stein, N. (Eds.) (2003). *Community Based Participatory Research for Health.* San Francisco: Jossey-Bass.

Obionu, C. N. (1996). *Primary Health Care for Developing Countries.* Enugu:, Exodus Productions.

Onuzulike, N. M. (2004). *Health Care Delivery Systems.* Owerri: Achugo
Publishers.

WHO (1978). Primary Health Care Report of the International Conference on
Primary Health Care Alma-Ata USSR,6-12 September,1978 Switzerland.

Bhatnagar, B. *et al*. Participatory Development and the World Bank. [World Bank Discussion Paper] Washington, DC: The World Bank, 1992.

Macqueen, K. M. *et al*. What is community? An evidence-based Definition for Participatory Public Health. Am J Pub Health 2001;91:1929-1938.

Cornwall A. Training handout. [s.l.], 1995.

Advocates for Youth. UN Published Data from the Burkina Project. Washington, DC: 2001.

National Institutes of Health (NIH). Theory at a Glance: A Guide for Health Promotion Practice. Bethesda, MD: National Institutes of Health, National Cancer Institute, [1995].

Howard-Grabman, L., Snetro, G. How to Mobilise Communities for Health and Social Change. Baltimore, MD: Johns Hopkins University Center for Communication Programs, forthcoming.

Cheetham, N. (2002). Community Participation. What is it? Transitions: Community Participation vol. 14, No. 3:1-10.

Egwu, I. N. (2000). Primary Health Care System in Nigeria. Theory, Practice and Perspectives. Lagos: Elmore Publishers.

Onuzulike, N. M. (2004). Health Care Delivery System. Owerri: Achugo
Publishers.

Peter, O. (2006). Principles and Practice of Primary Health Care. Onitsha: Noble

UNIT 5 RATIONALE FOR COMMUNITY PARTICIPATION

CONTENTS

1.0 INTRODUCTION

Since you have acquired an overview of the concept of community participation, let us at this juncture take a look at the rationale for community participation in health care delivery. Rationale for community participation in health care delivery simply means the basic reasons or ideas behind community participation. The need for community participation cannot be overemphasised. Community mobilisation will be more sustainable than external solutions that do not fit well with the local situation, culture and practices. When communities define the problem, set common goals and work together on their own programs, to achieve the goals, the communities change in ways that will last after the project ends.
Mobilisation strengthens and enhances the ability of communities to work together to achieve goals that are important for that community.

Community mobilisation is not something that is done overnight, but it is a process that requires time and commitment from all parties involved. The key to successful mobilisation efforts is making sure that communities are in the driver's seat during the process. Mobilisation is not something that happens to the community; it is something that the community does. One of the primary goals of mobilisation is to make sure mobilisation efforts are community driven. This allows a community to solve its problems through its own efforts which is the key to having sustained outcomes within a community.

In planning health programmes, the following steps are taken into consideration:
i. Need Assessments
ii. Identification of target audience

iii. Definition of the objectives and desired outcome
iv. Content and subject matter
v. Identification of training tools, activities and outpost
vi. Budget and inputs
vii. Publicity
viii. Implementation
ix. Evaluation and assessment
x. Reporting

Community mobilisation or participation is ensured before the above steps are taken. It is required especially for the first stage which is the needs assessment.

2.0 OBJECTIVES

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

- discuss the rationale for community participation/mobilisation
- explain the importance of using community participation approaches in adolescent reproductive and sexual health programming.

3.0 MAIN CONTENT

3.1 Rationale for Community Participation

The discussions on the rationale for community participation are as follows:

I. Community participation ensures the participation of local people in identifying their needs.
ii. The rationale includes the possibilities of the community setting their priorities, planning and implementing health programmes in the community.
iii. Community participation helps to make the community at large aware of their health needs and problems as well devising means to solve some of their problems.
iv. Members of the community meet with health care providers to decide jointly on remedial actions and cooperate with health officials in carrying out health programmes and campaigns.
iv. Community participation encourages inter-sectoral collaboration because the community as their acceptance for the end product of all essential elements and principles of primary health. Therefore, community participation foster multi-sectoral collaboration.

v. Community participation ensures costs sharing. Health care programmes are viewed as accessible and affordable programmes. Consequently, funding should be shared by the government and community members as this promotes successfulimplementation of the health care programmes.

You can adduce from the facts above that community participation is important in the achievement of health services coverage and objectives.

Even though some authors have contested that participation makes no difference, the usefulness of community participation has been well documented in the literature. Involving stakeholders and empowering community participants in programs at all levels, from local to national, provide a more effective path for solving sustainable resource management issues (Chamala, 1995). Community participation enhances project effectiveness through community ownership of development efforts and aids decision-making (Kelly and Van Vlaenderen, 1995; Kolavalli and Kerr, 2002). Price and Mylius (1991) also identified local ownership of a project or program as a key to generating motivation for ecologically sustainable activities. Community participation also leads to dissemination of information amongst community members, particularly local knowledge that leads to better facilitation of action (Price and Mylius, 1991; Stiglitz 2002). Community participation results in learning and learning are often a pre-requisite for changing behaviour and practices (Kelly, 2001).
The four affirmations that summarize the importance of community participation in development as identified by Gow and Vansant (1983) include:

i. People organise best around problems they consider most important.
ii. Local people tend to make better economic decisions and judgments in the context of their own environment and circumstances.
iii. Voluntary provision of labour, time, money and materials to a project is a necessary condition for breaking patterns of dependency and passivity.
iv. The local control over the amount, quality and benefits of development activities helps make the process self-sustaining (Botch way, 2001).

White (1981) identified a number of beneficial reasons for community participation in projects as follows:

i. More work is accomplished with community participation.
ii. Services can be provided more cheaply.

iii. Community participation has an intrinsic value for participants:
- it is a catalyst for further development;
- it encourages a sense of responsibility.
- it guarantees that a felt need is involved
- it ensures things are done correctly.
- It uses valuable indigenous knowledge; frees people from dependence on other peoples' skills; and makes people more conscious of the causes of their poverty and what they can do about it.

Policies that are sensitive to local circumstances will be more likely to be successful in their implementation through the involvement of the local community (Curry (1993). Again, communities that have a say in the development of policies for their locality are much more likely to be enthusiastic about their implementation (Curry, 1993). It has been found that participation has a role in enhancing civic consciousness and political maturity that makes those in office accountable (Golooba-Mutebi, 2004).

Importance of Using Community Participation Approaches in Adolescent Reproductive and Sexual Health Programming

To showcase the importance of community participation, we use adolescent reproductive and sexual health programming as an example. Youth do not live in a vacuum, independent of influences around them. Rather, social, cultural, and economic factors strongly influence young people's ability to access reproductive and sexual health information and services. To improve young people's sexual and reproductive health, therefore, programs must address youth and their environment. In order to address youth adequately and appropriately, programs should be designed and implemented with the meaningful involvement of youth. To address youth's environment, planners must acknowledge that community and families significantly influence youth(Cheetham,2002).

Programs that ignore the influence of community and family in the lives of young people are, in fact, creating a nearly impossible situation i.e. asking young people to change their world on their own. It is unfair to ask youth to change their beliefs and behaviours without also providing community support for these changes. Especially when reproductive and sexual health issues are controversial and/or taboo, it is critical to bring other community members into the process so that they, too, can support healthy change (Cheetham, 2002).

If implemented properly, community participation can be effective for a number of reasons shown below:

i. Communities have different needs, problems, beliefs, practices, assets, and resources related to sexual health. Getting the community involved in program design and implementation helps ensure that strategies are appropriate for and acceptable to the community and its youth.
ii. Community participation promotes shared responsibility by service providers, community members, and youth themselves for the sexual health of adolescents in the community.
iii. When communities "own" adolescent sexual health programs, they often Mobilise resources that may not otherwise be available. They can work together to advocate for better programs, services, and policies for youth.
iv. Community support can change structures and norms that pose barriers to sexual health information and services for youth and can increase awareness regarding youth's right to information and treatment.
v. Community participation can increase the accountability of sexual health programs and service providers.
vi. Participation can empower youth within the community.

SELF-ASSESSMENT EXERCISE

List the beneficial reasons for community participation in projects according to White (1981).

4.0 CONCLUSION

In this unit, you learnt the rationale for community participation in the dispensation of health care delivery. At this point you should be able to enumerate the rationale for community participation.

5.0 SUMMARY

This unit has emphasised on the rationale for community participation in health care delivery. Community participation in health care delivery identifies needs, set priorities and ensures planning and implementation of healthcare programmes.

6.0 TUTOR-MARKEDASSIGNMENT

List three rationales for community participation.

7.0 REFERENCES/FURTHER READING

Botchway, K. (2001). Paradox of Empowerment: Reflections on a Case Study from Northern Ghana. World Development 29: 135-153.

Chamala S. (1995). Overview of Participative Action Approaches in Australian Land and Water Management. In: Participative Approaches for Land Care. Keith K. (Ed.) Pp. 5-42. Brisbane: Australian Academic Press.

Claridge, T. (2013). Importance of Community Participation.

http://www.socialcapitalresearch.com/designing-social-capital-sensitive-participation-methodologies/importance-participation.html. Retrieved 10th January, 2017

Curry, N. (1993). Rural Development in the 1990s: Does Prospect Lie in Retrospect? In: Rural Development in Ireland: A Challenge for the 1990s. Greer J. (ed.) Aldershot: Avebury.

Golooba-Mutebi, F. (2004). Reassessing Popular Participation in Uganda. Public Administration and Development in Press.

Gow, D. & Vansant, J. (1983). Beyond the Rhetoric of Rural Development Participation: How can it be done? World Development 11: 427-443.

Ibet-Iragumina, M. W. (2010). Fundamentals of Primary Health Care. (Rev.ed.). PortHarcourt: Minson Publishers.

Kelly K. & Van Vlaenderen H. (1995). Evaluating Participation Processes in Community Development. Evaluation and Program Planning 18: 371-383.

Kelly, D. (2001). Community Participation in Rangeland Management: a Report for the Rural Industries Research and Development Corporation. (RIRDC: Barton ACT).

Kolavalli, S. & Kerr, J. (2002). Scaling Up Participatory Watershed Development in India. Development & Change 33: 213-235.

Onuzulike, N. M. (2004). Health Care Delivery Systems. Owerri: Achugo Publishers.

Price, S. & Mylius, B. (1991). Social Analysis and Community Participation.

Stiglitz, J. E. (2002). Participation and Development: Perspectives from the Comprehensive Development Paradigm. Review of Development Economics 6: 163-182.

Storey, D. (1999). Issues of Integration, Participation and Empowerment in Rural Development: The Case of LEADER in the Republic of Ireland. Journal of Rural Studies 15:307-315.

White, A. (1981). Community participation in water and sanitation: concepts, strategies and methods. IRC: The Hague.

Peter, O. (2006). Principles and Practice of Primary Health Care. Onitsha: Noble Publishers.

UNIT 6 FORMATION AND ORGANISATION OF DEVELOPMENT COMMITTEES

CONTENTS

1.0 INTRODUCTION

Development committees are important because prior to the establishment of primary healthcare in Nigeria, decisions and actions relating to health were unilaterally taken by Government Agencies on behalf of the communities Primary Healthcare (PHC) emphasises the importance of full and active involve men to fall communities to ensure the success of PHC in accordance with the Alma-Ata declaration of 1978. Hence, the communities are empowered to manage in a coordinated manner, the health programmes of their people at all times. In order to strengthen and sustain the management process, the communities are empowered to participate and effect this management process; the bottom up concept of planning from the village to the federal level must be applied. It's important to establish and sustain functional and effective development committees at all levels to achieve health for all. This strategy emphasises on health by the people.

2.0 OBJECTIVES

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

* describe the various development committees
* mention the title of the committee
* list the composition of the committee
* the terms of reference/responsibilities/roles of the committees
* elaborate the role of donors, policymakers, and external organisations.

3.0 MAIN CONTENT

3.1 Description of the Various Development Committees

It is important to establish and sustain functional and effective development committees at all levels to achieve health for all. The Development Committees at the various levels must choose members who reside in the community, understand and speak the local language, know and share the community's culture, attitudes and beliefs, are respected and willing to contribute selflessly to community programmes.

3.2 Titles of Committees

Village Development Committee (VDC) or Community Development Committee (CDC).

a. Composition of the VDC/CDC Committee

i. A respectable person elected by the committee members as chairman
ii. An elected literate member of the village/community shall serve as secretary.
iii. Representative of religious groups
iv. Representative of women's group/associations
v. Representative of occupational/ professional groups
vi. Representative of Non-Governmental Organizations (NGOs)
vii. Representative of Village Health Workers (VHWs) and Traditional Birth Attendants (TBAs)
viii. Representative of the disabled
ix. Representative of Youths
x. Representative of Traditional Healers
xi. Representative of patent medicine stores owners
xii. A trusted member of the committee will serve as the Treasurer

b. Role And Responsibilities of the Village Development Committee (VDC) or Community Development Committee (CDC)

The committee shall:

i. Identify health and health related needs in the village/community
ii. Plan for the health and welfare of the community
iii. Identify available resources (human and material)within the community and allocate as appropriate to PHC programme.
iv. Supervise and implementation of PHC work plan

v. Monitor and evaluate the progress and impact of the implementation of health activities
vi. Mobilise and stimulate active community involvement inthe implementation of developed health plans.
vii. Determine exemptions for drug payment and deferment; but provide funds for the exemptions/deferments.
viii. Determine the pricing of drugs to allow for financing of other PHC
Activities.
ix. Supervise all account books,(monies at hand should be deposited in a bank within 24hours or 72hours at weekends).
x. Supervise and monitor quantity of drug supply
xi. Select appropriate persons within the community to be trained as Village Health Workers (VHWs/TBA) for PHC, AIDS /STD and other programmes.
xii. Supervise the activities of Village Health Workers and Traditional Birth Attendants; including review of monthly record of work;
xiii. Remunerate in cash or kind, the Village Health Workers for his/her work in the community;
xiv. Agree with the Village Health Worker the number of hour she/she should work per day;
xv. Establish a village health post, where there is none already;
xvi. Ensure that VHW/TBAK its are stocked to top-up level for drugs.
xvii. Liaise with other officials living in the village to provide health care and other development activities;
xviii. Provide necessary support to VHW for the provision of healthcare services;
xix. Forward local community health plan toward level.

c. Operational Guidelines

In following the above terms of reference, the committee shall:

i. Meet once every month;
ii. Record minutes of meetings;
iii. Minutes of meetings shall be signed by the Chairman and Secretary after adoption at subsequent meetings
iv. Comply with the quorum set for starting meetings;
v. The Treasurer should record and keep all monies;
vi. The Treasurer should record all expenditures;
vii. Where there is a Bank Account ,signatories will be the Committee Chairman and Treasurer, and if necessary the Secretary;
viii. Send minutes of meetings to Ward Development Committee

2. Ward Development Committee (WDC) A:

a. Composition of the Committee

Composition of the WDC is as follows:

The head shall be elected by members.

Wards head or Autonomous Clan head (Chairman), but where no such person exists, the most respectable village head or any other person selected may serve as Committee Chairman. In such a case, the appointment o Chairman should be left entirely in the hands of Committee members;

i. The WDC consist of representative from each VDC in the village.
ii. The chairman shall be elected by members.
iii. The secretary of the committee shall be electedby the members.
iv. The Wards Community Development Officer ,if available

The committee can where necessary co-opt members of health related sectors such as Secondary School Principals and Primary School Headmasters Agric-Extension Workers PHCN/Water Works Staff, NGOs. At least 20% of membership will be women and they should be given effective post such as Head of Health facilities in the area.

b. Roles and Responsibilities of WDC Committee

The Ward Committee will:

i. Identify health and social needs and plan for them.
ii. Supervise the implementation of developed work plans.
iii. Identify local human and material resources to meet these needs.
iv. Forward for health /community development plans (village, facility and Wards levels) to LGA.
v. Mobilise and stimulate active involvement of prominent and other local people in the planning, implementation and evaluation of projects.
vi. Take active role in the supervision and monitoring of the Wards Drug Revolving Fund/B.I.
vii. Raise funds for community programmes when necessary at village, facilities and Wards levels.
viii. Provide feedback to the rest of the community on how funds raised are disbursed.

ix. Liaise with government and other voluntary agencies in finding solutions to health, social and other related problems in the Wards.
x. Supervise the activities of the VHWs/TBAs, CHEWs;
xi. Monitor activities at both the health facilities and village levels;
xii. Oversee the functioning of the Health facilities in the Wards;
xiii. Provide necessary support to VHWs/TBAs;
xiv. Ensure that a Bank account is opened with is liable bank. The signatories will be as given by the NPHCDA guidelines on the Ward Health Systems document.
xv. Monitoring equipment and inventory of monthly intervals.
xvi. Ensure the proper functioning of the Health Facility using a maintenance plan.

c. Operational Guidelines of WDC Committee

The Committee shall:

i. Meet monthly;
ii. Record minutes of meetings;
iii. Recommend that minutes of meetings be signed by the Chairman and Secretary after approval at the next meeting;
iv. Monitor drug revolving at the Ward/Facility level;
v. Ensure that NHMIS forms are correctly filled and submitted ontime;

vi. Give feedback of data collected at LGA PHC Management Development Committee meetings;
vii. Comply with the quorum of members set for starting the meeting;
viii. Authorise the Treasurer to record and keep all monies;
ix. Authorise the Treasurer to spend money only after approval by Committee;
x. Instruct the Treasurer to record all expenditure;
xi. Chose where applicable, the ward referral centre to serve as the meeting venue and
xii. Secretariat of the Ward Development Committee;
xiii. Advise, where there is a Bank Account, signatories to be the Committee Chairman and Treasurer and if necessary, the Secretary;
xiv. Send minutes of meetings to Local Government Area Committee.

3. The LGA Primary Health Care Management Committee

Each LGA should have a LGAPHC Management Committee.

The objective of this committee is to provide an overall direction for Primary Health Care in the LGA.

a. The Composition of the LGA PHC Management Committee

i. The Chairman of the LGA (Chairman)
ii. Supervisory Councilor for Health (member)
iii. The LGA Secretary;
iv. LGA PHC Coordinator (Secretary);
v. A representative of CHO Training Institutions.
vi. Principal of School of Health Technology.
vii. Representative of health-related occupational groups/associations;
viii. The Chief (or most senior) Community Health Officer in the LGA;
ix. The Community Development Officer for the LGA;
x. The Medical Officers of the secondary health facility
xi. Chairman of Ward Development Committee
xii. Ward heads
xiii. Representatives of International Organizations having PHC programmes in the LGA;
xiv. Heads of other health-related departments in the LGA (Education, Agriculture, Works, etc);
xv. Representatives of NGOs;
xvi. Representatives of Women/Youth Groups;
xvii. Representatives of Religious Groups;

b. Terms of Reference

The Terms of Reference of the LGA PHC Management Development Committee shall be to:

i. Provide overall direction for PHC including endemic, communicable diseases (HIV/IDS/STD, TB, Malaria, Onchocerciasis, etc)
ii. Plan and manage PHC Services in the LGA
iii. Health Manpower Development for the LGA
iv. Provide the Operational Guideline for the LGA

4. Local Government Area PHC Technical Committee

There should be a PHC Technical Committee at the LGA level.

a. Composition

i. LGAPHC Coordinator–Chairman
ii. All Assistant PHC Coordinators
iii. Program Managers in the LGA.

b. Roles and Responsibilities

i) Plan and budget for implementation of activities of PHC department and present same to the LGA PHC Management Development Committee;
ii) Identify training needs for Health Workers and make proposals to th LGA PHC Management Development Committee;
iii) Design minimum acceptable performance standard for monitoring LGA PHC Services and develop monitoring indicators.
iv) Monitor activities of health workers;
v) Design supervisory checklist for LGA PHC services;
vi) Identify health related needs of communities within the Local Government Area;
vii) Plan for mobilisation of local and external resources to enhance PHC Activities;
viii) Provide feedback to committees at all levels;
ix) Monitor drug revolving fund for the health services at the LGA level;
x) Discuss PHCM'S report and take appropriate action;
xi) Give feedback of data collected at LGA PHC Management Committee meeting/facility staff/community.
xii) Review progress of PHC in the LGA and evaluate their indicators.

c. Operational Guidelines

In carrying out the above functions, the committee shall:

i) meet monthly;
ii) Record minutes of meetings;
iii) Adopt minutes of meetings and ensure that the Chairman and Secretary sign them;
iv) Comply with the quorum set for starting meetings.

5. The State PHC Implementation Committee

a. Composition

i. Commissioner for Health–Chairman
ii. Permanent Secretary Health
iii. Director of Primary HealthCare–Secretary
iv. Representatives of Health-related Ministries
v. Representatives of Women's Associations
vi. Representatives of Extra-Ministerial Department
vii. Representatives of International Agent
Viii. Local Government Areas Chairmen
ix. Representatives of Religious Groups
x. Representative of the Directorate of Local Government
xi. Chairman of LGA Service Commission
xii. Any other member as maybe deemed appropriate.
xiii. Director of LGA Affairs.

b. Terms of Reference

The Committee shall:

i. Review PHC implementation plans as developed by the LGAs in the State;
ii. Provide necessary materials, technical, financial, and other support to LGAs in the implementation of the plans;
iii. Commission periodic assessment surveys of the progress made in PHC Implementation and its impact on the quality of lives of the people;
iv. Receive reports of PHC activities in the LGAs through the State PHC Coordinator and give feedback to LGAs.
v. Liaise with other State Ministries and Federal officials operating in the State for the enhancement of PHC services;
vi. Collaborate with NGOs and other International Agencies through the Federal Ministry of Health and National Primary Health Care Development Agency (NPHCDA) for necessary support and assistance ;and
vii. Monitor and evaluate LGA activities at all levels in conjunction with the NPHCDA.

3.3 The Role of Donors, Policy Makers, and External Organisations

Here, we want to use maternal and newborn health as an example to illustrate the role of donors and policymakers in community mobilisation. The role of donors and policymakers in community mobilisation for maternal and newborn health is to ensure that programs:

i. Integrate community mobilisation into the broader national or regional health plan.
ii. Prioritise communities with the highest mortality and that could benefit most.
iii. Hire implementing organisations with proven experience and expertise in community mobilisation and maternal and newborn health.
iv. Engage communities as full partners in planning, implementation, and evaluation.
v. Have sufficient financial support; have realistic timelines; are supported by policies that promote community participation.
vi. Establish links to external assistance within the health and other sectors.
vii. Establish mechanisms to coordinate the work of all implementing agencies and communities to ensure that perspectives at all levels are taken into account as strategies and materials are developed, to maximise program learning and use of resources.

External assistance is most effective when it starts from where people are and facilitates a process through which interested community members, especially the most vulnerable, identify and implement strategies and approaches that will reduce mortality within their local context. Additionally, external facilitators may share valuable information with community members on effective strategies, practices, and experiences to complement Local knowledge, making for better informed community decision-making and planning (Howard-Graham, 2005).

To play these roles successfully, external organisations must establish relationships with communities built on respect and trust, with faith in the ability of community members to identify and resolve their challenges in the most appropriate way in the local cultural setting. Ideally, community mobilisation will work together with other, complementary program strategies (mass media, services strengthening, and policy advocacy) rather than on its own. For example, Home Based Life Saving Skills (HBLSS) training may be offered to interested communities that have limited access to health services; community members may participate in the development and dissemination of educational messages and materials; and community members may help design health facilities and health protocols that take into account their perspectives on quality care (Howard-Graham, 2005).

SELF-ASSESSMENT EXERCISE

Enumerate the composition of PHC Technical Committee at the LGA level.

4.0 CONCLUSION

In this unit, we have discussed the various development committees including their titles, composition and responsibilities. Consequently, you should be able to discuss the various committees, their parameters and characteristics.

5.0 SUMMARY

Primary Health Care emphasizes on the importance of full involvement by all communities to ensure health by the people. In order to achieve this strategy it is expedient to establish functioning and effective development committees at all levels from the Village, Ward, LGA and State. This unit really focused on the titles, composition and responsibilities of all the five committees such as: the Village Development Committee (Community Development Committee),Ward Development Committee (WDC), the State PHC implementation committee, Local Government Area PHC technical committee and The LGA Primary Health Care management committee.

6.0 TUTOR-MARKED ASSIGNMENT

1 List three members of the Community Development Committee.
2. Enumerate five responsibilities of the Community Development Committee.
3. Enumerate two terms of Reference of the LGA Primary Health Care.
   Management Committee.
4. List five members of the State PHC Implementation Committee.

7.0 REFERENCES/FURTHER READING

Abosede, O. A. (2003). Primary Health Care in Medical Education in Nigeria. Lagos: University of Lagos Press.

Community Health Practitioners Registration Board of Nigeria (2006), Curriculum for Higher Diploma in Community Health Abuja, Mitral Press.

FMOH (2004) Operational Training Manual and Guidelines for the Development of Primary Health Care System in Nigeria, Abuja.

Howard-Graham, L. (2005). Demystifying Community Mobilisation: An Effective Strategy to Improve Maternal and Newborn Health. Storti C. ed. Pp. 1-32.

Ransome-Kuti, O, Sorungbe, A. O. O., Oyegbite, K. S. & Bamisaiye, A. (1993). Strengthening Primary Health Care of Local Government Level; The Nigerian Experience. Lagos: Academy Press.

MODULE 2 COMMUNITY DIAGNOSIS

UNIT 1 CONCEPT OF COMMUNITY DIAGNOSIS

CONTENTS

1.0 INTRODUCTION

In order to provide the necessary health services for a community, health care providers must be able to identify the prevailing health issues or problems and determine their priorities. In spite of the fact that health care facility is available, it is advisable to continue to reassess the health situation in the community and plan services that are appropriate to the priority health problems of the community health workers must possess the requisite skills for diagnosing the health problems of the community.

This unit will enable you to understand the concept of community diagnosis. Before we do this, let us have a view of what you should learn in this unit as indicated in the objectives below:

2.0 OBJECTIVES

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

- explain the meaning of diagnosis
- define community diagnosis
- discuss the types of health needs in the community
- define the community diagnosis process
- enumerate the types of health needs
- describe how community diagnosis is carried out
- list the characteristics of indicators
- highlight the different classes of health indicators.

3.0 MAIN CONTENT

3.1 Meaning of Diagnosis

Diagnosis simply means to determine the nature of something e.g. disease .It is a statement of the result of findings. Family Medical Compassion defined diagnosis as the process whereby a particular disease or condition is identified after analysis and consideration of the relevant parameterie .symptoms, physical manifestation, results of laboratory tests etc. Parker (1985) stated that the diagnosis of a disease in an individual patient is a fundamentalideainmedicine. It is based on signs and symptoms and the making of inferences from them. When this is applied to a community it is known as community diagnosis.

3.2 Definition of Community Diagnosis

Kyari (2002) defined community diagnosis as a process of finding out about the health needs of the community. The focus of community diagnosis is on the identification of the basic health needs of the community. FMOH (2004) defined community diagnosis as an organised process involving identified needs, resources, wants, constraints, problems, and disease patterns, physical, social, cultural and demographic characteristics of the community. In community diagnosis, the entire community is regarded as a patient requiring community diagnosis and treatment. Community diagnosis generally refers to the identification and quantification of health problems in a community as a whole in terms of mortality and morbidity rates and ratios, and identification of their correlates for the purpose of defining those at risk or those in need of health care.

3.3 The Community Diagnosis Process

The Community Diagnosis Process is a means of examining aggregate and social statistics in addition to the knowledge of the local situation, in order to determine the health needs of the community.

3.4 Types of Health Needs of a Community

i. **Felt Needs**
These needs are those identified by the community itself which require solutions for example shortage of water supply, poor roads etc.

ii. **Identified Needs**
These are health needs which members of the community are not aware of and are identified during the process of community diagnosis for example pattern of disease occurrence etc.

3.5 How Is The Community Diagnosed?

Community analysis is the process of examining data to define needs strengths, barriers, opportunities, readiness, and resources. The product of analysis is the community profile.To analyse assessment data is helpful to categorise the data.

This may be done in the following ways:

i. Demographic
ii. Environmental
iii. Health resources and services
iv. Health policies
v. Socioeconomic
vi. Study of target groups.

Community is diagnosed using health indicators. Indicators of health are variables used for the assessment of community health.

3.6 Characteristics of Indicators

i. **Validity:** they should actually measure what they are supposed to measure.
ii. **Reliability and objectivity**: the answers should be the same if measured by different people in similar circumstances.
iii. **Sensitivity:** they should be sensitive to changes in the situation concerned.

iv. **Specificity:** they should reflect changes only in the situation concerned.
v. **Feasibility:** they should have the ability to obtain data needed
vi. **Relevant:** they should contribute to the understanding of the phenomenon of interest.

3.7 Classification of Health Indicators

1. Mortality indicators
2. Morbidity indicators
3. Disability rates
4. Nutritional status indicators
5. Health care delivery indicators
6. Utilisation rates
7. Indicators of social and mental health
8. Environmental indicators
9. Socio-economic indicators
10. Health policy indicators
11. Indicators of quality of life
12. Other indicators

1. Mortality Indicators

Mortality or death rates are the traditional measures of health status. They are widely used because there are ready available. For example, death certificate is a legal requirement in many countries.

Mortality indicators include the following:

i. Crude death rates
ii. Specific death rates: age/disease
iii. Expectation of life
iv. Infant mortality rate
v. Maternal mortality rate
vi. Proportionate mortality ratio
vii. Case fatality rate

2. Morbidity Indicators

Morbidity indicators are morbidity rates or disease rates. Data on morbidity are preferable, although often difficult to obtain.

Examples of morbidity examples are:

i. Incidence and prevalence
ii. Notification rates
iii. Attendance rates: out-patient clinics or health centers.

iv. Admission and discharge rates
v. Hospital stay duration rates

3. Disability Indicators

Disability indicators are disability rates. Examples are as follows:

i. Number of days of restricted activity
ii. Bed disability days
iii. Work/School loss days within a specified period.
iv. Expectation of life free of disability

4. Nutritional Indicators

Examples of nnutritional indicators are:

i. Anthropometrics measurements
ii. Height of children at school entry
iii. Prevalence of low birth weight
iv. Clinical surveys: Anaemia, Hypothyroidism, Night blindness

5. Health Care Delivery Indicators

Health care delivery indicators reflect the equity and provision of health care.

Examples are as follows:

i. Doctor / Population ratio
ii. Doctor / Nurse ratio
iii. Population / Bed ratio
iv. Population / per health center

6. Utilisation Indicators

Utilisation indicators are health care utilisation rates which show the extent of use of health services. It indicates the proportion of people in need of service who actually receive it in a given period or year.

Examples are as follows:

i. Proportion of infants who are fully immunised in the 1st year of life ii. immunisation coverage.
iii. Proportion of pregnant women who receive antenatal care (ANC).
iv. Hospital-beds occupancy rate.

v. Hospital-beds turn-over ratio

7. Social/Mental Health Indicators

Indicators of social and mental health are indirect measures of health status. Often, valid positive indicators do not often exist so in direct measures are commonly used. Examples are as follows:

i. Suicide & Homicide rates
ii. Road traffic accidents
iii. Alcohol and drug abuse.

8. Environmental Indicators

Environmental health indicators reflect the quality of environment. Examples include:

i. Measures of Pollution
ii. The proportion of people having access to safe water and sanitation facilities
iii. Vectors density

9. Socio-economic Indicators

Socio-economic indicatorsare not direct measures of health status. They are used for the interpretation of health care indicators. Examples are as follows:

i. Rate of population increase
ii. Per capital Gross Net Profit (GNP)
iii. Level of unemployment
iv. Literacy rates - females
v. Family size
vi. Housing condition e.g. number of persons per room
vii. Age

10. Health Policy Indicators

Health Policy Indicators assesses the aallocation of adequate resources. Examples are:

i. Proportion of GNP spent on health services.
ii. Proportion of GNP spent on health related activities.
iii. Proportion of total health resources devoted to primary health care

11. Other Indicators

Other health indicators include:

i. Indicators of quality of life.
ii. Basic needs indicators.
iii. Health for all indicators.

SELF-ASSESSMENT EXERCISE

Define community diagnosis according to FMOH.

4.0 CONCLUSION

In this unit you have known about the meaning of diagnosis and that in the definition of community diagnosis the focus is on identification of health needs. You have also classified these health needs as felt and identified needs, defined the community diagnosis process, enumerated the types of health needs, described how community diagnosis is carried out, listed the characteristics of indicators as well as discussed the different classes of health indicators.

5.0 SUMMARY

Community diagnosis is the process of working with the community member to find out about the needs of the community. These needs include those already identified by the community itself (felt needs) and others identified during the process (identified needs). It also includes finding out information about the structure, the people, association's resources and other characteristics of the community. Community diagnosis helps us to identify the important health problems and diseases in a community and how we can present them with suitable health programmes. Community diagnosis is carried out using health indicators; some are direct indicators while some are indirect indicators.

6.0 TUTOR-MARKED ASSIGNMENT

1. Explain the term diagnosis.
2. What are the various definitions of community diagnosis?.
3. Differentiate between felt needs and identified needs, with one example in each case.

7.0 REFERENCES/FURTHER READING

Abosede, O. A. (2003). *Primary Health Care in Medical Education in Nigeria*. Lagos: University of Lagos Press.

FMOH (2004). Curriculum for Community Health Officers Lagos, Nigeria.

Salama R. (nd). Community Analysis. Community Medicine. Egypt: Suez Canal University.

Egwu, I. N. (2000). Primary Health Care Theory, Practice & Perspective. Lagos: Elmore Publishers.

UNIT 2 RATIONALE FOR COMMUNITY DIAGNOSIS

CONTENTS

1.0 INTRODUCTION

The previous unit has exposed you to the concept of community diagnosis; therefore it will be necessary also for you to know the rationale for community diagnosis. Rationales are basic ideas behind an activity. Thus, for you to have an in-depth knowledge of the subject matter the rationale must be stated clearly for you to grasp.

According to Eng. and Blanchard (1990) it appears that conducting a needs assessment is a necessary component of program planning, but the information is not sufficient for designing sustainable interventions. An action-oriented community diagnosis procedure has been developed over several years to identify normative and comparative needs determined by service agencies as well as expressed and perceived needs experienced by clients; assess community conditions contributing to collective competence as well as the barriers and gaps contributing to disease and illness; and increase collective competence of communities and agencies to collaborate in defining problems and needs.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- identify the goals of community diagnosis
- State the rationale for community diagnosis.

3.0 MAIN CONTENT

3.1 Goals of Community Diagnosis

The aims of community diagnosis are to:

i. Analyse the health status of the community
ii. Evaluate the health resources, services, and systems of care within the community
iii. Assess attitudes toward community health services and issues
iv. Identify priorities, establish goals, and determine courses of action to improve the health status of the community
v. Establish an epidemiologic baseline for measuring improvement over time.

3.2 The Rationale for Community Diagnosis

The rationales for community diagnosis are as follows:

i. Community diagnosis provides realistic information specific to a community for which definite relevant plans are made in order to solve problems.
ii. It makes the Community to be self-reliant and enables the people to have their initiatives.
iii. Community diagnosis enables the people to identify their health needs and use resources in a culturally and acceptable manner to promote their health.
iv. It helps to identify constraints which can be addressed in the planning process of any health programme in the community.

SELF-ASSESSMENT EXERCISE

List the goals of community diagnosis

4.0 CONCLUSION

In this unit you have learned the rationale for community diagnosis and it is expected that you can state clearly the rationale for community diagnosis.

5.0 SUMMARY

In order to achieve success in the delivery of adequate and effective health care and for health facility to be utilised information about the health status and infrastructure in the community must be understood. It is therefore important to discuss the rationale for community diagnosis which include the provision of realistic information relevant to Solve health problems using identified resources, in a culturally and acceptable manner.

6.0 TUTOR-MARKED ASSIGNMENT

State, at least, two rationales for community diagnosis.

7.0 REFERENCES/FURTHER READING

FMOH. (1996). Curriculum for Community Health Officers, Lagos.

Kyari, U. M. (2002). *Introduction to Primary Health Care for Beginners in*
Community Health. Zaria: Sankore Educational Publishers.

Eng, E. & Blanchard, L. (1990). Action-oriented Community Diagnosis: A Health Education Tool. Int Q Community Health Education. 1990 January 1;11(2):93-110. doi: 10.2190/W8MU-5H9X-PQW1-LV38.

NwaforR, O. (2008). Health Management. Enugu: Beloved Computer Services.

UNIT3 STEPS IN COMMUNITY DIAGNOSIS

CONTENTS

1.0 INTRODUCTION

In this unit, emphasis will be led on the necessary steps involved in diagnosing a community. In order to carrying out community diagnosis steps must be followed as a pre-requisite for community cooperation.

2.0 OBJECTIVES

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

- explain the steps in community diagnosis
- discuss steps in community health assessment development process.

3.0 MAIN CONTENT

3.1 Steps Involved in Carrying Out Community Diagnosis

In the process of community diagnosis the following steps are necessary:

i. Make entry through the LGA into the community.
ii. Identify boundaries of the community.
iii. Make a sketch map of the community using established symbols e.g. rivers, schools, markets and other important landmarks or obtain a sketch map of the community from the Local Government Office.
iv. Make a list of resources available in the community e.g. industries, markets, churches, mosques, healthcare facilities and personnel, organisations e.g. transport unions, non-government organisations.

v. Make a list of cultural practices and attitudes affecting health e.g. those that are useful, harmful and harmless.
vi. Describe social customs and important festivals of the community.
vii. Make a list of infrastructures in the community, e.g. electricity, water supply, means of transportation etc.
viii. Collate information from the community.
ix. Conduct interviews and survey of social groups in the community.
x. Write report using Federal Ministry of Health format.
xi. Give feedback to the LGA/State/ FMOH.

3.2 Steps in Community Health Assessment Development Process

Assessment, planning models and frameworks, identifies ten steps in the community health assessment development process (Department of health, (DOH, 2006)). They are:

i. Establish the assessment team.
ii. Identify and secure resources.
iii. Identify and engage community partners.
iv. Collect, analyse, and present data.
v. Set health priorities.
vi. Clarify the issue.
vii. Set goals and measure progress.
viii. Choose the strategy.
ix. Develop the community health assessment document.
x. Manage and sustain the process.

SELF-ASSESSMENT EXERCISE

List the 10 steps in the Community Health Assessment development process as indicated by Department of Health, (2006).

4.0 CONCLUSION

In this unit you have learned about the steps involved in carrying out community diagnosis you should at this point be able to state the steps for community diagnosis.

5.0 SUMMARY

This unit focused on the description of the steps involved in carrying out community diagnosis. The steps should be followed starting with making entry in the community and carrying othe activities.

6.0 TUTOR-MARKED ASSIGNMENT

1. List the first three (3) steps involved in community diagnosis.

7.0 REFERENCES/FURTHER READING

Community Health Practitioners Registration Board of Nigeria (2006). Curriculum for Diploma in Community Health. Abuja: Miral Press.

DOH (2006). 10 Steps in Community Health Assessment Development Process. https://www.health.ny.gov/statistics/chac/10steps.htm, Accessed 16/1/17.

National Primary Health Care Development Agency (2005). Briefing Manual on Primary Health Care Services for NYSC Health Professionals. Amawbia, Lumos Nig. Ltd.

FMOH (2004). Operational Training Manual and Guidelines for the Development of Primary Health Care system in Nigeria. Abuja.

UNIT 4 METHODS FOR COMMUNITY DIAGNOSIS

CONTENTS

1.0 INTRODUCTION

This unit will focus on the various methods used in community diagnosis.

2.0 OBJECTIVES

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

* describe the methods used in Community diagnosis
* explain Observation
* define Interview
* explain Group discussion
* discuss review of existing records.

3.0 MAIN CONTENT

3.1 Description of the Methods used in Community Diagnosis

Every activity has methods of achieving its goals. There are different ways of gathering information for community diagnosis.

These includes:

i. Observation,
ii. Interviews,
iii. Group discussion and
iv. review of existing records.

3.1.1 Observation

It is very important to determine the disease that affect the community through observation and physical examination, because some diseases are not easily recognised in the community e.g. Anaemia, dental caries malnutrition, diabetes. In observation you observe their surroundings, living conditions ,eating habits and life pattern to avoid wrong impression. In observation also you are to use your eyes to see and also hear some relevant information with your ears.

3.1.2 Interview

The act of interviewing, involves communicating with somebody e.g. household heads, mothers. These are people who play important role in the community in decision making on health matters or issues. You should create a good rapport with the person so that he/she will feel free to talk with you and give you the correct information about what you need. The interview maybe face to face (verbally) or through questionnaire (filling a prepared form).

3.1.3 Focused Group Discussion

Focused group discussion, unlike interview, is held with groups of people and not an individual. It is useful in getting information on health needs of the community that is what they feel as their most pressing problems.

3.1.4 Review of Existing Records

Useful information can be obtained by reviewing existing records particularly when trying to determine the population of a community, the health facilities sand the health personnel as well as disease pattern in the area. This information can be obtained from existing records. These records maybe found in the:

i. Local Government Area office or in the health statistics department;
ii. Reports on nutritional status surveys, basically, monitoring of health status in the communities to determine the incidence of

mal nutritional diseases and proper treatment. This survey report is important in community diagnosis;

iii. Maps: the map of the area is required for community diagnosis

iv. Reports by private organizations: NGOs and others could produce useful reports on health status to assist in community diagnosis; and

v. Research records of disease pattern: The incidence and pattern of diseases in the area can help community diagnosis. These can also be obtained from past records or research.

SELF-ASSESSMEENT EXERCISE

List the four methods of community diagnosis.

4.0 CONCLUSION

In this unit, you have known the various methods used in collecting information for community diagnosis. At this juncture, you should be able to describe the various methods.

5.0 SUMMARY

This unit has focused on the description, explanation and discussion on the various methods used in community diagnosis which include observation, interview, group discussion and review of existing records.

6.0 TUTOR-MARKED ASSIGNMENT

1. Discuss interview as a method in community diagnosis.
2. Explain the term focused group discussion

7.0 REFERENCES/FURTHER READING

Akinsola, H. A. (1993). A–Z of Community Health and Social Medicine in Medical and Nursing Practice with Special Reference to Nigeria. Ibadan: 3AM Communications.

Egwu, I. N. (2000). Primary Health Care Theory, Practice & Perspective. Lagos: Elmore Publishers.

Olise, P. (2007). Primary Health Care for Sustainable Development. Abuja: Ozege Publications.

UNIT 5 INFORMATION SOUGHT DURING COMMUNITY DIAGNOSIS

CONTENTS

1.0 INTRODUCTION

When services are to begin in a community there is the tendency to have a careful assessment of existing situations and relevant pieces of information in the community that will enhance the planning of interventions or health actions. This unit will help you to understand the important information you will need for community diagnosis. In order to discuss this subject properly, it will be necessary to have a view of what you should learn in this unit, as indicated in the objectives stated below.

2.0 OBJECTIVES

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

- discuss the geography of the area (map)
- explain the Epidemiological information needed
- discuss the Demographic information needed
- state the socio-economic conditions
- state the factors that affect health in the community.

3.0 MAIN CONTENT

3.1 Geography of the Area

The major aspects that relate to this idea are mainly based on them of the area, which will also include major settlements, seasons, type of vegetation and location in relation to other communities.

In order to carry out community diagnosis in a Community or Local Government Area the use of maps is necessary. Oxford Advanced Learner's Dictionary 6th Edition defined Map as a drawing or plan of the earth's surface or part of it, showing countries, towns etc.

Ibet-Iraquinma (2006) defined Map as a flat representation of a place including villages, Towns, Local Government Area, State and Country on a paper in a diagrammatic form. Maps enables one to obtain information about the topography of the area which include physical features of a place for example terrain, mountains, rivers, streams, vegetation seasons etc. It also ensures the identification of target areas, shows distances to various facilities and settlements as well as to locate population, and proximity of one settlement to another. The Local Government Area map including that of towns and villages could be obtained from the Chairman or the Local Government Council Area office. If such a map is not available efforts should be made to initiate the drawing of such a map.Using the characteristics of a map.

3.2 Epidemiological Information Needed for Community Diagnosis

Akinsola, (1993) defines Epidemiology as the study of the pattern of distribution of disease in human populations and the factors which influence the distribution. The information required in this context will include types of diseases and infections prevalent in the community, their magnitude and distribution by sex, age, ethnicity, seasonal variations and other dynamics.

Below are some of the necessary Epidemiological factors to take cognisance of:

i. **Disease:** Nature and patterns of occurrence of illness in the community.
ii. **Occurrence**: Sources of the disease and how it occurs in the community.
iii. Frequency: Concerned with the estimation of amount of disease or the condition of occurrence either during a given period of time or at a particular time.

iv. Distribution: The pattern produced by the disease in terms of time it occurred per(a)person:-Male, Female (b) Place:-Temperate, Tropical

v. Population: Group of individuals, community with common characteristics.

vi. Dynamism: Progress of the disease in the population in terms of changing pattern Over a period of time.

vii. Determinants: Variables affecting the frequency and Dynamism of the disease in a community e.g .age, sex and Nutritional factors.

viii. Population at Risk: Total number of community members in the population tohave likelihood (Risk) of developing the diseases or health problems.

ix. Morbidity: Degree of damage or effect caused by the disease in the population of the community

x. Mortality: Percentage of death caused by the disease in the population in a Community.

3.3 Demographic Information Needed for Community Diagnosis

Demographic information required for community diagnosis will involve the distribution of the population by sex, age, ethnic and religious groups as this will determine how many people that will later require specific adequate and effective services. The basic information about the demographic profile of the committee is as follows:

- Population Size: Total number of people in the community.
- Population Growth: Rate of increase in population of the community.
- Immigrant: Population of those people coming into the community from other country
- Emigrants: Population of those persons moving outside the community.
- Death Rate: Total number of death in a population of a community.
- Birth Rate: Total number of birth in a population of a community.
- Sex: Gender quality of the community populace male or female.
- Age: Years of birth for individual community member.

3.4 Socio-Economic Conditions of the Community

These areas include occupations, income level, housing types, and living conditions, educational level, source and nature of water supply and

others. These aspects of the Socio-economic status of the community will be explored for community diagnosis to be carried out.

3.5 Factors that Affect Health in the Community

There are certain factors in the community that are detrimental to the health status of the members of the community such as environmental sanitation, personal hygiene, attitudinal and behavioral factors, customs and beliefs.

Obionu, (2001) defined environmental sanitation as the process of taming the environment so that it does not constitute hazard to man. When the environment is not kept dirty,it becomes hazardous to man and affect the health status of the community.

Ibet-Iragunima, (2006) defined Personal hygiene as all those personal factors which influence the health and wellbeing of an individual. The factors include lack of cleanliness, exercise, diet, alcoholism, smoking and others influence the health of man. The way of life of the people (culture) and their inclination to certain things (beliefs) also affect them even their lifestyles. The areas of food, female circumcision and perceptions about the values of health as well as illness behaviour should be given priority attention.

4.0 CONCLUSION

In this unit, you have learned about the necessary information that will be sought during community diagnosis. It includes map of the area, epidemiology, and demographic and factors affecting health. You should at this point be able to state the information to be sought during the process.

5.0 SUMMARY

This unit has focused on the type of information to be sought during community diagnosis. They include information about population, birth, deaths, age, sex, geographical characteristics, and disease patterns, environmental and cultural factors.

6.0 TUTOR-MARKED ASSIGNMENT

1. List six demographic information needed during community diagnosis.

2. Enumerate three factors that affect the health status of the community.

7.0 REFERENCES/FURTHER READING

Akinsola, H. A. (1993). *A–Z of Community Health and Social Medicine in Medical and Nursing Practice with Special Reference to Nigeria*. Ibadan: 3AM Communications.

FMOH (1996). Curriculum for Community Health Officers, Lagos.

Hornby, A. S. (2000). Oxford Advanced Learner's Dictionary of Current English (6^{th} ed.). Oxford University Press.

Ibet – Iraqunima, M. W. (2006). *Fundamental of Primary Health Care*. Port Harcourt: Paulimatex Printers.

Obionu, C. N. (2001). Primary Health Care for Developing Countries. Enugu: Delta Publications.

Nwafor, R. O. (2008). *Health Management*. Enugu: Beloved Computer Services.

MODULE 3 SITUATION ANALYSIS

UNIT1 CONCEPT OF SITUATION ANALYSIS

CONTENTS

1.0 INTRODUCTION

In order to determine the ability of the health services to respond to the problems existing in the area a careful assessment of the health situation in the community is important. Information is collected from various sources in the Wards/Local Government Areas to be covered. Thus, situation analysis will determine the actual status of health in a given community. This unit will enable you to understand the concept and definitions of situation analysis. Before, we go further; it will be expedient to have a view of what you will learn in this unit, based on the unit objectives below.

2.0 OBJECTIVES

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

- explain the concept of situation analysis
- define the terms situation analysis.

3.0 MAIN CONTENT

3.1 Explanation of the Concept of Situation Analysis

Situation Analysis consists of a comprehensive inventory of health facilities in the LGA, their distribution, the category of personnel and other existing infrastructure. No health program can be adequate and effective without the personnel in the system carrying inventory of what is on ground. Therefore, Situation Analysis is a pre-requisite for effective health services in the any area. The idea is to tackle the problems identified during community diagnosis.

3.2 Definitions of Situation Analysis

FMOH (1996) defined Situation Analysis as the process of finding out the actual status of health in a given community.

Ransome-Kuti, (1993) defined Situation Analysis as the process of determining the ability of the health services to respond to the problems identified through community diagnosis.

Ibet–Iragunima, (2006) defined Situation Analysis as the ability to find out the health status of the community and the available personnel and infrastructure to meet their needs.

The above definitions have emphasised on the health status of the community in which case certain structure will be in existence or will be required for them to maintain good health status.

4.0 CONCLUSION

In this unit, you have learned about the concept and definitions of Situation Analysis as finding out the health status of a community. You should at this juncture be able to explain the concept and definition of Situation Analysis.

5.0 SUMMARY

This unit has focused on the concept of situation Analysis as a pre-requisite for any health intervention in the community. It has also defined Situation Analysis as the process of determining the health status of the community. Unit two will build on this in discussing the rationale for Situation Analysis.

6.0 TUTOR-MARKED ASSIGNMENT

1. Discuss the concept of Situation Analysis.
2. Define the term Situation Analysis.

7.0 REFERENCES/FURTHER READING

FMOH, (1996). *Curriculum for Community Health Officers.* Lagos.

Ibet-Iragunima, M. W. (2006). *Fundamentals of Primary Health Care.* Port Harcourt: Paulimatex Printers.

Ransome-Kuti O., Sarumgbe, A. O. O., Oyegbite, K. S. & Bamisaiye, A. (1992). *Strengthening Primary Health Care at Local Government Level. The Nigerian Experience*. Lagos: Academy Press Ltd.

Olise, P. (2007). *Primary Health Care for Sustainable Development*. Abuja: Ozege Publications.

UNIT 2 RATIONALE FOR SITUATION ANALYSIS

CONTENTS

1.0 INTRODUCTION

Rationale for situation analysis simply means the fundamental reasons or ideas behind the process of Situation Analysis. Since Situation Analysis is a necessary condition for adequate health intervention in the communities, it must have rationale. This unit will help you to understand as well as state the rationale for situation analysis.

2.0 OBJECTIVE

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

- enumerate the rationale for Situation Analysis.

3.0 MAIN CONTENT

3.1 Enumerating the Rationale for Situation Analysis

The rationales for Situation Analysis are as follows:

1. To determine the effectiveness of the health services and to respond to the problems found in the Community or Local Government Area.
2. To provide complete inventory of health facilities in the Local Government Area or Community.
3. To identify the distribution of health facilities in the Community.
4. To identify category and number of personnel in the facilities.
5. To provide information on the type and adequacy of services provided in all the facilities.
6. To provide information on the number of settlements in each Community or Local Government Area.

7. To identify the availability of certain basic infrastructure that affect health e.g. roads,electricity,telephones,portablewatersupply,schoolsetc.

8. To provide a complete overview of health services, their strength and weaknesses,health-relatedproblemsandinfrastructure.

4.0 CONCLUSION

In this unit you have learned the rationale for situation analysis. You should at this point be able to enumerate the rationale for situation analysis.

5.0 SUMMARY

This unit is based on the rationale for situation analysis and these include determining the effectiveness of the services in the area, distribution, availability as well complete overview of the problems and infrastructure. Unit three will dwell on the information sought in situation analysis.

6.0 TUTOR-MARKED ASSIGNMENT

State three (3) rationales for situation analysis.

7.0 REFERENCES/FURTHER READING

Kyari, U. M. U. (2002). *Introduction to Primary Health Care for beginners in Community Health: Nigerian Experience.* Zaria: Sankore Educational Publishers.

NDHCDA (2005). *Brief Manual on Primary Health Care Services for NYSC Health Professionals*. Abuja.

UNIT 3 INFORMATION SOUGHT FOR SITUATION ANALYSIS

CONTENTS

1.0 INTRODUCTION

Information is a necessary tool for planning any intervention or health actions. In order to conduct situation analysis specific information will be required for the success of the exercise. This unit will help you to understand the necessary information required for this important process.

2.0 OBJECTIVE

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

- state the information sought during Situation Analysis

3.0 MAIN CONTENT

3.1 Information Sought for Situation Analysis

In the process of carrying out situation analysis, the following information is necessary:

1. Information on LGA and Community.
2. Population by District/Wards
3. Information on LGA Health Budget
4. Health facility by type
5. Health Personnel category, number and location.
6. School population and type.
7. Socio-economic status (income level, occupation)
8. Public Utilities and Services
9. LGA PHC activities
10. LGA logistic support etc.

These information are needed for situation analysis process to achieve its rationale.

4.0 CONCLUSION

In this unit, you have learned the necessary information to be sought in the process of situation analysis. You should be able to state the information required for situation analysis.

5.0 SUMMARY

This unit has focused on the information required for situation analysis. In determining the health needs of the local government area or community, adequate consideration must be given to the situations in the community. This is based on the collection of relevant information about health facilities, personnel and other infrastructure in the community.

6.0 TUTOR-MARKED ASSIGNMENT

Enumerate at least five (5) information sought for Situation Analysis

7.0 REFERENCES/FURTHER READING

Abosede, O. A. (2003). *Primary Health Care in Medical Education in Nigeria.* Lagos: University of Lagos Press.

Olise, P. (2007). *Primary Health Care for Sustainable Development*. Abuja: Ozege Publications.

WHO (1978). Report of the International Conference on Primary Health Care, Alma Ata USSR 6-12 September, 1978.

NPHCDA (2004). Operational Training Manual and Guidelines the Development of Primary Health Care System in Nigeria, Abuja.

UNIT 4 STEPS IN CONDUCTING SITUATION ANALYSIS

CONTENTS

1.0 INTRODUCTION

In an attempt to conduct situation analysis certain steps are required for easy access to the local government areas and communities. This unit will expose you to the necessary steps for this exercise.

2.0 OBJECTIVE

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

- Identify the steps in conducting Situation Analysis

3.0 MAIN CONTENT

3.1 Identification of the Steps in Conducting Situation Analysis

This process involves the following:

1. Contacting the Local Government Area Office.
2. Contacting the village development committee;
3. Obtaining the instrument to be used from the Federal Ministry of Health;
4. Training the Interviewers;
5. Practice role-playing with the instruments;
6. Arranging for snacks and transportation for the interviewers;
7. Assign individuals and provide them with materials;
8. Collating data from the field; and

9. Writing report using FMOH format.
10. Give feed back to the community and other health workers.
11. Submit report to LGA/State/FMOH

4.0 CONCLUSION

In this unit you learned the steps involved in conducting situation analysis in the local government area or community. At this point, you should be able to identify the steps necessary in conducting situation analysis.

5.0 SUMMARY

This unit has emphasised on the necessary steps in conducting Situation Analysis which includes contacts with LGAs, communities training individuals and assigning task to them as well as writing reports on the exercise for the improvement of the health status of the communities. Unit five will describe the instruments used for this exercise.

6.0 TUTOR-MARKED ASSIGNMENT

List the steps involved in conducting Situation Analysis

7.0 REFERENCES/FURTHER READING

FMOH. (2004). Operational Training Manual and Guidelines for the Development of Primary Health Care system in Nigeria. Abuja.

NPHCDA. (2005). Brief Manual on Primary Health Care services for NYSC Health Professionals. Abuja.

UNIT 5 INSTRUMENTS USED IN SITUATION ANALYSIS

CONTENTS

1.0 INTRODUCTION

For situation analysis to be effectively conducted certain instruments have been established for this purpose by the federal ministry of health. This unit will acquaint you with the instruments useful for this exercise.

2.0 OBJECTIVES

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

- describe the instruments used in situation analysis
- explain Form H
- discuss Form C
- explain Form F.

3.0 MAIN CONTENT

3.1 Description of the Instruments used in Situation Analysis

There are specific instruments designed for this exercise. They include Form H for household, Form C for children and Form F for married women under 50years and women who have never been pregnant.

3.2 Explanation of Form H

Form H: This is called household questionnaire. These forms contain the list of all members of the household – their demographic characteristics and also documented illness episode for the past months.

3.3 Discussion on Form C

Form C: It is the children questionnaire. It focuses on children, their immunization status, their diarrhea episode and what was used for treatment or to cure them. Information from this form gives an in-depth understanding of the health problem in each Local Government Area and it also gives information on health knowledge and health-seekingbehaviour. The questionnaire also provides a list of illnesses that are prevalent in the community or Local Government Area.

3.4 Explanation of Form F

Form F: This is the female questionnaire for female, married or unmarried under fifty (50) years and women who have never been pregnant. This questionnaire probes into the number of children each woman in the household had dead or alive. It also inquires into what material health services the woman had during her last pregnancy.

4.0 CONCLUSION

In this unit, you have learned what the instruments used in situation analysis are such a s Forms H, C and F. the forms have also been described. You should at this juncture be able to discuss or explain any of the Forms.

5.0 SUMMARY

This unit has focused on the description of the instruments used in situation analysis. The instruments include For ‘H’ to collect household information, Form ‘C’to collects child information and Form ‘F’to collect information on female married and under fifty (50) years and women who have never been pregnant.

6.0 TUTOR-MARKED ASSIGNMENT

1. Briefly explain the following:
   (a) Form‘H’
   (b) Form‘C’
   (c) Form‘F’

7.0 REFERENCES/FURTHER READING

CHPRBN (2006). Curriculum for Higher Diploma in community Health Abuja. Miral Press.

EgwuI, N. (2000). Primary Health Care system in Nigeria: Theory Practice & Perspective. Lagos: Elmore Publishers.

Ransome-Kuti, O., Sorungbe, A.,O.,O., Oyegbite, K.,S. & Bamisaiye, A. (1992). Strengthening Primary Health care at Local Government Level: The Nigerian Experience. Lagos: Academy Press Ltd.

MODULE 4 ADVOCACY

UNIT 1 CONCEPT OF ADVOCACY

CONTENTS

1.0 INTRODUCTION

This unit examines the concept and definitions of advocacy. It basically involves soliciting support for any programme at the Local Government, State and Federal Levels. This unit will assist you to understand Advocacy and its components.

2.0 OBJECTIVES

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

- explain the concept of Advocacy
- define the term Advocacy.

3.0 MAIN CONTENT

3.1 Concept of Advocacy

Much needs to be done to maintain effective communication strategy for advocacy as regards to any programme. At the policy level, there is very little awareness on the part of some policy makers about certain programmes especially a regards the irrational and benefits.

Consequently, advocacy greetings and visits are necessary for the achievement of some major objectives of such programmes.

3.2 Definition of Advocacy

FMOH (2005) defined Advocacyas a process ofsensitizing with subsequent followup of policymakersandotherstoarousetheirinterest soastogetthem committedtoprogrammesespeciallyPHC programmes.

Olise, P. (2007) stated that advocacy is also the process of creating awareness concerning any programme among policy makers and others inorder to solicit their support and commitment.

You will discover that in these definitions emphasis is laid on sensitization, creating awareness and arousing interest of people so as to be involved in health programmes. It is not one day activity but a continuous process.

4.0 CONCLUSION

In this unit, you have learned what concept and definition of advocacy meant. The idea of Getting people committed to a programme and creating awareness among policy makers and others on health issues.

You should at this point be able to explain the idea behind Advocacy. Also you should be able by now to define Advocacy as a mean or process of sensitisation of people.

5.0 SUMMARY

This unit has focused on the concept of Advocacy and definition of Advocacy. It explain that there is need to interact with people as well create awareness and sensitise them towards health progress so as to achieve the objectives of Health Services.

Advocacy meetings are organised for Community leaders including government functionaries, councilors, local government chairman, traditional rulers, governors, presidents, legislators, permanent secretaries, and directors commissioners of health etc.

6.0 TUTOR-MARKED ASSIGNMENT

1. Explain the concept of Advocacy.
2. Define Advocacy.

7.0 REFERENCES/FURTHER READING

FMOH. (2005). Brief Manual or Primary Health Care Services for NYSC Health Professionals. Abuja.

Ibet-Iragunima, M. W. (2006). Fundamentals of Primary Health Care. Port Harcourt: Paulimatex Printers.

FMOH. (2004) Operational Training Manual and Guidelines for the Development by Primary Health care system in Nigeria. Abuja.

UNIT 2 RATIONALE FOR ADVOCACY

CONTENTS

1.0 INTRODUCTION

Rationale simply refers to fundamental reasons or ideas behind an activity. Since Advocacy is a very important strategy to achieve the objectives of any programmes especially health interventions the rationale should be explicit for people to understand. It should however be borne in mind that for us to discuss more on this unit you will take a look at the objectives indicated below.

2.0 OBJECTIVE

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

- discuss the rationale for advocacy

3.0 MAIN CONTENT

3.1 Discussion on the Rationale for Advocacy

Advocacy is necessary for acquainting policy makers of their role and responsibility in relation to identified health goals. This will usually include explanations why such roles are important. When policy makers understand their roles and underlying reasons, they will be better disposed to provide the support and the help required from them.

In view of the facts stated above one can adduce that Advocacy is necessary for the implementation of any health programme or any other programme.

4.0 CONCLUSION

In this unit, you have learned about the rationale for advocacy as in equanon (necessary condition) for the execution of any programme. At this point you should be able to discuss or explain the rationale for advocacy.

5.0 SUMMARY

This unit emphasised on the rationale for advocacy as a pre-requisite for programme implementation. Advocacy is arousing interest of people to support any programme. It aims to achieve programme objective and the rationale are concise.

6.0 TUTOR-MARKED ASSIGNMENT

Explain the rationale for Advocacy.

7.0 REFERENCES/FURTHER READING

Olise, P. (2007). Primary Health Care for Sustainable Development. Abuja: Ozege Publications.

Ransome-Kuti, O. S., Orungbe, A. O. O., Oyegbite, K. S. & Bamisaiye, A. (1992). *Strengthening Primary Health Care at Local Government Level: The Nigerian Experience*. Lagos: Academy Press Ltd.

FMOH (2004). Operational Training Manual and Guidelines for the Development of Primary Health Care System in Nigeria. Abuja.

UNIT 3 STEPS IN ADVOCACY

CONTENTS

1.0 INTRODUCTION

This unit involves making initial contacts or visits to policy makers and discussing the objectives of the programmes in order to get the people fully involved.

2.0 OBJECTIVE

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

- list the steps in Advocacy

3.0 MAIN CONTENT

3.1 Steps in Advocacy

In order to carry out a successful Advocacy, there is the need to follow concrete steps to have contacts with policy makers and other groups that are relevant in the implementation of programmes especially health programmes .In order to follow the steps we must note the focus groups bo that the Local Government, State and Federal Levels.

A. Focus Groups of Advocacy at the LGA level

1. The Chairman
2. The Secretary
3. The Supervisory Councilor for Health

4. The LGA PHC Co-ordinator (MOH)
5. The LGA PHC Committee
6. Traditional Rulers etc.

Steps in Advocacy at the Local Government level

1. Make initial visit to LGA/Policy Makers.
2. Discuss with the LGA functionaries, the following:
   (a) Objective of the Programme;
   (b) The responsibility of the LGA, NGOs, communities and individuals;
   (c) Explain the National Health Policy as its relates to PHC Programme.
   (d) The need for proper implementation of the programme; and
   (e) Formation of management committees at various levels.

B. Focus Groups for Advocacy at the State Level

1. The State Governor
2. House of Assembly Members
3. Commissioner for Health and others.

Steps in Advocacy at State Level

Make initial visit to the governor and other policy makers and discuss intentions and objectives of the programme as well as for them to launch the programme.

C. Focus Groups for Advocacy at the Federal Level

1. The President
2. Members of the National Assembly
3. Chief Executives of Federal Government Agencies and Parastatals.

Steps in Advocacy at the Federal Level

Make initial visit to the President, Ministers and members of the National Assembly as well as other important in the system. Solicit for the launching of the programmes as well as expatiating on the objectives of the programmes and its relationship to the national Policy.

4.0 CONCLUSION

This unit has exposed you to the focus groups at the different levels for advocacy and the specific steps at each level. At this point, you should be able to list the steps in advocacy.

5.0 SUMMARY

This unit has focused mainly on the steps to be adopted in ensuring that initiators of programmes solicit for support from policy makes in order for the programmes to be vibrant and successful.

6.0 TUTOR-MARKED ASSIGNMENT

1. List the steps in Advocacy at the Local Government level.
2. Enumerate the focus group for Advocacy at the Federal Level.

7.0 REFERENCES/FURTHER READING

NPHCDA. (2005). Briefing Manual on Primary Health Care Services for NYSC Health Professionals. Abuja.

CHPRBN. (2006). Curriculum for Higher Diploma in Community Health. Abuja: Miral Press.

Abosede, O. A. (2003). Primary Health Care in Medical Education in Nigeria. Lagos: University of Lagos Press.

UNIT 4 PROCESSES AND METHODS FOR THE DESIGN OF ADVOCACY MESSAGES

CONTENTS

1.0 INTRODUCTION

The processes of designing Advocacy messages involve a series of things that are done in order to achieve results of advocacy. Since advocacy is a means of seeking support to ideas, the methods to be used should be in the mainstream of activities. It will be necessary for individuals, groups or organisations to formulate concrete action plans to enable advocacy yield results. This unit will help you understand the processes and methods for the design of advocacy messages. Before we do this, let us have a view of what you should learn in this unit, as stated in the objectives

2.0 OBJECTIVES

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

- identify the processes and methods for the design of advocacy messages
- discuss the methods for the design of advocacy messages

3.0 MAIN CONTENT

3.1 Identification of the Processes and Methods for the Design Advocacy Messages

The most likely processes and methods to be used by individuals, groups or organisations to design advocacy messages are as follows:

1. Invitation of key policy makers to take part in selected activities
2. Strategic alliances among like–minded initiatives
3. Joint/collaborative activities
4. Media (TV, Print, Electronic, Radio)
5. Field Visits
6. Brainstorming
7. Lecture
8. Symposium
9. Lobbying

3.2 Discussions on the Processes and Methods for the Design of Advocacy Messages

Methods for the design of advocacy message are synonymous with methods used in health education. These methods are strategies and/or processes through which information is presented to the target during advocacy.

1. **Invitation of Key Policy**–makers to take part in selected activities:
   Advocacy part in selected activities: Advocacy messages should occupy the mainstream of the activities. Many organisations do this by inviting key policy makers to take part in selective activities such as training events and workshops, and often inviting them to open and or close the events. Basically there is the need to prepare and use a combination of specific tools and approaches.

2. **Strategic Alliances among Like-Minded Initiatives**: In line with the overall advocacy strategy and for results to be achieved, strategic alliances among like-minded initiatives should be encouraged. This alliance which involves people of like-minds could form a growing alliance especially when it involves members of the target group. This will create a greater impact too.

3. **Joint/Collaborative Activities**: Joint activities with members of the target audience could enhance Advocacy through a working

process. In collaborative activities, ideas of the advocates gradually become cleaver to all involved, ensuring deeper knowledge of the programme by the target audience. To convince senior officials in government, NGOs, and other relevant organisations of approaches behind any programme, there need to participate in interesting programme activities

4. Media (TV, Print, Electronic, Radio) the use of various media, experiences and other programmes can be shared with members of the target audience. When the main target audience consist so factors in policy making the media will probably be printed material and electronic media to enable policy makers understand the ideas behind the intended programme.

5. **Field Visits:** This involves the target group being taken out to visit some programmes/events that need to be carried out concerning the intended programmes. This is ideal for developing policy makers' attitudes and decision making on the intended programme.
6. Brainstorming: This is a critical examination of ideas, problems, situations and appraisal of issues between the campaigners/advocates and the target audience or policy makers

7. **Lecture:** This involves a straight forward discussion, a pre-planned structured scheme delivered as a topic in a session. Here, the Advocates talk to the target audience about the intended programme including its objectives

8. **Symposium:** This involves presentation of papers on relevant facts about the intended programme to the target audience in a venue. The idea is to express the full aspects of the intended, programme for the public to buy the idea and support its implementation.

9. **Lobbying:** This is a process of convincing individuals or members of the public on the need to support the intended programme. Lobbying and advocating with external institutions, organisations and people provide a weightier support base to convince or influence positively towards the intended programmme that needs implementation.

4.0 CONCLUSION

In this unit, you have learned the processes and methods for the design of Advocacy messages. You have realised that the messages can be passed to target audience through some methods like alliances, collaborative activities, field visits and lobbying.

Advocacy methods can only succeed only where there is commitment on the campaigners or those who are to use it. The people must believe in the issue that is the subject of their campaigns, even when they lose, let the loss be a reference point for hard work and not a setback. Conclusively, no matter the amount of preparation before deciding to use any of these methods, remember that the unexpected might happen but always have hope and believe in our potential success.

You should at this point be able to identify processes and methods for the design of advocacy messages. Also, you should be able to discuss the various methods for the design of advocacy messages.

5.0 SUMMARY

This unit has focused on the processes and methods for the design of advocacy messages by groups or organisations to enable policy makers support and ensure the implementation of the programme. The processes and methods include invitation to policy makers, collaborative activities, field visits, brainstorming, symposium lobbying and others

6.0 TUTOR-MARKED ASSIGNMENT

1. Identify at least five methods for the design of Advocacy messages
2. Discuss the following Advocacy methods
   (a) Brainstorming
   (b) Field visit
   (c) Lobbying

7.0 REFERENCES/FURTHER READING

Abosede, O. A. (2003). Primary, HealthCare in Medical Education in Nigeria. Lagos: University of Lagos Press.

CHPRBN (2006). Curriculum for Higher Diploma in Community Health. Abuja: Miral Press.

Keck, M. E. & Sikkink, K. (1998). Activists Beyond Borders: Advocacy Networks in International Politics. Baltimore: MD Cornel University Press.

Jernugan, D. H & Wright, P. (1996). Media Advocacy: Lessons from Community Experiences Journal of Public Health Policy Vol. 17. N03:306-330.

UNIT 5 USE OF ADVOCACY MATERIALS

CONTENTS

1.0 INTRODUCTION

In order for effective Advocacy to take place some materials including information, communication and audio–visual aids are necessary. These materials are essential because, in order for an individual to accept or adopt a new behaviour he must pass through some stages which the materials must address. This unit will help us to understand the uses of the materials for advocacy which was partly discussed n unit four.

However, before we go further, let us take a look at what you should learn in this unit as indicated in the unit objectives below:

2.0 OBJECTIVES

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

- identify advocacy materials
- state the uses of Advocacy materials.

3.0 MAIN CONTENT

3.1 Identification Advocacy materials

Advocacy materials and processes include information, communication, education, audio-visuals, flip charts, reference books and journals. These materials help to enhance advocacy messages in order to achieve the objectives of the intended programmes and satisfy the desires of the advocates.

3.2 Uses of Advocacy Materials

Exposure to advocacy materials is necessary for conviction and acceptance of the intended program me by the target audience.

Advocacy materials are useful for:

1. Creating awareness
2. Motivating people and promote desired changes in behaviour of the target audience
3. Advocacy materials educate and inform people
4. They explain the need for change
5. Advocacy materials carry information that is easily understood, remembered and retained for future use.

4.0 CONCLUSION

In this unit, you learned about advocacy materials and their usage. The materials include audio-visuals and their uses and understanding of the initiated programme. You should at this point be able to identify the materials. Also you should be able by now to state he uses of the advocacy materials.

5.0 SUMMARY

This unit emphasised on the identification of advocacy materials and their uses. The Advocacy materials include information, education, communication, audio- visuals, reference books, journals and others. The uses of Advocacy materials are creating awareness, motivation, explanation of ideas and changes as well as education.

6.0 TUTOR-MARKED ASSIGNMENT

1. Identify three Advocacy materials.
2. Enumerate three uses of Advocacy materials.

7.0 REFERENCES/FURTHER READING

Abosede, O. A. (2003). Primary Health Care in Medical Education in Nigeria. Lagos. University of Lagos Press.

Douglas Oronto Lecture Note Nigeria: Using a Variety of Advocacy tools in the Niger Delta. Port Harcourt.