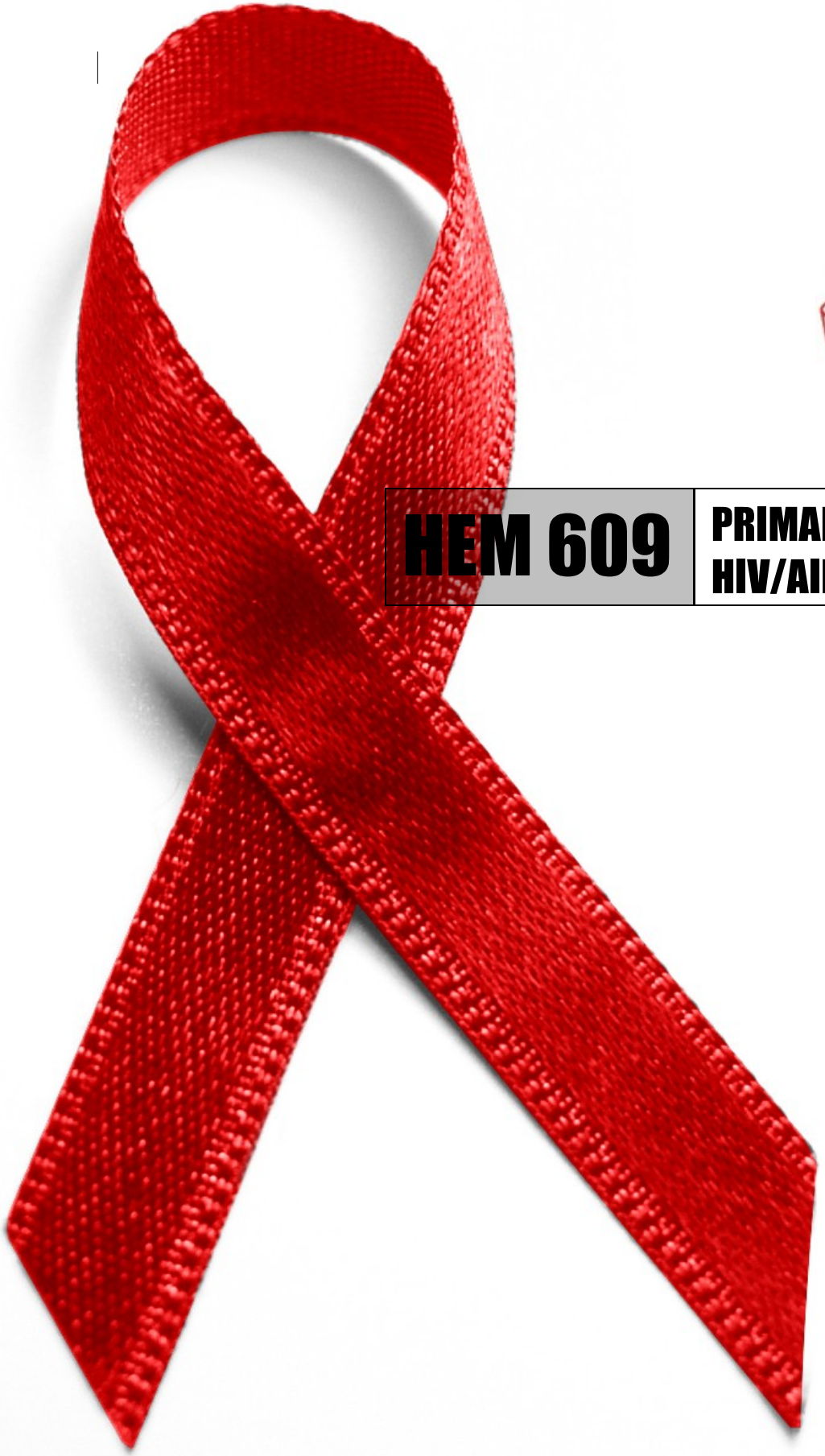


HEM 609 PRIMARY HEALTH CARE AND HIV/AIDS

Course Code	HEM 609
Course Title	Primary Health Care and HIV/AIDS
Course Developer/Writer	Kayode S. Olubiyi National Open University of Nigeria Lagos
Programme Leader	Prof. Afolabi Adebanjo National Open University of Nigeria Lagos
Course Coordinator	Jane-Frances Agbu National Open University of Nigeria Lagos

NATIONAL OPEN UNIVERSITY OF NIGERIA

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

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

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

First Printed 2008

ISBN: 978-058-616-4

Printed by….
For
National Open University of Nigeria

TABLE OF CONTENTS PAGE

MODULE 1 PRIMARY HEALTH CARE AND THE ANALYSIS OF HEALTH CARE SERVICES

UNIT 1 INTRODUCTION TO PRIMARY HEALTH CARE

1.0 INTRODUCTION

Primary health care being the key to attaining "Health for All" was declared in September 1978. It forms an integral part of the National Health Care Plan, the central function and main focus of which is the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community for health care.

Primary health care represents in full the global consensus among member nations, that "the people have the right to participate individually and collectively in the planning and implementation of their health care and lead socially and economically productive lives at the highest possible level".

In this unit, you will be introduced to primary health care, form your own concept on the delivery of the world wide acclaimed panacea to meeting the health care challenges, the Alma-Ata Declaration, as well as components and principles of primary health care.

2.0 OBJECTIVES

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

- Explain the concept of primary health care
- Discuss the implications of the Alma-Ata Declaration of 1978 on all participating countries.
- Highlight the principles of primary health care.

3.0 MAIN CONTENT

3.1 Definitions of Primary Health Care

Primary health care is essential health care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost that both the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community (WHO, 1978).

Primary health care is the hub of the health system. Around it are arranged other levels of the system whose actions converge on primary health care in order to support it and to permit it to provide essential health care on a continuous basis.

Primary health care as an essential health that people need, has a wide coverage, is reasonably cheap, it is affordable for the people and the country, provided that people participate actively in it, and contribute to it in labour and in kind. In view of the expressed opinion, the concepts of primary health care should be the driving force behind the determination of development efforts in all community policies.

In recent years, there has been an increasing recognition of the pivotal role of primary health care. The definition of this role culminated in the Alma-Ata Declaration of 1978.

The Alma-Ata Declaration on primary health care is reproduced here in full as it represents a global consensus among governments on this important issue (Box 10.3). As defined, primary health care includes seven important features (Table 10.4). The salient features are highlighted below:

The primary health care concept is not intended to represent second best medicine acceptable only to the rural poor or the dwellers of urban slums. Rather, it is the essential care for all based on practical, scientifically sound and socially acceptable methods and technology.

It is not a stopgap solution to be replaced by something better at a later stage. Rather, the primary health care approach is intended to be a permanent feature of all health services; the quality of care should steadily improve, and at all times it should be appropriate to the resources and the needs of the community.

Primary health care is not intended to function in isolation but in collaboration with the referral and specialist services. These various services should be mutually supportive. Without good primary health care, the referral services would be overwhelmed by problems, which could have been dealt with efficiently at the primary level.

Many of these would be advanced cases with complications, which could have been prevented by early detection and prompt care at the primary unit. On the other hand, primary health care requires the support of the referral services to cope with problems, which are beyond the scope of the peripheral units.

SELF ASSESSMENT EXERCISE 1

What is your concept of primary health care?

3.2 The Alma-Ata Declaration On Primary Health Care

The Alma-Ata Declaration adopted on 12th September, 1978 by the International Conference on Primary Health Care, which and jointly by the World Health Organisation and the Government of Soviet Union, clearly viewed primary health care as the key to attaining the target of health for all as part of the overall development and in the spirit of social justice.

The Declaration resolved the following:

- All governments are to formulate national policies, strategies and plans of action to launch and sustain primary health care (PHC) as part of a comprehensive national health system and in coordination with other sectors.
- The need for urgent and effective action to develop and implement PHC throughout the world, and in particular in developing countries with unacceptable health status.
- The need for political will and the coordinated efforts of the health sectors and relevant activities of other social and economic developments such as education, agriculture and rural development, housing, etc.
- The support of governments, WHO, UNICEF and other international organisations as well as multi lateral and bilateral agencies.

- The need for all health workers to support national and international commitment to primary health care and channel increased technical and financial support to developing countries.

SELF ASSESSMENT EXERCISE 2

Describe in not more than 50 words the implications of the Declaration to the member countries.

3.3 Principles of Primary Health Care

The fundamental principles of primary health care include the following:

1. Absolute responsibility of the government for the health of the people.
2. The right and duty of people (individually and collectively) to participate in their own health activities.
3. Emphasis on preventive measures well integrated with curative, rehabilitative and environmental measures.
4. Equitable distribution and accessibility of health services.
5. Application of appropriate technology through well-defined health programmes integrated into a country wide health system.
6. The social orientation of health workers of all categories to serve the people.
7. A multisectoral approach.

3.4 Components of Primary Health Care

Primary healthcare activities vary from place to place according to political, economic, social and culture patterns. It includes the following:

- Education concerning prevailing health problems and the methods of preventing and controlling them
- Promotion of food supply and proper nutrition.
- An adequate supply of safe water and basic sanitation.
- Maternal and child healthcare (MCH) including family planning.
- Immunisation against the major infectious diseases.
- Prevention and control of locally endemic diseases.
- Appropriate treatment of common diseases and injuries.
- Provision of essential drugs.
- Mental health promotion.

4.0 CONCLUSION

The primary health care concept is not intended to represent second best medicine acceptable only to the rural poor or the dwellers of the urban slums. It is an essential care for all. It is not a stopgap solution to be replaced by something better at a later stage.

Primary health care is intended to be a permanent feature of all health services; the quality of care should steadily improve and at all times be appropriate to the resources and the needs of the community. Primary health care is not to function independently or in isolation but in collaboration with the referral and specialist services. Poor PHC services result in cases of advanced diseases, which could have been prevented by early detection at the primary level.

5.0 SUMMARY

In this unit we have examined the concept of primary health care , the Alma-Ata Declaration of 1978 and its implications to member nations, as well as principles and components of PHC. The next unit will build up on this foundation by further highlighting the components of primary health care.

6.0 TUTOR MARKED ASSIGNMENT

Clearly define primary health care showing its significance in the prevention and control of HIV/AIDS.

Answers to Self Assessment Exercises

Exercise 1

The implications must include launching and sustaining the primary health care as part of a comprehensive national health system, the need for urgent and effective action to develop and implement PHC throughout the world, political will and support of governments at all levels as well as non-governmental organisations.

Exercise 2

Expressions and explanations must show the key words underlined in the main content

7.0 REFERENCES/FURTHER READINGS

Lucas and Guiles (1989). *A Short Textbook of Preventive Medicine for the Tropics* (2nd ed). ELBS.

Guide to the Integration and Strengthening of PHC Components in the Basic Nursing Education Curriculum. University of Ibadan, 1994.

Mahler (1978). *Action for Change in Nursing*. WHO Production on Primary Health Care.

UNIT 2 HEALTH CONCEPTS AND PREREQUISITES

CONTENTS

1.0 INTRODUCTION

You must have had a good concept of health at your foundation level in your chosen career. We shall review and build on that in order to give you a deeper understanding of health. It will increase your knowledge and skill in providing and promoting the health of the people you are expected to serve.

Health is a fundamental human right and a worldwide social goal. In this unit, we shall concentrate on the concept and definition of health as well as the concept of positive health and well-being. Health is affected by various interlinked factors, which we will also examine. At the end you will learn about the prerequisites of good health.

2.0 OBJECTIVES

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

- Explain concepts of health
- Define health
- Discuss the determinants of health
- List and explain the prerequisites of health

3.0 MAIN CONTENT

3.1 Concepts of Health

Every individual and in fact, all communities have their own concept of health, which is closely related to their culture. The oldest concept of health is “absence of disease”. As at today, maintenance of health is

neglected except in conditions of ill health. It is only during the past few decades that health became conceived as a fundamental human right and a world wide social goal. It is essential to the satisfaction of basic human needs and improved quality of life. It is to be attained by all people. The perception of health varies from person to person, culture to culture, community to community and in particular in relation to professional groups. We shall from now begin to examine these changing concepts

Changing Concepts of Health

Health has evolved as a concept from an individual concern to a world wide social goal and encompasses the whole quality of life. A brief account of changing concepts of health is given below in Fig 1.1:

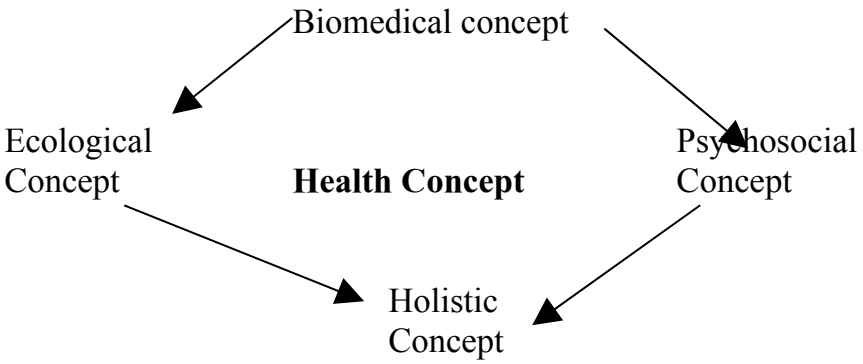


Fig. 1 Changing concepts of health

We shall now examine each of the concepts one after the other.

1. The Biomedical Concept: This concept stresses the germ theory i.e. disease or ill health is caused due to disease causing organisms. The individual is considered to be healthy only if he or she is free from disease. The human body was viewed as a machine and disease was considered a consequence of the breakdown of the machine; and one of the doctor's tasks was to repair the machine. This concept was criticised on the basis that it had minimised the role of social, environmental, psychological and cultural determinants of health.

   This model was found to be inadequate to solve some of the major health problems (e.g., malnutrition, chronic diseases, accidents, drug abuse, mental illness, environmental pollution, population explosion). In other words, we can say that this concept focused on the view that disease can only be caused by the organism without taking other causative factors into consideration.

2. The Ecological Concept: Health is defined as the relative absence of pain and discomfort and a continuous adaptation and adjustment to the environment to ensure optimal function, which leads to longer life expectancy and a better quality of life. Ecology focuses on a mutual relationship between man and his environment and visualises health as a dynamic equilibrium between man and his environment. Maladjustment of a human being to his environment results in disease.

   The ecological concept raises two issues: an imperfect man and an imperfect environment. For example, environmental pollution caused by deforestation and urbanisation, resulting in water pollution, overcrowding and air pollution creates an imbalance between man and his environment thus affecting his health.

3.) The Psychological Concept: This concept visualises health not only as a biomedical phenomenon but it is also influenced by other factors, such as. social, psychological, cultural, economic and political factors. These factors are essential in defining and measuring health. This is both a biological and social phenomenon.

   If we are physically tired, our capacity to respond to social interactions will be diminished. Some studies have shown that people who live isolated, friendless lives, face a much greater chance of becoming ill or dying than people with close relatives and good friends.

3. The Holistic Concept: This concept is a synthesis of all the concepts mentioned above. It focuses on the impact of socioeconomic, political, environmental and biomedical influence on health. It sees the well being of a person as a whole in the context of his total environment.

   The holistic approach to health insists that total good health and well being can be achieved only by understanding the whole person in a perspective that includes physical, mental, social and spiritual dimensions.

   All these four aspects are not separate but are constantly interacting. It thus corresponds to the ancient view that health implies a sound mind in a sound body, in a sound family and in a sound environment.

We know from our daily experiences that problems in one area of our lives affect other areas as well; emotional strain and conflicts can lower our resistance to illness.

SELF ASSESSMENT EXERCISE 1

1. Explain the view of the holistic approach to health.

   ---
2. Itemise the changing concepts of health.

3.2 Definitions of Health and Disease

According to the World Health Organisation (WHO), health is "a complete state of physical, social, mental well-being and not necessarily the absence of infirmity or disease" (cited in Lewis 1953). Disease on the other hand has been defined as a form of deviation from normal functioning which has undesirable consequences because it produces personal discomfort or adversely affects the future health status of individuals.

Health, according to biomedical science is not only the absence of disease or physical disability in individuals. Physicians are also quick to argue that disease connotes pathology and its state of disequilibrium (Fabrega 1978).

The concepts of health, disease and illness, generally speaking, are amplified by the belief of a people (Erinosho 2005).

Looking at the definition of health carefully, you will realise that three dimensions emerge from it namely: physical, mental and social well-being.

Physical well-being means having the physical strength, endurance and energy to work towards your life goals. **Mental** well-being is the ability to cope with the world in a way that brings you satisfaction; while **social** well-being means the development of healthy relationships with others.

It therefore implies that the goal of health calls not only for the cure or alleviation of disease but more of prevention of disease.

3.3 Dynamics of Health

The concept of health dynamics visualises health as a dynamic phenomenon and as a process of continuous change, i.e. the health of an individual keeps on changing and is not static. It varies within a continuum that ranges from optimum well-being to various levels of dysfunction including the state of death. Health and sickness also form a continuum ranging from total well-being to death with many intermediate stages.

It can be said also that health is a dynamic of life rather than a static entity. No longer is an individual thought of as being "healthy" or "unhealthy". It is possible for one to function normally throughout the day with varying degrees of efficiency depending upon the many factors which affect their state of well-being, which fluctuates on a health continuum rather than remaining static at one point

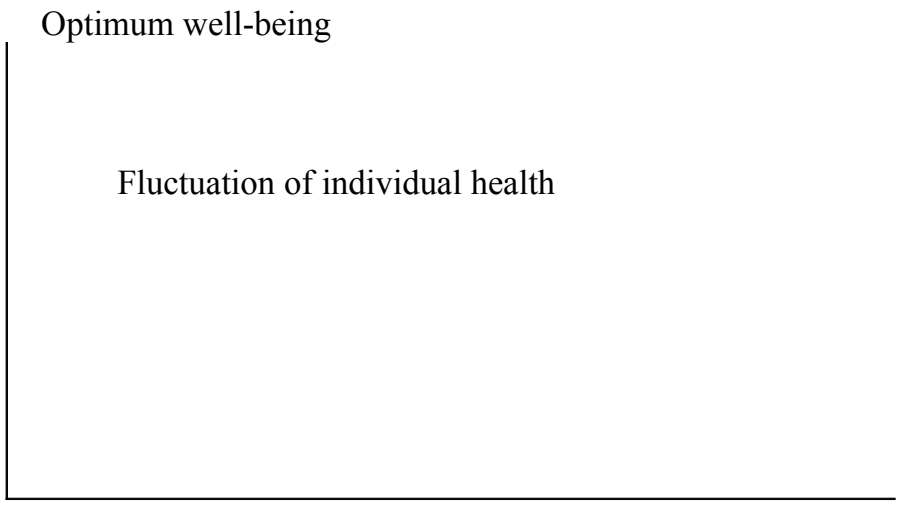


Fig. 2 Health continuums

Health is not merely a continuum of physical, mental, spiritual or social well-being but a combination of all four dynamics, being interrelated.

Critically examine Fig.I.3 and you will find out that health and sickness lie along a continuum. The lowest point of the scale is death and the highest point corresponds to positive health. A person may be healthy today but may fall sick tomorrow. The transition from optimum health to ill health can also be rather gradual.

Well being	Positive health Better health Freedom from sickness
Dysfunction	Unrecognised sickness Mild sickness Severe sickness Death

Fig. 3 The health and sickness scale

SELF ASSESSMENT EXERCISE 2

State **T for True or F for False** for any of these:

1. Standard of health varies according to culture, social class, geographical location and age groups
2. There is a fixed International standard for health
3. Health is static.

3.4 Prerequisites of health

The determinants of health namely heredity, environment, lifestyle, socio-economic conditions and health and family welfare services affect the health of an individual and the community as a whole. With this background information, you are set to identify some of the prerequisites for health. These could be identified at individual, environmental and societal levels:

1. The Individual Level: In order to be healthy, an individual has to do the following:
   - Follow hygienic practices
   - Eat a well balanced diet
   - Avoid unhealthy practices such as overeating, smoking, immoral behaviour, etc
   - Rest well, sleep well, exercise regularly and select recreational activities
   - Go for preventive screening and immunisations.

2. The Environmental Level: Activities include:
   - Sanitary housing
   - Safe water supply
   - Clean air, standard light and sound
   - Safe surroundings-proper disposal of wastes

- Good placement of schools, markets, parks, slaughter houses and recreation facilities
- Removal of harmful vectors.

3. The Societal Level: Activities must include:
   - Good social relationships and working condition in the family
   - Healthy relationships in the workplace
   - Good neighborliness
   - Association with professional colleagues and organisations.

4.0 CONCLUSION

The concept of health traditionally means the absence of disease; the WHO definition however took cognisance of the physical, mental, and social state of man with proper consideration for international standards of health and individual and cultural perceptions of health.

5.0 SUMMARY

Discussions here are on the changing concepts of health, definitions of health and diseases, the dynamics of health as well as the prerequisites for health.

6.0TUTOR MARKED ASSIGNMENT

In view of the changing concepts of health, describe the prerequisites for optimal health by individuals and the society.

Answers to Self Assessment Exercises

Exercise 1

The holistic approach to health is achieved by understanding the whole person in a perspective that includes the physical, mental, social and spiritual dimensions.

- Biomedical, Ecological, Psychological and Holistic

Exercise 2

- 1) True 2) True 3) False

7.0 REFERENCES/REFERENCES/FURTHER READINGS

Lucas and Guiles (1989). *A Short Textbook of Preventive Medicine for the Tropics* (2nd ed). ELBS.

Guide to the Integration and Strengthening of PHC Components in the Basic Nursing Education Curriculum. University of Ibadan, (1994).

Mahler, (1978). *Action for Change in Nursing.* WHO production on Primary Health Care.

UNIT 3 GENERAL ANALYSIS OF HEALTH CARE SERVICES

CONTENTS

1.0 INTRODUCTION

There is usually a hierarchy in pathways to health care in every society. Illness is acted upon when it becomes a discomfort to the individual. The channels for receiving health care tend to vary from one society to another. There are specific health care organisations in all known human societies that are charged with the responsibility of providing health care for the citizenry.

2.0 OBJECTIVES

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

- Highlight the concept of health organisations;
- Know the need for seeking health care;
- Identify different levels of health care in different societies;
- Appreciate various channels for receiving health care services.

3.0 MAIN CONTENT

This unit contains materials on the concept of health care organisations and the reason for seeking medical care. It also contains materials on different levels of health care in different societies and various channels for receiving health care services.

3.1 Health Care Organisations

Health Care Organisation, weather in advanced or developing nations can be classified into two: the public and private. In advanced economies where there is an elaborate national health system, the two are interrelated in their operations or functions and not as parallel systems.

In Nigeria, the services in the public system are organised under the auspices of the federal and state ministries of health and the local government authorities. The private health care service in Nigeria consists of solo practitioners and partnership/group practitioners. Their services are rendered in the facilities that are built by corporations and voluntary agencies like Christian and Muslin missions. The private health care providers also include traditional healers, chemists and patient medicine sellers.

SELF ASSESSMENT EXERCISE

List out five health care organisations that are operational in your area.

3.2 The Reason for Seeking Medical Care

To the extent that illness and disease are health burdens which threaten the normal functioning of the body system, it becomes crucial therefore, for the sick individuals to seek medical care and in good time. Illness militates against the performance of one's social role and the disability and discomfort arising thereof can become worrisome. Even though, factors such as cost of medical bills, proximity to health facilities, and accessibility to health facilities and personnel can create major obstacles for patient's seeking medical care, yet, effort should be intensified to overcome these challenges because "health is wealth."

3.3 Levels of Health Care

There are three main levels of health care, namely the tertiary, secondary and comprehensive (primary) levels.

A tertiary health care institution performs several functions which include research and teaching. . Teaching hospitals and specialist hospitals are tertiary health care institutions.

Secondary health care institutions perform services that are next to those being performed by the tertiary ones. These institutions provide medical, surgical and (or) psychiatric care for the sick (Erinosho, 2005). Comprehensive or primary health care institutions are of a lower order

than that of the other two. These institutions are mainly for ambulatory care. Those who work there are sometimes described as comprehensive, cottage or community health workers. Patients through a well defined referral network can have access to health facilities and services at any of the health care levels.

3.4 Channels for Receiving Health Care Services

There is a hierarchy in the pathway to health care in any society. In Western societies, the practice of obtaining health care services oscillates between the private and the public health system. The two are off-shoots of orthodox medicine. In Africa south of the Sahara, this is a bit different. A good number of patients tend to utilise the services of traditional healers before seeking help from Western-style health workers and facilities. Next to this we have the services of Western-style care agents such as specially trained practitioners, patent medicine sellers and pharmacists. Quite often, there is a simultaneous use of both modern and traditional medicine by patients in traditional Africa.

4.0 CONCLUSION

The pathways to health care services in most societies in our contemporary world are rooted largely in the people's culture. In Nigeria for instance, magico-religious and several socio-environmental factors play a significant role in health care services utilisation. This partly explains why there is an admixture of the use of both traditional and Western medicines by patients. Even though cosmopolitan Western-style health care institutions like the clinics, general and specialist hospitals are the major force of health care in most technologically developed countries, some form of alternative medicine (e.g. herbal medicine) is also utilised in some of this countries.

5.0 SUMMARY

In this unit, we have learnt the following:

The concept of health organisations
The reason for seeking health care
The different levels of health care in different societies
The various channels for receiving health care services.

6.0 TUTOR MARKED ASSIGNMENT

A good number of patients tend to utilise the services of traditional healers before seeking help from Western-style health workers and facilities. Discuss.

Answer to Self Assessment Exercise

Red Cross, Girls Guild, The Leprosy Mission Nigeria, World Health Organization, United Nations Development Project, among others .

7.0 REFERENCES/FURTHER READINGS

Erinosho, A. O. (2005). *Sociology for Medical, Nursing and Allied* in *Professions Nigeria*.

Cockerham ,W. C. (1982). *Medical Sociology*(2nd ed).Prentice Hall: Englewood Cliffs.

Metiboba, S. (2007) .*Issue*s *in Health Sociology*. Nathadex Publications.

MODULE 2 THE CONCEPT OF HEALTH AND HEALTH PROMOTION

UNIT 1 HEALTH FOR ALL

CONTENTS

1.0 INTRODUCTION

In the previous units, we discussed the concepts and prerequisites of health as well as the concepts, principles and elements of primary health care (PHC). You must appreciate the essentiality of PHC in the provision of available, affordable, accessible and acceptable health care to individuals and for the community as a whole. You have also become aware of Alma-Ata Declaration (see Appendix 1) which affirms that primary health care is considered the basic strategy for achieving the goal of Health for All by the year 2000AD and beyond. In May 1977, the thirteenth World Health Assembly adopted a resolution in which it was decided that the main social target of governments and of the World Health Organization in the coming decades should be the attainment by all people of the world by the year 2000 AD of a level of health that will permit them to lead socially and economically productive lives. This is popularly known as “Health for All by the year 2000 AD” (HFA/2000).

In this unit, we shall discuss the concept, definition and meaning of Health for All. Health for all aims at restructuring health systems and reorienting and training all categories of health workers/professionals. As you go through this unit, you are required to refer to the appendices

given at the end of the unit for a broader perspective wherever indicated in the text.

2.0 OBJECTIVES

After studying this unit, you should be able to:

- Define health for all
- Discuss the meaning of health for all
- Describe the global strategy for attaining health for all
- Explain the national strategy adopted to achieve the goal of health for all.

3.0 MAIN CONTENT

We shall examine the concept and definitions of "Health for All" in the following discussions.

3.1 The Concept of Health for All

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

In Nigeria, 90% of the population lives in rural areas and urban slums in contrast to 5-10% who live in urban areas. It is only this small fraction of urban people that enjoy ready access to health services and facilities. Similarly, taking a cursory look at the health status of Nigeria, the need for urgently improving our health status is obvious.

This disparity in health and socio-economic conditions between the rich and the poor within countries and between countries and the concern of WHO member countries regarding the status of health and deterioration of existing health status leads to new thinking in the provision of health care in order to narrow this gap and finally eliminate it. It was also realised that the underprivileged population constituting 90% of the total population have an equal claim to their rights and privileges of health services such as:

- Health care
- Protection from vaccine prevented communicable diseases of childhood e.g. diphtheria, tetanus, tuberculosis, whooping cough, poliomyelitis, etc

- Maternal and child care and
- Treatment and control of non-communicable diseases.

So the health planners/administrators felt the need to evolve a health care approach that would answer the problems and needs of the underprivileged. Ultimately, the thirteenth World Health Assembly resolved in May 1977 that the main social target of governments and WHO in the coming decades should be the attainment of health for all by the year 2000AD and beyond. Further to this, there are several experiences and developments which led to the evolution of the goal of Health for All by the year 2000 which are as follows:

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

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

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

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

  All the above mentioned concepts led to a continuing discussion of how the health care system should evolve and how WHO could best support countries to struggle to improve their health systems.

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

With this concept in mind, we shall now identify the definition and meaning of Health for All.

SELF ASSESSMENT EXERCISE 1

The basis for evolution of Health for All concepts includes:

1. ----------
2. ----------
3. ----------
4. ----------
5. ----------

3.2 Definition and meaning of Health for All (HFA)

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

If you analyse this definition, you will realse that the goal of HFA implies the realisation of WHO objective of the attainment by all people of the highest possible level of health which includes: physical, mental and social well-being.

Secondly, it also implies that as a minimum all people in all countries should at least have such a level of health that they are capable of being economically productive (removal of unemployment and poverty) and participating actively in the social life of the community in which they live (i.e. in education, housing, water supply and sanitation).

> Health for All means that health care/services are to made accessible (*within reach*) of every individual in a given community.

It implies the removal of obstacles to health that is the elimination of ignorance, malnutrition, disease, contaminated water supply, unhygienic housing, etc.

"Health for All" is a holistic concept. It calls for efforts in education, agriculture, industry, housing or communication first, as much as in public health and medicine. It symbolises the determination of countries of the world to provide an acceptable level of healthy living for all people.

It is an expression of the feeling for social justice from all those who suffer inequity in health care services. It is intended to draw attention to the importance of health, to a serious search for new ways of solving the problems of health and to help mobilise all available resources for health. To have a correct perception of the meaning of "Health for All" you should be convinced that HFA does not mean that as at the year 2000 and beyond, we shall all be free of disease and disability.

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

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

- Health begins at home, in school and at the work place
- People will use better approaches for preventing disease and alleviating unavoidable illness and disability
- There will be an even distribution among the population of whatever health resources are available
- That the essential health care will be accessible to all individuals and families, in an acceptable and affordable way and with their full involvement.

The achievement of the Health for All goal, calls for dramatic changes, and a social revolution in health development. It aims at bringing about

the change in the mentality of people, restructuring of the health system, and reorientation and training of health workers/professionals. So, to bring about these changes the practical shape to the slogan of HFA could be given only through development as a strategy. This will be considered in the next section.

3.3 Strategy for Health for All

You may wish to recall that the Alma-Ata conference called on all governments to formulate national policies, strategies and plans of action and set down the principles of primary health care, which is the basis of the "Health for All" strategy.

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

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

We shall now examine the global and national strategies in the following sub-sections.

3.3.1 The Global Strategy

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

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

Health is an integral part of the overall development of the countries. Energy generated by improved health should be channeled into sustaining the development of a country. There is the need for the appropriate use of the world's resources to promote health and development; this will help to promote world peace and prevent conflict among nations.

3.3.2 National Strategy for Health for All

The Alma-Ata Declaration and Nigeria's commitment to HFA resulted in the formulation of the National Health Policy with these processes.

- The Federal Government of Nigeria designed a national strategy and action plan to achieve Health for All
- In July 1988, a working group on Health for All was put in place to evolve national strategies for the implementation of the health care programme to move towards the goal of Health for All by the year 2000 AD and beyond and to suggest suitable indicators to monitor the progress achieved from time to time. The working group submitted its report in 1989, which was accepted by the Federal Government.

Thus a National Health Policy was evolved by the government of Nigeria in 1989 that committed the government and people of Nigeria to achieve the goal of HFA.

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

The National Health Policy in Nigeria has the following key elements:

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

The National Health Policy has the following important health indicators:

1. Reduction of infant mortality rate from 87 to below 60
2. To raise the life expectancy at birth from the present level of 58 years to 64 years.
3. To reduce the crude death rate from the present level of 10.4 to 9

4. To reduce the crude birth rate from the present level of 27 to 21
5. To provide portable water to the entire rural population
6. To achieve a net reproduction rate of 1.

As a follow up to this, during the 6th and 7th Five Year Plan, steps were taken to implement the strategies outlined in the National Health Policy. These are:

1. Establishment of one health centre for every 5,000 rural population
2.. Establishment of one primary health centre for every 30,000 rural population
3. Training of traditional birth attendants (TBA) in each village
4. Training of various categories of health personnel.

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

SELF ASSESSMENT EXERCISE 2

The important health indicators to monitor progress towards Health for All are:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

4.0 CONCLUSION

You have studied the concept and definition of Health for All by the year 2000 AD and beyond. This implies “attainment of a level of health that will enable every individual to lead a socially and economically productive life”. This concept has emerged out of the fact that the existing health care approach was not able to solve the health problems mainly in developing countries including Nigeria and there is gross inequality in health service distribution within countries and among countries.

5.0 SUMMARY

We have examined the concept and definition of health for all by the year 2000 AD and beyond, the global strategy which defines the broad

lines of action, the national strategy that resulted in the formulation of the national health policy and various health indicators.

6.0 TUTOR MARKED ASSIGNMENT

Describe the strategies being employed by the government at the three levels to provide health for all.

Answers to Self Assessment Exercises

Exercise 1

1.. cause of death and disease
2.. nutritional status
3.. water supply and sanitation
4.. literacy and economic situation
5.. demographic trends

Exercise 2

1. Infant mortality rate
2. Maternal mortality rate
3. Crude death rate
4 Crude birth rate
5. Life expectancy
6. Net reproductive rate

7.0 REFERENCES/FURTHER READINGS

Ekunwe, O.A (1966). *The Nigerian Primary Health Care Delivery System: The Challenges of Implementation.*

Lucas and Guiles (1989). *A Short Textbook of Preventive Medicine for the Tropics* (2nd ed) ELBS.

Santhosh, M. (2000). *Primary Health Nursing (PHN)* Indria Gandhi National Open University, New Deli: Berny Art Press.

UNIT 2 HEALTH ASSESSMENT FOR PRIMARY HEALTH CARE PRACTICE

CONTENTS

1.0 INTRODUCTION

Assessing health status is a major component of primary health care. Smith (1982) remarked that if good nursing care entails meeting the needs of the clients, then these needs must first be identified. As such, the skill of observation becomes an invaluable asset. Assessment techniques are therefore skills that health practitioners must develop right from the very beginning of their training. Speaking in the same vein, Swash and Mason (1986) submitted that one statement that gets near to the truth is that diagnosis should precede treatment whenever possible. They observed that there are two steps critical to making a diagnosis: the first involves observation by history taking, physical examination, and ancillary investigations; and the second involves the interpretation of information obtained in terms of a disorder of function and structure, then in terms of pathology.

However, as beginners, we will be limiting ourselves to the first step, knowing fully well that a thorough understanding of it is vital to elucidating our clients' problems without which the resolution of such problems will be elusive. Therefore, this unit focuses on the purpose, components, and techniques related to the health history and physical examination.

2.0 OBJECTIVES

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

- Explain the purpose, components, and techniques related to health history and physical examination.
- Understand health history.

- Identify information to collect from health history before an examination.
- Describe the appropriate use and techniques of inspection, palpation percussion, and auscultation.
- Identify some of the equipment needed to perform a physical examination.
- Conduct physical assessments correctly in the right sequence and in an organised fashion.

3.0 MAIN CONTENT

3.1 Types of Assessment

Generally speaking, three types of assessment are employed in evaluating the health status of patients/clients. They are: **comprehensive assessment, focused assessment,** and **ongoing assessment.** However, it is the health care setting and the needs of the patient that literally dictate what type of assessment that is needed.

Comprehensive Assessment – As the name suggest, this is a comprehensive assessment that is usually collected upon admission to a health care agency. It includes a complete health history to determine the current needs of the client. This database provides a baseline against which changes in the client's health status can be measured and should include the assessment of physical and psychosocial aspects of the client's health, the client's perception of health, the presence of health risk factors and the client's coping patterns (Moffett, 1998). While it is true that comprehensive assessment is the most desirable in the initial assessment of the client's health needs, time constraint or special circumstances may indicate the need for the abbreviated data collection, the focused assessment.

Focused Assessment – As suggested in the preceding paragraph, this assessment is limited in scope (in comparison with the comprehensive assessment) in order to focus on a particular need or health care problem or potential health care risks. It is often used in health care agencies in which short stays are anticipated (e.g. emergency departments), in specialty areas such as labor and delivery, and in mental health settings or for the purposes of screening for specific problems or risk factors as obtainable in well child clinic (Moffett, 1998).

Ongoing Assessment – An ongoing assessment is a continuous systematic assessment and reassessment or evaluation of a client's health status with a revision of care plan. This type of assessment allows the health care provider to broaden the database or to confirm the

validity of the data obtained during the initial assessment and to measure the effectiveness of interventions.

3.2 Indications for Health Assessment

The purposes of health assessment include to:

- Collect data about the client through observation, interview and physical examination
- Assess the patient's current physical condition.
- Establish a database for future comparisons
- Continuously update database
- Detect early signs of developing health problems
- Evaluate responses to medical and nursing interventions
- Make clinical judgments about a client's changing health status and management.

3.3 Data Collection

This is the process of gathering information about a client's health status. It must be both systematic and continuous to prevent omission of significant data and reflect a client's changing health status. A **database** (baseline data) is all information about a client; it includes the health history, physical assessment, the physician's history and physical examination, results of laboratory and diagnostic tests, and materials contributed by other health personnel (Wilkinson, 2000).

Types of Data

There are basically two types of data**: objective data** and **subjective data**. **The objective data** also referred to as **signs** or **overt data** are factual measurable and observable information about the patient and his overall state of health i.e. they can be seen, heard, felt, or smelled, and they can be obtained by observation or physical examination. Example includes vital signs; height; weight; urine colour, volume and odour; skin rashes etc. **The subjective data** sometimes called **symptoms** or **covert data** are data a client's point of view that cannot be empirically validated. It encompasses the patient's opinion or feelings, the client's sensations, values, beliefs, and perception of personal health status and life situation. For instance, only the patient can tell you that he/she is afraid or has pain or is experiencing itching.

Methods of Data Collection

The basic methods employed in data collection or data gathering are: observation, interview and physical examination.

SELF ASSESSMENT EXERCISE 1

List the indications for patients' assessment.

3.1.1 Observation

The term observation is defined as a systematic and exhaustive search for any significant physical deviation from the normal. Observation has two aspects: (a) noticing the stimuli and (b) selecting, organising, and interpreting the data, including distinguishing stimuli in a meaningful manner. Observation as an assessment technique involves the use of all the five senses:

Visual Observation: Sight provides an abundance of visual clues about general appearances, mannerisms, facial expressions, mode of dress, family – friend's interaction, to mention a few.

Tactile Observation: Touching or palpating any part of the patient can provide information such as hotness/coldness of the body, swelling, edema, muscle strength etc.

Auditory Observation: Quite a lot of information can be gathered through mere listening to the patient or using specialised equipment like the stethoscope to listen to breath sounds, bowel sounds, and heart sounds.

Olfactory or Gustatory Observation: The sense of smell identifies odors that can be specific to a patient's condition or state of health. These include body and breath odour which might indicate gamalin poisoning, alcohol intoxication, poor hygiene, diabetic ketoacidosis, etc..

3.4 Interviewing/History Taking

This is a planned communication or a conversation with a purpose, for example, to get or give information, identify problems of mutual concern, evaluate change, teach, provide support, or provide counseling or therapy (Wilkinson, 2000). During assessment, the purpose of the interview is to gather information about the client's health history. The goal of history taking is to get from the client an accurate account of his complaint and see this against the background of his life as a whole. How well this is achieved is a factor of the nurse's knowledge and skill at eliciting information from the client using appropriate techniques of communication and observation of nonverbal cues. Effective communication is therefore a key factor in the interview process (Cecere & McCash, 1992).

There are two approaches to interviewing: They are directive interviewing and nondirective interviewing. The **directive interview** is highly structured and elicits specific information. The nurse establishes the purpose of the interview and controls the interview, at least at the outset, by asking closed-ended questions that call for specific data. During the **nondirective interview,** or rapport-building interview, the health care provider allows the client to control the purpose, the subject matter, and pacing. He also encourages communication by asking open-ended questions and providing empathetic responses (Wilkinson, 2000).

Guidelines for an Effective Interview/History Taking

- **Be prepared –** The interview will be more productive if the health care provider has an opportunity to prepare for the interaction. Such preparation should include the review of the client's clinical records, conversation with other health care personnel, and literature about the client's health problem (Moffett, 1998, Wilkinson, 2000). This will focus the interview and prevent tiring the client. It will also save your time.
- **Schedule the interview appropriately–** Schedule interviews with client at a time when the client is physically comfortable and free of pain, and when interruptions by friends, family, and other health professionals are minimal.
- **Create a pleasant atmosphere –** A quiet, well-lit, well-ventilated and relaxed setting, relatively devoid of noise and interruptions enhances communication. A relaxed atmosphere eases the patient's anxiety, promotes comfort, and conveys your willingness to listen. Ensure privacy, as some clients will not share personal information if they suspect others can overhear. In all instances, the client should be made to feel comfortable and unhurried.

- **Establish a good rapport –** Greet the client by name if possible; sit and chat with him before the interview. Be sure to explain the purpose of the interview and show concern for the patient's story.
- **Set the tone and be focused –** Encourage the client to talk about his chief complaint. This helps you to focus on his most troublesome symptoms. Keep the interview informal while still being professional. Speak clearly and simply, avoiding medical jargons and be sure the patient understands you.
- **Choose your words carefully –** Ask open-ended questions to encourage the client to provide complete and pertinent information.
- **Take notes –** Avoid documenting everything during the interview but make sure you jot down important information such as date and times.

3.5Health History

The primary focus of data collection in an interview is on health and other history. A health history is designed to collect data to be used primarily by the physician to diagnose a health problem and it is usually collected by the medical team. Often the admitting nurse also collects this same information during the admission interview. However, there is a growing disapproval of the nurse repeating this process, as credibility is lost when the nurse repeats virtually all the questions that others have already asked.

The components of a health history include the following:

- **Demographic information** –This encompasses demographic variables such as name, date, age, sex, etc.
- **Chief/presenting complaint** – Try to define what has motivated the client to seek health care, and its duration.
- **History of present illness (HPI)** – HPI provides detailed data about the chief complaint or reason for entering the health care system.
- **Past health history** – This provides information about the client's prior state of health. It includes questions about childhood and adult illnesses, immunisations, injuries, hospitalisations, surgeries, therapeutic regimens, allergies, travels, habits, and use of supportive devices.
- **Family health history (FHH)** – FHH notes illnesses that have environmental, genetic, or familial tendency or that are communicable. A genetic chart or family tree of three generations can be developed to illustrate the family health history.
- **Social and occupational history** – Enquire about what may be grouped as the client's physical and emotional environment, his surroundings both at home and at work, his habits and his own mental attitude to life and to his work.

- **Review of systems** – This is the final portion of health history. It is a systematic collection of specific information about the client's past and present health status related to common problems of body systems. (Swash & Mason, 1986; Cecere, & McCash, 1992).

It is important to mention here as Swash & Mason, (1986) noted, that in taking history, it is neither possible nor desirable to tie a patient down to a particular sequence. The client must be allowed to tell his own story. Besides, a good clinician begins the examination of a patient as the latter walks into the room – his appearance, the way he walks, the way he answers questions and so on – and only finishes taking the history when the consultation is over. Occasionally a vital piece of information may come out just when the patient is leaving. Swash & Mason, (1986) remarked that while the list of headings is formidable, it takes some experience to know in a given case which part of the history is particularly worth pursuing. And following the health history, a **general survey** statement is made, which is a statement of the provider's impression of a client, including behavioral observations.

Health-Perception-Health-Management Pattern –This focuses on the client's perceived level of health and well-being and on personal practices for maintaining health. It also embraces preventive screening activities such as breast and testicular examination; hypertension and cardiac risk factor screening etc.

Nutritional-Metabolic Pattern – This assesses food and fluid intake, food preferences and taboos, cultural factors relating to food and nutrition, etc. It also explores difficulties if any with ingestion, digestion, absorption, transport and metabolism of nutrients.

Elimination Pattern – It assesses bowel and bladder functions such as frequency, amount, relationship of output to intake, and any discomfort or difficulty associated with each function.

Activity-Exercise Pattern – It explores the client's activities of daily living including his usual pattern of exercise, leisure and recreation.

Sleep-Rest Pattern – This inquires about the client's pattern of sleep, rest and relaxation in a 24hour period, noting any deviation from his premorbid rest and sleep pattern.

Cognitive-Perceptual Pattern – Assessment of this pattern involves a description of all the senses (vision, hearing, taste, touch, smell and pain) and the cognitive functions (such as communication, memory, and decision making).

Self-Perception-Self-Concept Pattern – This pattern explores the client's self-concept, which is critical to determining the way he interacts with others. Attitudes about self, perception of personal abilities and body image, and the general sense of worth are also addressed within this pattern.

Role-Relationship Pattern –This describes the client's role and relationships including major responsibilities of the individual. It examines a person's self-evaluation of the performance of expected behaviors related to these roles.

Sexuality-Reproductive Pattern – This pattern describes satisfaction or dissatisfaction with personal sexuality and describes the reproductive pattern.

Coping-Stress Tolerance Pattern – This pattern explores the client's general coping pattern and the effectiveness of the coping mechanisms. It encompasses analysing the specific stressors or problems that confront the client, the client's perception of the stressor and the person's response to the stressor.

Value-Belief Pattern –This describes the values, goals, and beliefs (including spiritual) that guide health related choices. (Cecere,& McCash, 1992).

3.6 Physical Examination

Physical examination or physical assessment is a systematic examination of the body structures. There are basically four techniques of conducting a physical examination and the examination may be done using the cephalocaudal (head – to – toe) approach or the body systems approach. The four techniques are as follows:

- **Inspection**: - Inspection is the most frequently used assessment technique. It involves a deliberate, purposeful and systematic observation to identify deviations from the normal.
- **Percussion**: - This is the assessment technique least used by nurses. It requires considerable skill. Percussion involves striking or tapping a particular part of the body to produce vibratory sounds. The quality of sound aids in determining the location, size and density of underlying structures. If the sound is different from that which is normally expected, it suggests that there may be some pathologic changes in the area being examined.

Types of Percussion

There are three types of percussion viz: **Indirect, Direct, and**

Blunt percussion.

Indirect Percussion: This is the most commonly used type. It produces clear, crisp sounds when performed correctly. To perform an indirect percussion, use the middle finger of your non-dominant hand as the pleximeter by placing it firmly on the part that is to be percussed. Strike the back of the middle phalanx with the top of the middle finger of the dominant hand (the plexor). Deliver the stroke from the wrist and finger joints, not from the elbow, and hold the percussing finger (the plexor) perpendicular to the pleximeter. Tap lightly and quickly, removing the plexor as soon as you have delivered each blow.

Direct Percussion: In direct percussion, the nurse strikes the area to be percussed directly with the pads of two or three or four fingers or with the pad of the middle finger. This method helps in assessing an adult sinus for tenderness.

Blunt Percussion: Do this by striking the ulnar surface of your fist against the body surface. Alternatively, both arms may be used with the palm of one hand placed over the areas to be percussed and then striking it's back with the fist of the other hand. Both techniques aim at eliciting tenderness (not to create a sound) over such organs as the kidneys, gallbladder, or liver (another blunt percussion method used in the neurologic exam involves tapping a rubber – tipped reflex hammer against a tendon to create a reflexive muscle contraction).

Palpation: This is an assessment technique that uses sense of feeling and pressure to assess structure size, placement, texture, temperature, distension, mobility, pulsation and tenderness. There are two types of palpation:

Light Palpation: It involves the use of the pads of the fingertips and the dorsum (back) of the hand or the palm. They are used because the concentration of nerve endings in them makes them highly sensitive to tactile discrimination. In light palpation, the body surface is indented gently using the slightest touch possible (as too much pressure blunts your sensitivity). The nurse extends the dominant hand's fingers parallel to the skin surface and presses gently while moving the hand in a circle.

Deep Palpation: Deep palpation is done with two hands (bimanually) or with one hand. In deep palpation, the hand is held flat and relaxed and molded to the body surface as in light palpation. The best movement is gentle but with firm pressure with the finger held almost straight but slightly flexed at the metacarpophalangeal joints. Indent the skin or tissue about $1\text{-}1^{1/2}$ inches (2.5 - 4cm). Place your other hand on top of the palpating hand to control and guide your movements. This approach

(bimanual palpation) is usually employed while palpating for deep, underlying, hard – to – palpate organs (such as the kidney, liver or spleen) or to fix or stabilise an organ (such as the uterus) while palpating with the other hand. To perform a variation of deep palpation that allows pinpointing an inflamed area, press firmly with one hand, and then lift your hand away quickly. If the patient complains of increased pains as you released the pressure, you have identified **rebound tenderness**. Other variations of deep palpation are **light ballottement and deep ballottement. Light ballottement is** usually performed by applying light rapid pressure from quadrant to quadrant of the patient's abdomen. Hands are kept on the skin surface to detect tissue rebound. **Deep ballottement** on the other hand, is performed by applying abrupt, deep pressure and releasing it while maintaining contact.

NOTE: Palpation forms the most important of abdominal examinations. Tell the patient to relax as best as he can, to breathe quietly and that you will be as gentle as possible. Enquire for the site of any pain and come to this region last. It is helpful to have a logical sequence to follow and if this is done as a matter of routine, then no important point will be omitted. Presented below are the different regions of the abdomen and the different incision lines employed in abdominal surgeries.

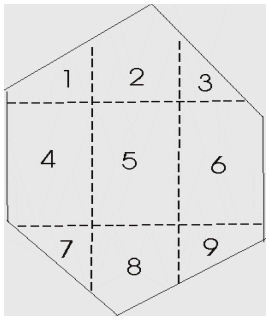


Fig 4 Regions of the Abdomen

1. Right hypochondrion
2. Epigastruium
3. Left hypochondrion
4. Right lumbar
5. Umbilical
6. Left lumbar
7. Right Iliac
8. Hypogastrum or suprapubic
9. Left Iliac

Source: Adapted from Swash & Mason, (1986). Hutchison's Clinical Methods (18th ed)

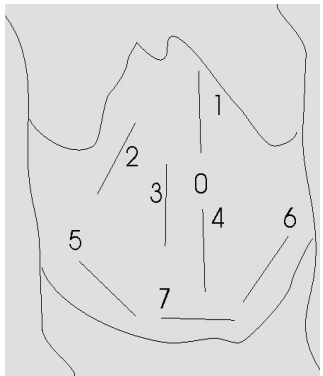


Fig 5 Some Commonly Employed Abdominal Incisions

1. Upper midline
2. Right sub costal (Kocher's)
3. Right paramedian
4. Lower midline
5. Gridiron (appendectomy)
6. Left
7. Suprapubic (pfannenstiel)

Source: Adapted from Swash & Mason, 1986. Hutchison's Clinical Methods (18th ed)

Auscultation: Auscultation is an assessment technique that involves listening to sounds created in body organs to detect variations from normal. Some sounds can be heard with unassisted ear, but most sounds are heard through a stethoscope. You must first become familiar with normal sounds before you can be pick abnormal sounds. The heart, lungs and abdomen are the organs that are most often assessed by this technique. To auscultate effectively therefore requires good hearing acuity, a good stethoscope and knowledge of how to use the stethoscope correctly.

Assessing High-Pitched Sounds – Example of high-pitched sounds are 1st and 2nd heart sounds (S_1 & S_2) and breath sound. This is done with the use of the diaphragm of the stethoscope. Ensure that the diaphragm's entire surface is closely / firmly applied to the patient's skin.

Assessing Low-Pitched Sounds – The heart murmurs, 3rd and 4th heart sounds (S_3 and S_4) are all low-pitched sounds. To pick such sounds, lightly place the bell of the stethoscope on the appropriate areas. Do not exert pressure. If you do, the patient's chest will act as a diaphragm and you will miss low-pitched sounds.

Like all the other assessment techniques, it requires conscious effort and regular practice to become proficient in its use.

SELF ASSESSMENT EXERCISE 2

What is the use of the five (5) special senses in observation/physical examination?

4.0 CONCLUSION

In spite of the proliferation of ancillary aids, history taking and physical examination remain essential skills for medical personnel. The unit though might not have included the interpretation of findings; it has presented a comprehensive package on assessment techniques, especially as relating to knowledge that are vital to skill acquisition.

5.0 SUMMARY

Health assessment is a vital part of patient care and it is conducted in a systematic manner through history taking and physical examination. Effective history taking assessment requires good communication and interpersonal skills while skills in inspection, palpation, percussion, and auscultation are needed for complete physical examination. Furthermore, knowledge of the normal structure and function of body parts and systems is an essential perquisite to conducting physical assessment.

6.0 TUTOR MARKED ASSIGNMENT

Assessing health status is a major component of primary health care. Discuss the major ingredients for assessment.

Answers to Self-Assessment Exercise

Exercise 1

For evaluating the patient's current physical condition
For detecting early signs of developing health problems
To establish a data base for future comparisons.
To evaluate responses to medical and nursing interventions.

Exercise 2

Eye (Sight) for visual clues e.g. patient's appearance, mannerisms, mode of dressing.

Touch (Tactile) for palpating any part of the patient to provide information such as coldness, swelling etc.

Auditory (Ear) - use of hearing aids to collect information (stethoscope).

Olfactory (Nose) an offensive smell when perceived around a patient can be suggestive of an underlying problem.

7.0 REFERENCES/FURTHER READINGS

Cecere, M. C. & McCash, K. E. (1992). Health History and Physical Examination. In S. M. Lewis and I. C. Collier (eds.) *Medical-Surgical Nursing; Assessment and Management of Clinical Problems* (3rd ed.). St Louis: Mosby-Year Book, Inc.

Swash, M. & Mason, S. (1986). *Hutchison's Clinical Methods* (18th ed). East Sussex: Bailliere Tindall.

Timby, B.K. (ed.) (1996). Vital Signs. *Fundamental Skills and Concepts in Patient Care* (6th ed.). Philadelphia: Lippincott.

Webster, C. (1995). Health and Physical Assessment. In H. B. M. Heath (ed.) *Potters and Perry's Foundations in Nursing Theory and Practice*. Italy: Mosby, an imprint of Times Mirror International

UNIT 3 HEALTH PROMOTION

CONTENTS

1.0 INTRODUCTION

The popular axiom – prevention is not only better than cure but also cheaper than cure – cannot be more relevant than in today's world. This is because the recent past has witnessed more natural disasters than ever recorded. Emerging infectious diseases have been on the rampage with the resurgence of those hitherto eradicated communicable diseases, that have not only become more virulent but resistant to the simple therapeutic agents. All these coupled with global economic recession and depreciation of currencies in many African states has compounded the already precarious condition of people in African nations. Therefore, health promotion becomes a veritable weapon to stem the all time high morbidity and mortality rate that has been trailing Africa .

Interestingly health promotion is an important component of health care practice. Health promotion as Kozier, Erb, Berman, & Burke (2000) put it is "a way of thinking that revolves around a philosophy of wholeness, wellness, and well-being". Implicit in the above statement is that there is a level of commitment that should be displayed by the individual, community, organisation, and the government if the goal of health promotion is ever to be achieved. The role of each of these players and how the nurse can assist in health promotion therefore forms the focus of this unit.

2.0 OBJECTIVES

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

- Identify variables affecting health and explain the relationship between such and health.
- Define health promotion and distinguish it from illness prevention.
- Enumerate health promotion goals and discuss the levels of preventive care.
- Describe the behaviours that promote health.
- Discuss theoretical models of health and illness together with their assumptions.
- Differentiate health preventive or protective care from health promotion.
- Discuss your roles in health promotion and illness prevention.

3.0 MAIN CONTENT

3.1 What Affects Health?

The health status of individuals in any community depends to a large extent on their level of awareness of factors that enhance and/or militate against their health. White (1998) contends that a great many things affect health. She grouped them into four broad categories namely:

1. **Genetic/Human Biology** – It is not uncommon to hear that certain diseases run in families or have familial tendency. This is because human traits are transmissible from parents to offspring via the genes. Hence an individual genetic make-up to a large extent affects his state of health.

2. **Personal Lifestyle/Behaviour** – This is the area that exerts the most influence on health and well-being, and it is controlled entirely by the individual. As such it is the individual's decision whether these factors will promote health or lead to ill health. Although an increasing number of people are becoming aware of the relationship between health, lifestyle and illness, and are already developing health-promoting habits, but a sizeable proportion of the population is still naïve of this relationship. Simply put health promoting habits encompasses such things as: diet, exercise, personal care, safe sex and controlled sex, tobacco and drug use, alcohol consumption, and safety.

3. **Environmental Influences** – The aggregate of people, things, conditions, or influences surrounding man is what is referred to as

the environment. It could be physical, biological or social. Man and his environment are constantly interacting. The environment influences man and man influences his environment at all times i.e. the relationship is never static but always changing. Interestingly, health and quality of life are greatly affected by this interaction.

Human beings enjoy optimum functioning when the air they breathe, the food they eat, the houses they live in, indeed the neighborhood in which they stay is of good quality. If they are bad, they tend to promote disease, disability and discomfort. For instance in metropolitan cities where domestic and industrial pollution is high, tarry particles, which contain cancer-producing chemicals, may exist. As such irritation to the eye and respiratory tissue may be rampant. In addition, overcrowding secondary to rural-urban migration and problems of population control enhances the spread of communicable diseases such as droplet infections. Besides, bad housing, lack of adequate facilities for the storage, preparation, and cooking of food are also intricately related to the development of malnutrition, poor growth and low immunity among people.

Poor sanitation as well as lack of provision of drinkable water will also promote the spread of water borne disease with adverse consequences on healthy living. It is also worth mentioning that technological advancement and industrialisation with its attendant problems has placed new stresses on man such as transport difficulties, noise, and loneliness. All these factors are associated with greater incidence of hypertension, mental disorder and suicide. Noise can produce alteration in respiration and circulation, in the basal metabolic rate, and in muscular tension. Even the fetus is affected by certain factors in the mothers' environment. For instance the baby's well-being to a large extent depends on its mother's capability and knowledge of standards of hygiene, good nutrition, and avoidance of harmful substances e.g. some drugs.

Health Care – This encompasses such things as immunisation, regular examinations and screening tests, prophylactic medications, to mention a few that men undertake to prevent invasion of disease causing organisms and prevent the body from breaking down. Failure to undergo such treatment could spell doom for the body with serious adverse consequences on healthy living.

SELF ASSESSMENT EXERCISE 1

Identify factors that enhance and/or militate against the health.

3.2 Defining Health Promotion

The concepts of health promotion, self-care and community participation emerged during the 1970s, primarily out of concerns about the limitation of professional health. Since then there have been rapid growth in these areas in the developed world, and there is evidence of effectiveness of such interventions although these areas are still in infancy in the developing countries (Bhuyan, 2004). The Ottawa Charter, an important milestone in health promotion practice worldwide, defines health promotion as "the process of enabling people to increase control over, and to improve, their health". To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is therefore, seen as a resource for everyday life, not the objective of living.

Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being (WHO Ottawa Charter for Health Promotion, 1986). Consequently, the Ottawa Charter noted that five key strategies for health promotion action are: *building a healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health service).* This no doubt settles any storm about the genesis of health promotion but has not addressed what health promotion is all about and how it is different from illness prevention.

Health promotion and illness prevention are closely related concepts, and in practice, overlap to some extent. Activities for health promotion help the patients/clients maintain or enhance their present levels of health while activities for illness prevention protect patients/clients from actual or potential threats to health. Both types of activities are future orientated. The difference between them involves motivations and goals. Health promotion activities motivate people to act positively to reach the goals of more stable levels of health. Illness prevention activities motivate people to avoid declines in health and functional states (Cox, 1995).

Health promotion activities can be *passive or active*. With passive strategies of health promotion, individuals gain from the activities of others without doing anything themselves. The fluoridation of municipal

drinking water, the fortification of salt with iodine and milk with vitamin D are common examples of passive health promotion strategies. The active health promotion strategies on the other hand, involves active participation of individuals i.e. individuals are motivated to adopt specific health programmes. For instance the weight reduction and smoking cessation programmes require the patient/client to be actively involved in measures to improve their present and future levels of wellness while decreasing the risk of disease. Some health promotion and illness prevention programmes are operated by health care agencies. Others are independently operated. Whichever, the point to be made is that health promotion and illness prevention activities are important to both the consumer and the health care provider (Cox, 1995).

The avian influenza (bird flu) that recently broke out in certain parts of Nigeria presents an excellent picture of how there could be an interplay of actions among the major actors in the health sector. The avian influenza epidemic, being a deadly disease that can be transmitted to man, arouses the society's concern about the disease. Being a communicable disease and one that affects poultry farming, it also arouses the interest of commercial organisations and agriculture. Besides it also has a political element, with potential global repercussions. The jobs and livelihood of some farmers and those within the food industry particularly the fast food centers are at stake. There is of course, the possibility of widespread trans-species infection. We can then appreciate the concerted efforts of individuals, organisations, the environment, the society, and the government (political). One cannot but therefore agree with Kelly et al. (1993) that health cannot be effectively promoted unless the organisational, social, individual, and environmental aspects are combined in an integrated approach.

3.3 Health Promotion Goals

Delaune & Ladner (1998) submitted the following as health promotion goals:

- Respect and support clients' right to make decisions.
- Identify and use clients' strengths and assets.
- Empower clients to promote own health or healing.

Levels of Preventive Care

The three levels of prevention are:

- **Primary Prevention** – This is true prevention. It precedes disease or dysfunction and is applied to patients/clients that are considered physically and emotionally healthy (Cox, 1995). The goal is to

decrease a person's vulnerability to disease. It includes such activities as health education, immunisation/vaccination, personal and environmental hygiene, good nutrition, good housing/avoidance of overcrowding, quarantine of patients, and chemoprophylaxis.

- **Secondary Prevention** – This focuses on individuals who are experiencing health problems or illness or who are at risk of developing complications or worsening conditions. Activities are directed at diagnosis and prompt treatment, thereby reducing the severity and enabling the patient/client to return to normal health at the earliest possible time (Edelman & Mandle, 1990; Cox, 1995). Secondary prevention includes screening techniques and treatment of early stages of disease to limit disability or delay the consequences of advanced disease (Cox, 1995; Delaune & Ladner, 1998).

- **Tertiary Prevention** – This is instituted when a defect or disability is permanent and irreversible. It involves minimising the effect of a disease or disability through such activities as rehabilitative nursing care for clients with permanent defects like blindness, to avert further disability or reduced function. The focus is to help clients reach and maintain their optimum level of functioning (Delaune & Ladner, 1998).

3.4 Behaviours that Promote Health (Healthy Habits)

Have you heard a saying like "Habit is stronger than information"? When we say something has become habitual, we mean it has become one's second nature; a regular way of behaving; a reflex action or an instinctive response to a stimulus. Good health habits help to prevent disorder and/or enhance total wellness. On the contrary poor health habits will almost always adversely affect an individual's health status and his capability and efficiency. What then can we consider as healthy habits? The answer to this is obvious as healthy habits cut across practically all aspects of our lives viz:

Exercise: It is important for everyone to exercise, and we should all find the preventive maintenance fitness programme which suites us best. There is neither an alternative, nor substitute that increases the potential for a happier, healthier and improved quality of life. "If exercise could be packed into a pill, it would be the single most widely prescribed, and beneficial medicine in the nation," says Robert N. Butler, MD, Director of the National Institute on Aging (DiMartino, 1999). Exercise is necessary to maintain muscle tone, to stimulate circulation and respiration, and to help control body weight. All people need some sort of exercise daily. A person's age, occupation and general condition help to determine the appropriate amount and kind of exercise (Rosdahl,

1995). A moderate amount of daily exercise is better than occasional sports of strenuous activity. A study conducted by the *Journal of Medical Association* (JAMA, 277(16), April 23-30, 1997) included 11,470 women to determine the numerous benefits that ensue when a sedentary level is increased to a normal level – daily routine movement. The study revealed that the life preserving aspect of this minor change is huge (DiMartino, 1999).

Nutrition and Diet: Nutrition is a first cousin to exercise. A regular exercise regime means eating a balanced menu of foods, watching fat intake and supplementing the diet with nutrients and vitamins. However, when people exercise regularly, their diet must compensate for the extra calories burned. Although, individuals' nutritional needs vary, according to body build, age and activity, everybody needs certain nutrients to keep the body functioning and in good repair Eating a regular and balanced diet and maintaining one's weight within the normal range are factors that contribute to wellness. Intake of salt, sugar, fat and red meat should be limited while liberal intakes of fruits, vegetables, and grains should be encouraged. Alcohol should be avoided.

Elimination: The integumentary, respiratory, urinary and digestive systems are the organs primarily concerned with elimination of wastes from the body. Moderate intake of fibers in form of roughage (fruits and vegetables) supplies the bulk that stimulates proper and adequate elimination of solids as faecal matter. Water intake assists the kidney in getting rid of liquid wastes. Avoidance of cigarette smoking and polluted air helps in preserving the lungs and the cardiovascular system (Rosdahl, 1995).

Sleep and Rest: Rest is soothing to the body. Most people need 7 – 8 hours sleep per night. Sometimes after the day's work, rest is needed rather than sleep. Try lying relaxed and letting your thoughts drift. Some people find that meditation or "emptying the mind of all thoughts" is restful (Rosdahl, 1995).

Personal Hygiene: Maintenance of personal hygiene is necessary for comfort, safety and well-being. Activities of personal hygiene are basic to normal functioning. Hygiene refers to practices that promote health through personal cleanliness and it is fostered through activities like bathing, brushing the teeth, cleaning and maintaining the fingernails and toenails, and shampooing and grooming the hair. Such activities help to protect the body from infections, make a good impression on others, and help to promote a positive self-image. For instance, regular bathing or cleansing removes perspiration, oil, and pathogens from the skin. It also increases blood circulation and helps maintain muscle tone. Besides, bathing is refreshing; it can help wake one up in the morning and

induce sleep at night. Many people shed their worries along with the day's accumulation of dirt by taking baths or showers. Grooming is equally important to one's well-being. Nails should be trimmed to a comfortable length. Bitten nails are unsightly and may lead to infection. Shoes should be well fitted and comfortable. Clothes should be clean, well fitting and comfortable too. They should be appropriate for the type of activity being performed. Dental care is also essential. The teeth should be brushed regularly and regular dental check-up should be encouraged. Fluorination of water to lessen tooth decay and consumption of food rich in calcium, phosphorus, vitamins A, C, and D for healthy and normal teeth formation and growth is expedient. Cutting down on the consumption of sugary foods (that is often overlooked) is vital to the prevention of dental caries. While the eating of soft food is good, continuous eating of such foods affects the gums and teeth because chewing itself is needed to maintain the tone and holding power of the gums and the strength of the teeth. Eye care is another important aspect of personal care that must not be neglected in order to achieve full health. To this end, eye examination should be done at least once a year.

Posture and Body Mechanics: Posture is the position of your body, the way its parts line up when you stand, sit, move or lie, while body mechanics refers to the use of the body as a tool. The way you stand, sit, or move affects your efficiency and the impression you create. Good posture improves your health, saves your energy and prevents unnecessary muscle strain and back disorder (Rosdahl, 1995).

Safer Sex: The late twentieth century recorded an astronomical increase in the emergence and spread of deadly infectious diseases emanating primarily from unhealthy sexual practices. This informs the gospel of safer sex and the doctrine of ABC in the prevention of AIDS (Acquired Immune Deficiency Syndrome) and other sexually transmitted diseases. Safer sex involves carefully choosing one's sexual partner, mutual fidelity and the use of condom when in doubt.

A Healthy Environment: As earlier stated, man and his environment are constantly interacting. The environment influences man and man influences his environment at all times i.e. the relationship is never static but always changing. Interestingly, health and the quality of life are greatly affected by this interaction. "It is difficult to have optimum health if the environment is not safe."

Note: As beginning health care providers, students are encouraged to develop their own health-promoting behavior to be better role models for clients.

SELF ASSESSMENT EXERCISE 2

What are health habits? Identify examples

3.5 Our Role in Health Promotion, Health Protection, and Disease Prevention

It is common knowledge that investment in the health sector is rapidly becoming an amalgam of public and private partnerships. While it is becoming increasingly glaring that the responsibility for health promotion does not lie with the health sector alone, Watinson (2002) argued that medical professionals nonetheless have an unequal contribution to make to alliances created in the pursuit of health. Speaking in the same vein, Delaune & Ladner (1998) asserted that health practitioners play a key role in promoting health and wellness. Therefore there is no doubt about their role in health promotion and disease prevention. However the challenge before us is to find ways to motivate clients and people generally to develop health-promoting behaviours. This is against the background that health promotion is not simply something that is done to the client or patient, as in changing a dressing, but something that pervades the entire health care, ranging from needs assessment, planning health gain to evaluating interventions and strategies for effectiveness and efficiency (Watkinson, 2002).

Delaune & Ladner (1998) identified health education/health counseling and motivation as two key components of health promotion strategies. Watkinson (2002) citing the English National Board's Higher Award (ENB, 1991) document observed the health promotion stands out as the 6th key characteristic of that document. Inherent in the said document (highlighted below), are salient features considered essential to the performance of health promotion activities.

- Promote understanding of health promotion, preventative care, health education and healthy living.
- Understand and apply the principles and practice of health promotion in the work setting and create, maintain and take responsibility for a healthy work environment.
- Facilitate responsibility and choice among clients for healthy living, and their ability to determine their own lifestyles.
- Develop and implement strategies for health care based on the understanding of the impact of health trends on resources.

Consequently, Watkinson (2002) illustrated the many sided roles of health workers in health promotion with this schematic diagram (Fig 6).

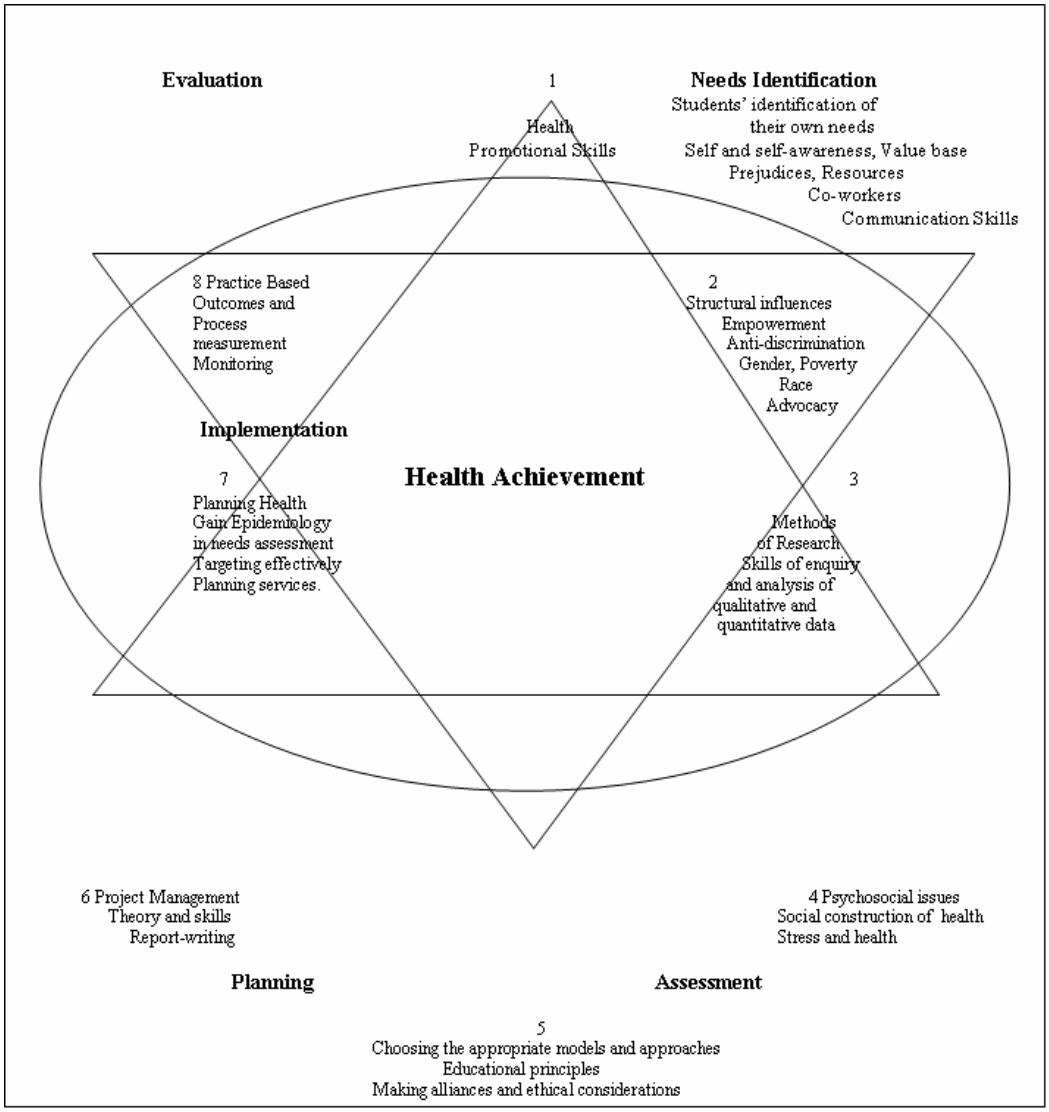


Fig 6 Our expected role in Health Promotion

4.0 CONCLUSION

The issue of health promotion is an all encompassing one. This unit has demonstrated on one hand the limitations of modern medicine and health care systems in single handedly improving the health status of the population. On the other hand it emphasised the role of health care providers as a key strategy for improving health through a holistic approach consisting of not only a medical dimension but also psychological, social and economic dimensions.

5.0 SUMMARY

The Ottawa Charter, an important milestone in health promotion practice worldwide, defines Health Promotion as the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Therefore the health status of individuals in any community depends to a large extent on their level of awareness of factors that enhance and/or militate against their health. However, good health habits help to prevent disorder and/or enhance total wellness. On the contrary poor health habits will almost always adversely affect health status and the individual's capability and efficiency.

6.0 TUTOR MARKED ASSIGNMENT

Discuss with examples the justification of needs identification in the expected role of the health care provider in health promotion.

Answers to Self Assessment Exercises

Exercise 1

Genetic, Personal life style, Environment, Technological advancements.

Exercise 2

These are activities that help an individual to achieve and maintain a healthy status.

Examples are: elimination, personal hygiene, sleep and rest, exercise, posture and body mechanisms.

7.0 REFERENCES/FURTHER READINGS

Bhuyan, K. K. (2004). Health Promotion through Self-care and Community Participation: Elements of a Proposed Programme in the Developing Countries. BMC Public Health. 4: 11

Cox, C.L.(1995). Health and Illness. In H. B. M. Heath (ed.) *Potters and Perry's Foundations in Nursing Theory and Practice*. Italy: Mosby, an imprint of Times Mirror International

Delaune, S. C. & Ladner, P.K. (eds.) (1998): The Individual, Health and Holism. *Fundamentals of Nursing, Standards and Practice.* Albany: Delmar Publishers.

DiMartino, C. (1999). Healthy Living: A Combination of Diet, Nutrition, and Exercise. *In Motion,* 9(6).

Edelman, C. L. & Mandle, C. L. (1990). *Health Promotion throughout the Life Span* (2nd ed.). St Louis: Mosby.

Kelly, M., Charlton, B and Hanlon, P. (1993). The Four Levels of Health Promotion: An Integrated Approach. *Public Health*, 107(5): 320.

Kozier, B., Erb, G., Berman, A.U. & Burke, K. (eds.) (2000). Health, Wellness and Illness. *Fundamental of Nursing: Concepts Process and Practice* (6th ed). New Jersy: Prentice Hall, Inc.

Rosdahl, C. B. (ed.) (1995). Optimum Health for All People; *A Textbook of Basic Nursing*. Philadelphia: J.B. Lippincott Company.

Watkinson, G. (2002). Promoting Health. In R. Hogston & P. M. Simpson (eds.) *Foundations of Nursing Practice; Making the Difference* (2nd ed.). New York: Palgrave Macmillan.

World Health Organization. Ottawa Charter for Health Promotion. Geneva. 1986.

MODULE 3 HIV AND AIDS PROPHYLAXIS

Unit 1 Introduction to HIV and AIDS Treatment
Unit 2 HIV/AIDS and Opportunistic Infections
Unit 3 Safety measures

UNIT 1 THE HIV AND AIDS TREATMENT

CONTENTS

1.0 INTRODUCTION

The choice of when to start HIV antiretroviral treatment is a very important decision. Once treatment has begun it must be adhered to, in spite of side effects and other challenges. Many factors must be weighed up when deciding whether to begin treatment, including the results of various clinical tests. These issues are addressed in this unit. I hope you will find it very interesting.

2.0 OBJECTIVES

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

- Describe the various types of treatment available
- Highlight the drugs for managing HIV/AIDS
- Describe the combination of drugs/Highly Active Antiretroviral Therapy (HATT)

3.0 MAIN CONTENT

3.1 What is HIV Antiretroviral Treatment?

This is the main type of treatment for HIV or AIDS. It is not a cure, but it can stop people from becoming ill for many years. The treatment consists of drugs that have to be taken every day for the rest of someone's life. To understand more about the treatment you need to have some basic knowledge of HIV and AIDS.

Antiretroviral treatment for HIV infection consists of drugs which work against HIV infection itself by slowing down the replication of HIV in the body. The drugs are often referred to as:

- antiretrovirals
- anti-HIV drugs
- HIV antiviral drugs

For antiretroviral treatment to be effective for a long time, it has been found that the patient needs to take more than one antiretroviral drug at a time. This is what is known as combination therapy. The term Highly Active Antiretroviral Therapy (HAART) is used to describe a combination of three or more anti-HIV drugs.

When HIV replicates (makes new copies of itself) it often makes mistakes. This means that within any infected person there are many different strains of the virus. Occasionally, a new strain is produced that happens to be resistant to the effects of an antiretroviral drug. If the person is not taking any other type of drug then the resistant strain is able to replicate quickly and the benefits of treatment are lost. Taking two or more antiretrovirals at the same time vastly reduces the rate at which resistance develops.

3.2 Antiretroviral Drugs

There are four groups of anti-HIV drugs. Each of these groups attacks HIV in a different way. They include:

- Nucleoside/Nucleotide Reverse Transcriptase Inhibitors
- Non-Nucleoside Reverse Transcriptase Inhibitors
- Protease Inhibitors
- Fusion or Entry Inhibitors

We shall briefly explain each of the four groups.

The first group of antiretroviral drugs consistsis of the **Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs).** These were the first type of drugs available to treat HIV infection in

1987. NRTIs (also known as nucleoside analogues or nukes) interfere with the action of an HIV protein called reverse transcriptase, which the virus needs to make new copies of itself. NRTIs are sometimes called the "backbone" of combination therapy because most regimens contain at least two of these drugs.

The second group of antiretroviral drugs is made up of **the Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)**, which started to be approved in 1997. Like the nukes, NNRTIs (also known as non-nucleosides or non-nukes) stop HIV from replicating within cells by inhibiting the reverse transcriptase protein.

The third type of antiretrovirals is **the Protease Inhibitor (PI)** group. The first protease inhibitor was approved in 1995. Protease inhibitors, as the name implies, inhibit protease, which is another protein involved in the HIV replication process.

The fourth group of antiretrovirals comprises E**ntry Inhibitors,** including **Fusion Inhibitors.** One of these drugs - commonly called T-20 - has been licensed both in the US and in Europe since 2003, but it is meant only for use by people who have already tried other treatments. The T-20 fusion inhibitor differs from the other antiretrovirals in that it needs to be injected (otherwise it would be digested in the stomach). Entry inhibitors prevent HIV from entering human cells.

3.3 Combination of Drugs/Highly Active Antiretroviral Therapy (HATT)

Highly Active Antiretroviral Therapy consists of a combination of three or more drugs. The most common combination given to those beginning treatment consists of two NRTIs combined with either an NNRTI or a "boosted" protease inhibitor. Ritonavir (in small doses) is the drug most commonly used to boost a protease inhibitor. An example of a common combination is the two NRTIs zidovudine and lamivudine combined with the NNRTI efavirenz.

SELF ASSESSMENT EXERCISE 1

What is the peculiarity of the non-nucleoside reverse transcriptase inhibitors and the entry inhibitors?

_____

_____

_

Although coverage has improved greatly in recent years, most people living with HIV in the developing world still have no access to

antiretroviral treatment. Instead, the best they can hope to receive is treatment for the diseases that occur as a result of a weakened immune system, which are known as opportunistic infections. Such treatment has only short-term benefits because it does not address the underlying immune deficiency itself.

4.0 CONCLUSION

Starting HIV antiretroviral treatment is a very important decision to be taken by the health care provider once the initial assessment of the patient shows a positive sign of HIV/AIDS infestation. Treatment must be adhered to in spite of side effects while efforts should be made to prevail on the conscious ego of the client to comply despite the challenge and other challenges.

5.0 SUMMARY

This unit has examined various antiretroviral treatments for HIV/AIDS positive and carriers. A combination of drugs has been found to be effective in the overall management.

6.0 TUTOR MARKED ASSIGNMENT

Describe three classes of antiretroviral drugs used for HIV management

Answer to Self Assessment Exercises

While the non-nucleosides or non-nukes stop HIV from replicating within cells by inhibiting the reverse transcriptase protein, the entry inhibitors prevent HIV from entering human cells.

7.0 REFERENCES/FURTHER READINGS

TDR News (2007). *Enhancing Drug Discovery for Neglected Tropical Diseases*. Published by WHO, Geneva

UNAIDS (2001). *Sources and Prices of Selected Drugs and Diagnostics for People Living with HIVS/AIDS*.

WHO (2006) *Guidelines on Co-trimoxazole Prophylaxis for HIV-related Infections among Children, Adolescents and Adults in Resource*-Limited *Setting*s Other site

UNIT 2 HIV/AIDS AND OPPORTUNISTIC INFECTIONS

CONTENTS

1.0 INTRODUCTION

People with advanced HIV infection are vulnerable to infections and malignancies that are called “opportunistic infections” because they take advantage of the opportunity offered by a weakened immune system. There are different conditions typically occurring at different stages of HIV infection. In early HIV disease people can develop tuberculosis, malaria, bacterial pneumonia, herpes zoster, staphylococcal skin infections and septicaemia.

In this unit, we shall examine the opportunistic infections: its meaning, the different types and the need to prevent them.

2.0 OBJECTIVES

At the end of this unit, you are expected to:

- Explain the concept of opportunistic infections
- Describe how they are acquired by the HIV/AIDS victim
- Enumerate different opportunistic infections
- Identify the class of treatment and method of control.

3.0 MAIN CONTENT

3.1 Definition of Opportunistic Infections

These are diseases that readily come on people with a drop or weakened immune systems such as in people with HIV who are at a higher risk. They may occur in people without HIV/AIDS but the recovery period for a person with HIV will be longer than that of someone with a healthy immune system.

Find below a list of the world's most common HIV-related opportunistic infections and diseases:

- Bacterial diseases such as tuberculosis, MAC, bacterial pneumonia and septicaemia (blood poisoning)
- Protozoal diseases such as PCP, toxoplasmosis, microsporidiosis, cryptosporidiosis, isopsoriasis and leishmaniasis
- Fungal diseases such as candidiasis, cryptococcosis and penicilliosis
- Viral diseases such as those caused by cytomegalovirus, herpes simplex and herpes zoster virus
- HIV-associated malignancies such as Kaposi's sarcoma, lymphoma and squamous cell carcinoma.

When the immune system is very weak due to advanced HIV disease or AIDS, opportunistic infections such as protozoal diseases such as toxoplasmosis and cryptococcosis develop. Some infections can spread to a number of different organs, these are known as “disseminated” or “systemic” disease. Many of the opportunistic infections that occur at this late stage can be fatal.

3.2 The Need to Prevent and Teat Opportunistic Infections

Highly Active Antiretroviral Therapy (HAART) can reduce the amount of HIV in someone's body and restore their immune system. The introduction of HAART has dramatically reduced the incidence of opportunistic infections among HIV-positive people who have received the drugs. Yet the prevention and treatment of opportunistic infections remains essential.

Around the world, millions of people living with HIV in resource-poor communities have no access to HAART. And even where the drugs are available, they do not entirely remove the need for preventing and treating opportunistic infections. Sometimes it is advisable for people with acute opportunistic infections to begin HAART right away, especially if the infection is difficult to treat. However in certain cases it may be better to delay beginning HAART and instead only to administer

treatment for the opportunistic infection, especially if there are concerns about drug interactions or overlapping drug toxicities.

Those who have already started taking antiretrovirals may require other drugs in certain circumstances. In particular, some opportunistic infections may be unmasked shortly after the beginning of HAART as the immune system starts to recover, and these may require specific treatment. Measures to prevent and treat opportunistic infections become essential if antiretrovirals stop working because of poor adherence, drug resistance or other factors.

Providing prevention and treatment of opportunistic infections not only helps HIV-positive people to live longer, healthier lives, but can also help prevent TB and other transmissible opportunistic infections from spreading to others.

3.3 Prevention of HIV-related Opportunistic Infections

HIV-positive people can reduce their exposure to some of the germs that threaten their health. They should be especially careful around uncooked meat, domestic animals, human excrement and lake or river water. However there is no practical way to reduce exposure to the germs that cause candidiasis, MAC, bacterial pneumonia and other diseases because they are generally common in the environment.

Several HIV-related infections (including tuberculosis, bacterial pneumonia, malaria, septicaemia and PCP) can be prevented using drugs. This is known as drug prophylaxis. One particular drug called cotrimoxazole (also known as septra, bactrim and TMP-SMX) is effective at preventing a number of opportunistic infections. This drug is both cheap and widely available. The World Health Organisation (WHO) recommends that, in resource-limited settings, the following groups of people should begin taking cotrimoxazole:

- HIV-exposed infants and children, starting at 4-6 weeks after birth, or at first contact with health care, and continued until HIV infection is excluded
- HIV-positive children less than 1 year old
- HIV-positive children aged 1-4 years who have mild, advanced or severe symptoms of HIV disease, or a CD4 count below 25%
- HIV-positive adults and adolescents who have mild, advanced or severe symptoms of HIV disease, or a CD4 count below 350 cells per ml
- HIV-positive people with a history of treated PCP.

According to WHO guidelines, treatment of HIV-positive children should continue until at least age five. In general, treatment of adults and children should continue indefinitely, though it may sometimes be stopped following successful antiretroviral treatment.

Some of the worst affected countries may choose to treat all infants and children born to mothers confirmed or suspected of living with HIV, until HIV infection is excluded. They may also choose to treat everyone who is diagnosed with HIV, regardless of symptoms or CD4 count.

Drug prophylaxis is sometimes recommended even for those who have started HAART if they have very weak immune systems or are otherwise considered to be especially vulnerable. They may be advised to stop taking the drugs if their immune system recovers.

SELF ASSESSMENT EXERCISE 1

Write briefly on the HAART

3.4 Treatment of HIV-related Opportunistic Infections

In a medium infrastructure setting, the facilities available include X-ray equipment and culture facilities. Using these, opportunistic infections such as extra-pulmonary tuberculosis, cryptosporidiosis, isopsoriasis, PCP and Kaposi's sarcoma can be diagnosed and treated.

Opportunistic infections such as toxoplasmosis, MAC and cytomegalovirus infections can be diagnosed and treated in places with advanced infrastructure. Treating these infections is often impossible in resource poor countries. Many developing countries lack the advanced equipment and infrastructure (such as CT scanning) needed to treat these more complex infections.

3.5 Types of Opportunistic Infections

Let us quickly look at some opportunistic infections that particularly affect people living with HIV.

3.5.1 Bacterial Pneumonia

Pneumonia can be caused by various bacteria. Symptoms among HIV-positive people are much the same as in those without HIV infection, and include chills, rigours, chest pain and pus in the sputum. The vaccine PPV can protect people against some of the more common pneumonia-causing bacteria, and is recommended in the US. Other forms of respiratory infection including PCP are common among HIV-

infected people. Doctors must be certain of diagnosis before administering antibiotics. This may require a chest radiograph, blood cultures, a white blood cell count and tests to eliminate other infections. Treatment is usually aimed at the most commonly identified disease-causing bacteria.

3.5.2 Candidiasis

There are two main types of candidiasis: **localised disease** of the mouth and throat or of the vagina and **systemic disease** of the oesophagus, and disseminated disease. The mouth and throat variant is believed to occur at least once in the lifetime of all HIV-infected patients. Occurrence of the vaginal variant is common among healthy women and is unrelated to HIV status. While the localised disease does not cause death, it can result in oral pain and make swallowing difficult. The main symptom is creamy white legions in the mouth that can be scraped away. Oesophageal gullet candidiasis is a more serious condition which can cause pain in the chest that increases with swallowing. Disseminated candidiasis causes fever and symptoms in the organs affected by the disease: for example, blindness when it affects the eyes which can be life threatening. The localised disease may be treated at first with relatively inexpensive drugs such as nystatin, miconazole or clotrimazole. Systemic candidiasis requires treatment with systemic antifungal agents such as fluconazole, ketoconazole, itraconazole or amphotericin

3.5.3 Cryptosporidiosis and Isosporiasis

Cryptosporidiosis (crypto) and isosporiasis are both caused by protozoan parasites. These diseases are easily spread by contaminated food or water or by direct contact with an infected person or animal. Both crypto and isosporiasis cause diarrhoea, nausea, vomiting and stomach cramps. In people with healthy immune systems, these symptoms do not last for more than about a week. However, if the immune system is damaged then they can continue for a long time. Diarrhoea can interfere with the absorption of nutrients and this can lead to serious weight loss.
To confirm diagnosis of either disease, the stool is normally checked for parasites and their eggs. There is no cure for crypto, but antiretroviral therapy to restore immunity can effectively clear up the infection. For isosporiasis, TMP-SMX (trimethoprim-sulfamethoxazole) is often the preferred treatment.

3.5.4 Cytomegalovirus

Cytomegalovirus is a virus that infects the whole body. It most commonly appears as retinitis, which causes blurred vision and can lead

to blindness. It can also affect other organs, and is capable of causing fever, diarrhoea, nausea, pneumonia-like symptoms and dementia. The infection may be treated with drugs such as ganciclovir, valganciclovir and forscarnet.

3.5.5 Herpes Simplex and Herpes Zoster

The usual symptoms of herpes simplex virus infection (HSV), which causes sores around the mouth and genitals and herpes zoster virus infection ("zonal" herpes or shingles) are not life-threatening but can be extremely painful. Both viruses are also capable of causing retinitis and encephalitis (which can also be life-threatening). Both herpes simplex and herpes zoster are usually diagnosed by a simple examination of the affected area, and may be treated with drugs such as acyclovir, famciclovir and valacyclovir.

3.5.6 Histoplasmosis

Histoplasmosis is a fungal infection that primarily affects the lungs but may also affect other organs. Symptoms can include fever, fatigue, weight loss and difficulty in breathing. Disseminated histoplasmosis infection may be diagnosed using an antigen test, and can be fatal if left untreated. Treatment usually involves amphotericin B or itraconazole.

3.5.7 Kaposi's Sarcoma

HIV-associated kaposi's sarcoma causes dark blue lesions, which can occur in a variety of locations including the skin, mucous membranes, gastrointestinal tract, lungs or lymph nodes. The lesions usually appear early in the course of HIV infection. Treatment depends on the lesions' symptoms and location. For local lesions, injection therapy with vinblastine has been used with some success. Radiotherapy can also be used, especially in hard-to reach sites such as the inner mouth, eyes, face and soles of the feet. For severe widespread disease, systemic chemotherapy is the preferred treatment.

3.5.8 Leishmaniasis

Leishmaniasis is transmitted by sand flies and possibly through sharing needles. The most serious of its four forms is visceral leishmaniasis (also know as kala azar) which is characterised by irregular bouts of fever, substantial weight loss, swelling of the spleen and liver and anaemia. In its more common forms, leishmaniasis can produce disfiguring lesions around the nose, mouth and throat, or skin ulcers leading to permanent scarring. Treatment of leishmaniasis with

pentavalent antimony is relatively expensive, partly because of the cost of drugs but also because hospital admission is recommended.

3.5.9 Mycobacterium Avium Complex

The germs of the mycobacterium avium complex (MAC) are related to the germ that causes tuberculosis. MAC disease generally affects multiple organs, and symptoms include fever, night sweats, weight loss, fatigue, diarrhoea and abdominal pain. This should be treated using at least two antimycobacterial drugs to prevent or delay the emergence of resistance. Such drugs include clarithromycin, azithromycin, ethambutol and rifabutin.

3.5.10 PCP

PCP is caused by a parasite that infects the lungs. It was formerly called pneumocystis carinii but has now been renamed, pneumocystis jiroveci. PCP is a frequent HIV associated opportunistic infection in industrialised countries but appears to be less common in Africa. The symptoms are mainly pneumonia along with fever and respiratory symptoms such as dry cough, chest pain and dyspnoea. Definitive diagnosis requires microscopy of bodily tissues or fluids. Severe cases of PCP are initially treated with TMP-SMX or clindamycin and oral primaquine. Mild cases can be treated with oral TMP-SMX throughout. With both of these regimens, toxicity (notably allergic-type reactions) often requires changes in therapy. Prevention of PCP is strongly recommended for HIV-infected persons with very weak immune systems wherever PCP is a significant health problem for HIV-infected persons, and also after their first episode of PCP. The preferred drug is usually TMP-SMX.

3.5.11 Toxoplasmosis

Toxoplasmosis (toxo) is caused by a protozoan found in uncooked meat and cat faeces. This microbe infects the brain and can cause headache, confusion, motor weakness and fever. In the absence of treatment, disease progression results in seizures, stupour and coma. Disseminated toxo is less common, but can affect the eyes and cause pneumonia. Definitive diagnosis of toxo requires radiographic testing (usually a CT or MRI scan). The infection is treated with drugs such as pyrimethamine, sulfadiazine and clindamycin. Leucovorin may also be used to prevent the side-effects of pyrimethamine.

3.5.12 Tuberculosis

Tuberculosis (TB) is a bacterial infection that primarily infects the lungs. Tuberculosis is the leading HIV-associated opportunistic disease in developing countries. For people who are dually infected with HIV and TB, the risk of developing active tuberculosis is 30-50 fold higher than for people infected with TB alone. And because mycobacterium can spread through the air, the increase in active TB cases among dually infected people means:

- more transmission of the TB germ
- more TB carriers
- more TB in the whole population.

Tuberculosis is harder to diagnose in HIV-positive people than in those who are uninfected. The diagnosis of TB is important because TB progresses faster in HIV-infected people. Also, TB in HIV-positive people is more likely to be fatal if undiagnosed or left untreated. TB occurs earlier in the course of HIV infection than many other opportunistic infections. A proper combination of anti-TB drugs achieves both prevention and cure. Effective treatment quickly makes the individual non-contagious, which prevents further spread of the TB germ. The DOTS (directly observed short course) treatment strategy recommended by WHO treats TB in HIV-infected persons as effectively as it treats those without the virus. A complete cure takes 6 to 8 months and uses a combination of antibiotics. In addition to curing the individual, it also prevents further spread of the disease to others. This is why treating infectious cases of TB has important benefits for society as a whole.

Isoniazid preventive therapy is recommended as a health-preserving measure for HIV-infected persons at risk of tuberculosis, as well as for those with latent tuberculosis infection.

4.0 CONCLUSION

Some opportunistic infections are easier to treat than others. Effective treatment depends on health services, being able to procure, store, select and administer the necessary drugs and to provide related treatment, care and diagnostic services to monitor health status and treatment response. A few opportunistic infections and symptoms such as candidiasis of the mouth, throat or vagina (thrush), herpes zoster (shingles) and herpes simplex can be managed effectively through home-based care. In a home-based care setting, diagnosis is made by observing symptoms. Some opportunistic infections may be diagnosed by observation or using a microscope, and treated where there is minimal health infrastructure.

Such infections include pulmonary tuberculosis and cryptococcal meningitis. For people who have already contracted an opportunistic infection and undergone successful treatment, secondary prophylaxis may be advisable to prevent recurrence. This applies to diseases such as tuberculosis, salmonella, cryptococcosis and PCP.

5.0 SUMMARY

In this unit, we have defined opportunistic infections and the need to prevent and treat them. We have also examined different conditions that have opportunistic advantage on those who suffers HIV/AIDS.

6.0 TUTOR MARKED ASSIGNMENT

People with advanced HIV infection are vulnerable to infections. Describe 3(three) opportunistic infections that are often attached to HIV/ AIDS.

Answer to Self Assessment Exercise

HAART is a short form of Highly Active Antiretroviral Therapy which reduces the amount of HIV in someone's body and restores their immune system. It has contributed in no small way to reducing the incidence of opportunistic infections among HIV-positive people who have received the drugs. However, millions of people living with HIV in resource-poor communities do not have access to HAART. It is suggested that people with acute opportunistic infections should begin HAART immediately as a first line of treatment.

7.0 REFERENCES/FURTHER READINGS

CDC (2004). “Treating Opportunistic Infections Among HIV-infected Adults and Adolescents”.

US PHS (2002). “Guidelines for Preventing Opportunistic Infections Among HIV-infected Persons”.

UNAIDS (1998). “HIV-related Opportunistic Diseases, Technical Update”, UNAIDS the Best Practice Collection.

WHO “Prevention and Treatment of HIV-related Infections”

WHO (2006). “Guidelines on Co-trimoxazole Prophylaxis for HIV-related Infections among Children, Adolescents and Adults in Resource-limited Settings”.

UNIT 3 SAFETY MEASURES

CONTENTS

1.0 INTRODUCTION

"Prevention is better and cheaper than cure." This old adage remains fresh and undisputable. A cursory look at the varying causes of HIV/AIDS has not foreclosed this premise. This unit thus examines the various safety measures capable of helping to reduce the menace of HIV/AIDS at home, at the workplace and in the society at large.

2.0 OBJECTIVES

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

- Identify those who are at risk of HIV/AIDS
- Outline the safety measures for the target group
- Enumerate the pharmaceutical services
- Describe the measures for caring for those affected with HIV/AIDS.

3.0 MAIN CONTENT

3.1 Safety Measures for Target Group

These are measures that essentially apply to risk groups such as long distance truck drivers, prostitutes, youths, intravenous drug users, market women and medical personnel.

1. Maintain regular and faithful sex partners. Do not share partners or engage in group sex.

2. Avoid patronising commercial sex workers. The highest percentage of HIVS/AIDS cases has been reported with this group.
3. Always use condoms if you must have casual sex but do not rely on them. The tensile strength of some condoms is inadequate because of our tropical environmental condition. A sizeable number of them tear during use. Moreover the pore sizes are much larger than the largest viral particle; hence do not offer absolute protection against HIV infection.
4. Do not share injection needles or other surgical appliances. Insist on fresh ones.
5. Do not patronise unqualified medical personnel for injection, tattooing, circumcision and scarification. If you must do any of the above, provide your own blades or surgical equipment.
6. Request and insist that your traditional medical practitioners use fresh blades or other incision instruments when any cut, or incision or scarification is to be made.
7. Insist that your barber disinfect his instruments before he applies them on you.
8. Do not donate blood if you have engaged in risky behaviors.

3.2 Safety Measures for Medical Personnel

1. Assume that all blood, blood products and other body products and other body fluids are infectious and adopt measures to prevent direct contact with them.
2. Sterilise all re-useable needles and syringes, surgical and skin piercing instruments after use.
3. Screen all blood for HIV before transfusion. It is worthwhile to maintain this standard in all situations so as to ensure safety.
4. Wash your hands with soap and disinfectant after any accidental exposure to blood, semen, vaginal secretions and body fluids.
5. Wear hand gloves during vaginal examinations, dental procedures and when in contact with blood.
6. Decontaminate all re-usable instruments immediately after use, then disinfect or sterilise them.
7. In case of accidental cuts, or needle stabs, wash the area thoroughly with soap and disinfect with suitable and effective agents.
8. Spills of body fluids and blood should be well cleaned using suitable disinfectants such as preparations containing chlorine.
9. Wash your hands with soap and water after working with a patient and before you start with a patient or another patient.
10. Avoid blood transfusion to patients except in critical cases and where there are no alternatives/options.

3.3 Safety Measures for the General Public

General preventive and control measures are needed for the general public and the main interests here are as follows:

1. To prevent HIV infection
2. To prevent and control cross-infection
3. To reduce the personal and social impact of HIV and to care for those already infected
4. Preventive measures for the general populace are designed to prevent the spread due to ignorance.

3.4 Pharmaceutical Services

1. Drug information for AIDS patients:Information on new drugs and therapies, medical literature (such as newsletters, computer bulletins, etc) must be available to all concerned.
2. Protection of patients: It is the ethical and legal responsibility of the pharmacist and others involved in AIDS patient care, to protect their confidentiality.
3. Counselling of HIV patients: Counsel patients from time on the use of medical devices and appliances.

For example, provide them with the following information;

a. The use of condoms made of latex as more effective barrier to the virus than lambkin or natural membrane that are porous.
b. Using a spermicidal along with a condom may provide additional protection.
c. It is safer to use condoms with a lubricant

All health providers involved in the care of HIV/AIDS patients should provide needed information to the patients and others in the community, including those who do not have AIDS. Health care providers should also emphasise prevention, which is often said to be safer and cheaper than cure.

3.5 Caring for the Affected People

1. Information, education and awareness creation: These three are the key to AIDS prevention. It is only through enlightenment and information that people can voluntarily and individually decide to change some of their risky behaviours. It should be remembered that such behaviours are private and often known to the individual alone. The media must be fully involved in the

dissemination of information to the general public and not to AIDS victims alone.

SELF ASSESSMENT EXERCISE 1

Describe the "ABC" acronym of HIV/AIDS prevention.

_____

_____

2. Health and social services for patients: Information and education programmes alone do not sustain prevention. A supportive social environment and health services must be put in place especially for those already infected

   The HIV infected individual needs counseling so also do their sexual partners and family members. A supportive social environment such as tolerance, avoidance of discrimination towards the infected individual at the workplace and at home, helps to protect and give assurance to the victim. There is no health rationale for the isolation of HIV/AIDS patients. What they need is empathy and understanding, and not pity. Actually, existing prejudices serve to scare people from volunteering for HIV screening. Certain health and social services such as counselling for I.V drug users, provision of free sterile needles and syringes to intravenous drug users during the period of counselling and drug withdrawal and supply of drugs free or at subsidised rates to strengthen people's capacity to make long term behaviour changes, should be put in place

   Treatment with drugs is a very crucial and integral part of HIV/AIDS control and in line with the National Drug Policy launched in 1990. It is absolutely necessary to make available at all times, drugs which are very effective, affordable, safe and of good quality in all sectors of health care through the rational use of drugs.

4.0 CONCLUSION

It is now well established that sexual activity is the main transmission route of HIV and with the lack of medical protection against AIDS, safer sex appears the surest option. However, more research and further studies of actual practice are necessary to confirm this and to specify the degree of protection which probably varies under different conditions of use. Contraceptive spermicidal may also inhibit HIV transmission.

There is also need for behavioral change as high rates of sexual contact with multiple partners is also incriminated in AIDS spread, as reports from developed and developing countries indicate that prostitutes and their clients are usually the first victims of AIDS in all circumstances. There is therefore greater need for awareness creation and effective mobilisation of human, material, medicinal and financial resources towards the effective control of the AIDS scourge.

5.0 SUMMARY

Due to the adverse effects of the ART drugs, particularly toxicity, combination therapy is preferable and in vogue.

There are other care services apart from treatment for HIV/AIDS victims and these include counselling, drug information and community services.

There are also preventive measures in place which include those targeted at specific groups such as the commercial sex workers (CSW), medical personnel, HIVS/AIDS patients and the general public.

6.0 TUTOR MARKED ASSIGNMENT

Describe the place of behavioural change as a means to ensuring safety in the fight against HIV/AIDS.

Answer to Self Assessment Exercise

ABC = A=Abstinence.
B= Be faithful to your partner
C= Contraceptives

(You are expected to explain further measures to achieve these).

7.0 REFERENCES/FURTHER READINGS

FMOH (1992). *Care of a Person with AIDS in the Community*. Lagos,Nigeria:Federal Ministry of Health and Social Services.

TDR News (2007). *Enhancing Drug Discovery for Neglected Tropical Diseases*. Published by WHO, Geneva.

UNAIDS (2001). *Sources and Prices of Selected Drugs and Diagnostics for People Living with HIVS/AIDS*.

MODULE 4 HEALTH SYSTEM BASED ON PRIMARY HEALTH CARE AND PUBLIC HEALTH ORGANISATIONS

UNIT 1 ORGANISATION OF THE HEALTH SYSTEM BASED ON PRIMARY HEALTH CARE

CONTENTS

1.0 INTRODUCTION

Please recall the definition of Health by WHO, the concepts and principles of primary health care as well as the goals for achieving the Health for All concept .In this unit, we shall be discussing the definition and essential characteristics of the health system. We shall also focus our attention on the organisation of the health system structure at federal, state and local levels. At the end, we will consider the organisational structure based on primary health care which mainly focuses on rural health services.

2.0 OBJECTIVES

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

- Define the health system
- List the characteristics of the health system
- Describe the organisational structure of the health system at the federal, state and local levels and
- Explain the roles and organisation of the National Primary Health Care Development Agency.

3.0 MAIN CONTENT

3.1 Meaning and Characteristics of the Health System Based On Primary Health Care

The health system can be broadly defined as the coherent whole of many interrelated components, both sectoral and intersectoral, as well as the community itself, which produces a combined effort on the health of the population. The health system should consist of coordinated parts extending to the home, the work place, the school and the community.

You may wish to ask what interrelated components are. The components of the health system include concepts (e.g. health and disease), ideas (e.g. equity coverage, effectiveness, efficiency, and impact), objects (e.g. hospitals, health centers, and health programmes) and persons (e.g. providers and consumers). Together, these form a united whole in which all the components interact to support one another. Of all these components discussed here we shall mainly highlight the objects and persons (health system infrastructure).

The health system aims at delivering health services to the beneficiaries. It constitutes the management sector and involves organisational matters and also allocation of resources, translating policies into services, evaluation and health education.

The aim of the health system is health development, which includes continuous and progressive improvement of the health status of a population i.e. community. The health system encompasses the promotive, preventive, curative and rehabilitative aspects of health and also caters for the extremely disabled and incurable.

These characteristics and principles are applicable to all health systems based on primary health care.

- The system should encompass the entire population on the basis of equality and responsibility. It should include components from the health sector and from other sectors whose interrelated actions contribute to health (e.g. the education sector, public works, animal husbandry and the agricultural sector etc). Health is a subject of the overall socio-economic milieu of the community.
- Primary health care, consisting of at least the essential elements included in the declaration of Alma-Ata, should be delivered at the first point of contact between individuals and the health system.
- At intermediate levels more complex problems should be dealt with and more skilled and specialised care as well as logistic support should be provided.
- Better trained staff, i.e. supervisory staff, should provide continuing education/training for primary health care workers, as well as guide the public of different communities and community health workers on practical problems arising in connection with all aspects of primary health care.
- The central level should co-ordinate all parts of the system and provide planning and management expertise. It should also provide highly specialised care and teaching for specialised staff.

SELF ASSESSMENT EXERCISE 1

Fill in the blanks:

i. The health system is defined as the coherent whole of many------ parts, both ------ and------- as well as the community itself.
ii. The aim of the health system is ----------
iii. The health system constitutes the management sector and involves---------- matters

3.2 Structural Organisation Of the Health System

Health care services in Nigeria are organised at three levels: Federal, state and local levels.

3.2.1 Organisation at the Federal Level

The official “organs” of the health system at the federal level consists of the Federal Ministry of Health and the National Council of Health. We shall examine the organisation and function of each of them.

.

The Federal Ministry of Health is headed by a minister and it has departments. They are:

- Department of Human Resources/Personnel Management
- Department of Finance and Supplies

- Department of Planning, Research and Statistics
- Department of Hospital Services
- Department of Primary Health Care and Disease Control

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

1. Review of the National Health Policy and its adoption by the Federal Government
2. Devising a broad strategy for giving effect to the National Health Policy through the implementation by the federal, state and local governments in accordance with constitutional provisions.
3. Submission of a broad financial plan to the Federal Government for approval to give effect to the Federal component of the health strategy.
4. Formulation of a national health legislation as required, for the consideration of the Federal Government.
5. Acting as coordinating authority on all health work in the country with a view to ensuring prompt implementation.
6. Undertaking related epidemiological surveillance and report.
7. Promotion of an informed public opinion on matters of health.
8. Provision of support for state and local governments in developing strategies and plans of action.
9. Allocation of Federal resources in order to foster selected activities to be undertaken by state and local governments
10. Issuance of guidelines and principles to assist states prepare, manage, monitor and evaluate their strategies and related technical programmes, services and institutions.
11. Defining standards with respect to the delivery of health care, monitoring and ensuring compliance with them by all concerned.
12. Promotion of research that is relevant to the implementation of the National Health Policy and state health strategies.
13. Promotion of cooperation among scientific and professional groups as well as non-governmental organisations in order to attain the goals of this Policy.
14. Monitoring and evaluating the implementation of this Policy on behalf of the Federal Government.

International Health

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

- Ensuring technical cooperation on health with other nations of the region and the world at large.

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

The National Council on Health

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

1. The Honorable Minister of Health
2. The Honorable Commissioner s of Health (states)
3. The Technical Committee and
4. The Expert Panels

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

- The development of national guidelines
- The implementation and administration of the National Health Policy
- Various technical matters on the organisation, delivery and distribution of health services.

The Technical Committee

The Technical Committee shall be composed of:

The Federal and State Permanent Secretaries of Health
The Directors of the Federal Ministry of Health
The Professional Heads in the State Ministries of Health
Representative of the Armed Forces Medical Services
Director of Health Services, Federal Capital Territory, Abuja

Function of the Committee

Advise the Council on health matters.

The Expert Panels

The Technical committee shall set up as required, appropriate programme expert panels including the representatives of health related ministries namely: Agriculture, Rural Development and Water Resources, Education, Science and Technology, Labour, Social Development, Youth and Sports, Works and Housing, National Planning and Finance.

Health related bodies

1. National Institute of Medical Research
2. Medical schools
3. Schools of allied health professionals
4. Professional health associations, e.g. The Nigerian Medical Association, The National Association of Nigerian Nurses and Midwives, The Pharmaceutical Society of Nigeria, among others
   Non governmental organisations (NGOs)

3.2.2 Organisation at the State Level

Today in Nigeria, there are 36 states and the Federal Capital Territory**,** Abuja with many types of health administration. In most of the states, the management sector for health lies with the Ministry of Health while in very few it is the Health Management Board.

The State Ministry of Health

Organisation: The State Ministry of Health is headed by an Honorable Commissioner, while in the Health Management Board there is a governing board with an Executive Secretary. The Commissioner is the political head of the Ministry while the Permanent Secretary is the administrative/accounting officer. There are Directors managing the affairs of each Directorate and they are assisted by Deputy and Assistant Directors.

Functions: The State Ministries of Health direct and coordinate health work within the state via:

- Ensuring political commitment
- Ensuring economic support
- Winning over professional groups
- Establishing a managerial process

- Public information and education
- Financial and material resource provision
- Intersectoral action
- Coordination within the health sector
- Organising primary health care in communities
- Logistic system
- Health manpower recruitment and retraining
- Priority health programmes
- Health technology

SELF ASSESSMENT EXERCISE 2

Draw an organogram of the health structure in your state stating their specific functions.

3.2.3 Organisation at the Local Government Level

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

The Local Government headquarters coordinate the activities of the health facilities providing manpower, funds, logistics and control. The LGAs are headed by elected Chairmen during the political era with council members. The Supervisory Councillors are also appointed to oversee various aspects of the local governments' activities including health and social services. The Health Department is always headed by a Primary Health Care Coordinator.

Functions of the Local Government

- Provision and maintenance of essential elements of primary health care: environmental sanitation, health education, etc.
- Designing and implementing strategies to discharge the responsibilities assigned to them, under the Constitution and to meet the health needs of the local community under the general guidance, support and technical supervision of state ministries.
- Motivation of the community to elicit the support of formal and informal leaders.
- Devising local strategy for health activities.

Examine this illustration which provides an overview of health care delivery system at the three levels of health care i.e. primary, secondary and tertiary levels. As you know a full range of primary health care (first level contact of the individual, family and community health system) is being rendered through the agency of primary health centers

Secondly, health care is being provided through the establishment of cottage and general hospitals where all basic specialty services are being made available.

Tertiary care is being provided at teaching and specialist hospitals where super specialty services including sophisticated diagnosis specialised therapeutic and rehabilitative services are available.

3.3 Structural Organisation of the Health System Based on National Primary Health Care Agency

The Federal Government of Nigeria as a member nation and signatory to the Alma-Ata Declaration has shown a deep commitment to achieving the goal of Health for All through the primary health care approach. Keeping in view the goal of HFA, the National Health Policy laid down a plan of action for orienting and shaping the existing rural health infrastructure within the frame work of various year plans. The establishment of primary health centers in Nigeria in 1986 under the National Primary Health Care Development Agency has been a valuable asset in our efforts to increase the outreach of our health system based on primary health care.

3.3.1 Organisation of the Agency

At the Federal level

The Agency as an administrative autonomous agency is directly supervised by the Federal Ministry of Health with the following composition:

- Board of Directors
- Executive Director
- Scientific Committee made up of various experts with relevant skills.

The Board consists of the following memberships:

- The Chairman – a highly respected primary health care practitioner;
- The Secretary who serves as the Executive Director of the Agency;
- The Federal Director of Primary Health Care & Disease Control;
- A representative of the Conference of Provosts of Colleges of Medicine;
- A representative of the Conference of Principals of Schools of Health Technologies;
- A representative of the National Association of Nigerian Nurses and Midwives(NANNM);

- One State Ministry of Health representative from each PHC zone nominated by the National Council of Health on a rotational basis to serve for a period of 3 years;
- One LGA representative of the Association of Local Government Chairmen (ALGON) from each PHC zone on rotational basis to serve for a period of 3 years;
- A representative of the National Planning Commission;
- A representative of NGOs working in PHC;
- A representative of the National Commission for Women

Functions of the Board

The Board has a small core of professional staff at the Federal Level who is expected to follow the guiding principles of team work and polyvalence and draw on outside expertise to the maximum extent possible. It shall carry out the following functions:

- Receive reports on the state of development of the national PHC programme;
- Approve the activities of the Agency and its budget;
- Have overall responsibilities for personal matters;
- Assist with the mobilisation of funds.

At the Zonal Level

The Agency at the zonal level shall collaborate with the State Ministries of Health to strengthen LGA PHC systems; it is organised in the same way as the LGA PHC Departments with the appointment of Assistant Coordinators to provide the LGAs with the required technical assistance in the following areas:

- Family health services: maternal and child health services, essential drugs and drug revolving fund, and health education, community mobilisation, water and sanitation;
- Promotion of health education: development of the managerial process through the establishment of a committee and training of committee members at all levels;
- Records, monitoring and evaluation, collection, collation and analysis of monthly reports from all LGAs. and states;
- Development of capabilities at LGA level to analyse and make use of monitoring and evaluation data for management decision-making;
- Writing periodic zonal reports and widely disseminating same; establishment and maintenance of zonal resource centre;
- Serving as focal point support of PHC project formulation in LGAs in the zone.

3.3.2 Functions of the Agency

The functions of the Agency include:

- **Supporting the Health Policy**

1. Review existing health policies, particularly as to their relevance to the development of PHC and to the integrated development of health services and health manpower and propose changes when necessary;
2. Prepare alternatives for decision makers at all levels based on scientific analysis, including proposals for health legislation;
3. Conduct studies on health plans for PHC at various levels to see whether they are relevant to the National Health Policy, feasible and multi-sectoral.
4. Promote the monitoring of PHC implementation of various levels;
5. Stimulate the development of PHC technical support on an equitable basis in all LGAs, for example technical support to the implementation of selected PHC components as required. This assistance will be provided strategically to enhance orderly development, for example, to improve upon or introduce new skills required for the service or to integrate new components into them.

- **Resource Mobilisation**

1. Mobilise resources nationally and internationally in support of the programme of the Agency.
2. **C**onduct or commission studies on resource mobilisation for health and issues of cost and financing, with particular reference to equity.

- **Supporting Monitoring and Evaluation**

1. Monitor the development of the nation's PHC programme so that it keeps as much as possible within the guidelines set out for its development in the National Health Policy and PHC guidelines and training manuals;
2. Develop guidelines and design a frame work for the periodic evaluation of primary health care at various levels;
3. Monitor the monitoring and evaluation process nationally, with particular respects to the development of capabilities of LGA level to analyse and make use of monitoring and evaluation date for management decision making.

- **Providing Technical Support**

1. Provide technical support to the preparation of a health manpower policy, including manpower projections to enable the development of PHC manpower plan;
2. Provide advocacy and support for the orientation of medical undergraduate education as well as the education of other health professionals towards PHC;
3. Identify orientation and continuing education needs of PHC manpower, including medically organised programmes to meet these needs using schools of health technology as resources;
4. Support directly the strengthening of the schools of allied health to meet the set goals.

- **Supporting the Village Health System:** In view of the importance of this level of the national health system in extending coverage, the Agency should:

1. **P**ay special attention and provide maximum support to the training, deployment, logistics support and supervision of village health workers and TBAs. It should examine the relationship between these workers and their communities and the mechanisms which link these workers to the other levels of the health system;
2. **P**ay special attention to the involvement of women and grass-roots women's organisations in the village health system.

- **Health System Research (HSR)**

1. Promote and support problem-oriented HSR as tool for finding better ways for the provision of essential care as a component of health for all, in particular the introduction of HSR in the LGA health system and the support of the other levels of this effort.
2.. Undertake or commission HSR operations research into the functioning of PHC programmes;
3. Respond to request from government and other agencies in organising special studies by mobilising experts who will respond rapidly and in depth to guide legislative and administrative action.

- **Technical Collaboration**

1. Stimulate universities, NGOs and international agencies to work with LGAs in nurturing their capacity for problem solving;
2. Develop LGAs' capacity to seek technical collaboration in developing and implementing their PHC programmes;
3. Promote collaboration with other sectors at all levels in the development and support of LGA primary health care system;
4. Monitor the collaboration for PHC between international agencies and government at all levels;
5. Promote and organise both the sharing of experience of the agency within the community (publications, reports, visitors, etc) and the collection of all relevant information from other countries and international organisations and disseminate it to all interested parties;
6. Promote maximum support to all its efforts by networking and creating formal and informal collaboration with relevant Nigerian and international institutions.

- **Promoting PHC Activities through**

1. Advocacy at the level of community leaders, mass media and NGOs to promote PHC, making particular efforts to ensure that elected officials and party functionaries are continually oriented towards PHC and HFA;
2. Re-orienting health professionals towards PHC by means of conferences, seminars and other meetings;
3. Providing support for the documentation of PHC through commissioning of case studies, reviews, books, articles, newsletters and other media productions as appropriate;
4. The establishment of resources centers to serve as national and zonal depositories of information on PHC implementation;

5. Seminars, reviews and other meetings to promote PHC and share experiences in implementation, with a view to strengthening LGA health systems;
6. The provision of annual reports which are widely disseminated on the status of PHC implementation nation-wide.

SELF ASSESSMENT EXERCISE 3

Highlight the 8 functions of the Primary Health Care Agency

4.0 CONCLUSION

The health system is a coherent whole of many interrelated components parts (sectoral and intersectoral) as well as the community itself producing a combined effect on the health of the population. Thus the health system is organised at three levels namely federal, state and local levels.

5.0 SUMMARY

In this unit we have discussed the following:

- The organisation of the health system in Nigeria at the federal, state and local levels. The official organs at the federal level are the Federal Ministry of Health and the National Council on Health, State Ministry of Health at the state level and the Department of Health at the local government areas.
- The structural organisation of the health system is based on national primary health care agency which focuses on primary health care.

6.0 TUTOR MARKED ASSIGNMENT

What are the expected roles of the following in the control of HIV/AIDS:

- The National Council on Health
- The Primary Health Care Agency

Answer to Self Assessment Exercises

Exercise 1

i. interrelated, sectoral and intersectoral
ii. development
iii. organisation

Exercise 2

Individual representation of the organogram of the State Ministry of health with their functions

Exercise 3

i. Supporting the health policy
ii. Promoting PHC activities
iii. Technical collaboration
iv. Health System Research (HSR)
v. Supporting the village health system:
vi. Technical support
vii. Supporting Monitoring and Evaluation
viii. Resource mobilisation

7.0 REFERENCES/FURTHER READINGS

Santhosh, M. (2000). *Primary Health Nursing* (PHN) Indria Gandhi National Open University, New Deli: Berny Art Press.

UNIT 2 MONITORING AND EVALUATION OF PRIMARY HEALTH CARE SERVICES

CONTENTS

1.0 INTRODUCTION

In the previous units, you learnt the organisation of the health system based on primary health care and the action required for promoting and supporting it, which is the hallmark of the global strategy of Health for All. Health service resources such as manpower, money and materials are needed to meet the many health needs of a community and no nation however rich, has enough resources to meet all the needs of her citizens. Therefore, an assessment of the available resources, their proper allocation and efficient utilisation are important considerations for providing efficient health care services. This and many more will be considered in this unit to help you know how to monitor and evaluate the primary health care services you are to provide.

2.0 OBJECTIVES

After completing this unit, you should be able to:

- Explain the action required for developing monitoring and evaluation
- Identify the process involved in monitoring and evaluation

- Describe the elements of evaluation process
- Appraise the indicators for health measurement

3.0 MAIN CONTENT

3.1 Monitoring and Evaluation

Manpower, money and materials are resources for health services in any country and the distribution is expected to cover the entire country and to cover specific programmes or tasks with definite goals.

In order to appreciate the progress in the implementation of any strategy and to evaluate the effectiveness in improving the health status of the people it is essential to set up a process of monitoring and evaluation. The success of any programme depends on constant monitoring of its different activities by the guidance of an inbuilt predetermined system of monitoring and evaluation right at the stage of its inception. The monitoring process and evaluation are complementary to each other to observe and assess the progress of a planned programme.

3.1.1 Monitoring and Surveillance

These words are often used interchangeably, however, in public health practice during the past 25 years they have taken on a rather different meaning.

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

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

2. **Surveillance:** Surveillance is defined in any of these ways. It means watching over with great attention and authority, the minute details in a situation. It can also be defined as the continuous scrutiny of the factors that determine the occurrence

and distribution of disease and other conditions of ill health. Surveillance programmes can assume any character and dimension – thus we have epidemiological, demographic and nutritional surveillance among others.

The main objectives of surveillance are:

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

According to the above definitions, monitoring becomes one specific and essential part of the broader concept embraced by surveillance. Monitoring requires careful planning and the use of standardised procedures and methods of data collection, but can then be carried over extended periods of time by technicians and automated instrumentation. Surveillance, in contrast, requires professional analysis and sophisticated judgment of data leading to recommendations for control activities.

3.1.2 Evaluation

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

Evaluation is the process of comparing results with intended objectives. It is usually crucial in identifying the health benefits derived (impact on morbidity, mortality, and patient satisfaction). Evaluation is useful in identifying performance difficulties, generating information to attract attention to a problem and in the extension of control activities, training and patient management.

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

3.2 The Evaluation Process

3.2.1 Elements of The Evaluation Process

Evaluation is perhaps the most difficult task in the whole area of health services. It has the following components:

- Relevance: This is also referred to as requisiteness which relates to the appropriateness of the service whether it is needed at all. If there is no expressed need, the service can hardly be of any value.
- Adequacy: It implies that sufficient attention has been paid to a certain previously determined course of action; the programme may be described as inadequate if sufficient attention was not paid to the quantum of work load and target to be achieved.
- Accessibility: It is the proportion of the given population that can be expected to use a specified facility or service. The barriers to accessibility may be physical, social and cultural.
- Acceptability: This is to examine if the service provided is acceptable to all, e.g. male sterilisation, insertion of Copper T as a form of family planning.
- Effectiveness: It is to measure the extent to which the underlying problem is prevented or alleviated. This tool thus measures the degree of attainment of the predetermined objectives and target of the programme, service or institution expressed, if possible, in terms of health benefits, problem reduction or an improvement of an unsatisfactory health situation.
- Efficiency: It measures how well resources (men, money, material and time) are utilised to achieve a given effectiveness.
- Impact:It is an expression of the overall effect of a programme, service or an institution on health status and socioeconomic development.

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

3.2.2 General Steps of Evaluation

1. Determination of what is to be evaluated; Here you must know what exactly is to be evaluated. Is it the **evaluation of structure** which includes the facilities, equipment, manpower and organisation, and does it meet the standard accepted by the experts? Is it the **evaluation of the process** of carrying out the given tasks such as problem recognition, diagnostic procedures, treatment and clinical

management, care and prevention? An objective and systematic way of evaluating the physician's (or nurse's) performance is known as "medical audit" Is it also the **evaluation of outcome** which is concerned purely with the end result, whether it measures the benefits of improved service or reduced disability. It often uses the 5Ds of ill health: disease, death, disability, discomfort and dissatisfaction.

2. Establishment of standards and criteria: Standards and criteria must be established to determine how well the desired objectives have been attained. Naturally, such standards are a prerequisite for evaluation. Standards and criteria to be used must be developed in accordance with the focus of evaluation: structure, process and outcome criteria.
3. Planning the methodology: A format in keeping with the purpose of evaluation must be prepared for gathering information desired and must be included at the planning stage.
4. Gathering information: Evaluation requires collection of data or information. These may include political, cultural, economic, environmental and administrative factors influencing the health situation as well as mortality and morbidity statistics. It may also concern health and related socio-economic policies, plans, programmes and use of health systems, services and institutions.
5. Analysis of results: The analysis and interpretation of data and feedback to all individuals concerned should take place within the shortest time feasible once information needed has been gathered. It is also expected that the evaluation results will be discussed with all concerned.
6. Taking action: Emphasis should be placed on actions designed to support, strengthen or otherwise modify the services involved if evaluation will be truly productive. This may call for shifting priorities, revising objectives, or developing new programmes or services to meet previously unidentified needs.
7. Re-evaluation: Evaluation is an on-going process aimed mainly at rendering health activities more relevant, more efficient and more effective.

3.4 Indicators Of Health Monitoring And Evaluation

Now that you have been exposed to the process of monitoring and evaluation of health services implemented to uplift the health of the people, the level of health has to be measured in some units in kilogrammes for weight and metres for height. For this purpose, we shall be considering different health indicators to measure the quantitative and qualitative variables in health.

Indicators are only an indication of a given situation or a refection of that situation. In W.H.O's guidelines for health programme evaluation,

indicators are defined as variables which help to measure changes. Often they are used particularly when these changes cannot be measured sequentially over time, they can indicate direction and speed of change and serve to compare different areas of people at the same moment in time.

3.4.1 Characteristics of Indicators

Indicators with scientific respectability must have the following characteristics:

- Validity:
- Reliability and objectivity
- Sensitivity: They should be sensitive to changes in the situation concerned.
- Specificity: They should reflect changes **only** in the situation concerned**.**

3.4.2 Broad Classification of Indicators in Health Measurement

Heath is multidimensional in nature and each dimension is influenced by numerous factors (known and unknown). No single indicator can adequately measure the health of the people. It must be conceived in terms of a profile employing many indicators like: mortality, morbidity, disability, nutritional status, health care delivery, utilisation, social and mental health, environmental indictors, socio-economic indicators, health policy, quality of life and specific situations indicators.

Mortality Indicators: some of the indicators are crude death rate, life expectancy, infant mortality rate, child mortality rate and maternal (puerperal) mortality.

Nutrition Status Indicators

They are positive health indicators. Three nutritional status indicators are considered important indicators of health. They are:

1. Anthropometrics measurements of preschool children e.g. weight and height, mid-arm circumference
2. Height and sometimes weight of children at school entry; and
3. Prevalence of low birth weight (less than 2.5kg).

Health Care Delivery Indicators

The frequently used indicators of health care delivery are: Doctor population, **n**urse population, population per hospital bed, population per health centre and population per traditional birth attendant (TBA) ratios.

Utilisation rates

The utilisation of services or actual coverage is expressed as the proportion of people in need of a service who actually receive it in a given period; usually a year. There is therefore a relationship between utilisation of health care services and health needs and status. This rate is affected by factors such as availability and accessibility of health services and the attitude of an individual towards his health and the health care system.

Socio-economic Indicators

These indicators do not directly measure health. Nevertheless, they are of great importance in the interpretation of the indicators of health care. These include:

- Rate of population increase
- Per capital Gross National Product(GNP)
- Level of unemployment
- Dependency ratio
- Literacy rates, especially female literacy rates
- Family size
- Housing: the number of persons per room
- Per capita "calorie" availability

Other indicators series are:

1. **Social indicators:** Social indicators as defined by the United Nations Statistical Office, have been divided into 12 categories namely: population, family formation, families and households, learning and educational services, earning activities, distribution of income, consumption, and accumulation, social security and welfare services, health services and nutrition, housing and its environment, public order and safety, time use, leisure and culture, social stratification and mobility.

2. **Basic needs indicators:** Basic needs indicators are used by International Labour Organisation. Those mentioned in "Basic needs performance" include calorie consumption, access to water,

life expectancy, deaths due to diseases, illiteracy, doctors and nurses per population, rooms per person, GNP per capital.

SELF ASSESSMENT EXERCISE 1

Briefly highlight the indicators of monitoring and evaluation of health services

3.4.3 Details of indicators Selected for Monitoring Progress towards Health for All

1. Health policy indicators:
   - Political commitment to Health for All
   - Resource allocation
   - Community involvement
   - Organisational framework and managerial process.

2. Social and economic indicators related to health are: Rate of population, increased GNP or GDP (Gross National Product or Gross Domestic Product), income distribution, work conditions, adult literacy rate, housing, food availability.

3. Indicators for the provision of health care includes: availability, accessibility, utilisation, quality of care.

4. Health status indicators include: low birth weight, nutritional status and psychosocial development of child, infant mortality rate, child mortality rate (1 – 4 years), life expectancy at birth, maternal mortality rate, disease specific mortality, morbidity incidence and prevalence and disability prevalence

4.0 CONCLUSION

Monitoring and evaluation are the essential parts of the strategy for implementing Health for All. To monitor progress during the implementation and to evaluate its effect, a suitable process for monitoring and evaluation must be put in place with appropriate indicators. At the global level, evaluation will be based on the number of countries in which certain indicators comply with predetermined norms. These are: endorsement of policy at the highest official level, availability of primary health to the whole population and using the W.H.O. mechanisms for reporting on progress and accessing the impact of the strategy.

5.0 SUMMARY

In this unit, we have discussed monitoring and evaluation touching on the elements, general steps of evaluation as well as indicators of health monitoring and evaluation.

6.0 TUTOR MARKED ASSIGNMENT

Enumerate the elements for monitoring and evaluation of a health care facility.

Answer to Self Assessment Exercise

Validity, reliability and objectivity, sensitivity, and specificity.

7.0 REFERENCES/FURTHER READINGS

Lucas and Guiles, (1989). *A Short Textbook of Preventive Medicine for the Tropics* (2nd ed), ELBS.

Santhosh, M. (2000). *Primary Health Nursing (PHN)* Indria Gandhi National Open University, New Deli: Berny Art Press.

UNIT 3 SOME PUBLIC HEALTH ORGANISATIONS INVOLVED IN HIV/AIDS

CONTENTS

1.0 INTRODUCTION

Since the emergence of AIDS in the 80s, a lot of funds have been committed to the various activities and a lot more is being required for the effective control of the scourge. Multinational organistions and agencies, non-governmental bodies and individuals have been involved with their time, money and resources.

2.0 OBJECTIVES

At the end of this unit, you are expected to know the following:

- Sources of funds for HIV/AIDS activities
- The agencies and organisations involved in the support of AIDS activities.
- The roles played by them individually and collectively.

3.0 MAIN CONTENT

3.1 **3.1 Sources of Funds**

Traditionally, the donors associated with population and reproductive health activities have been the bilateral and wing of wealthy Northern governments (notably the United States, Britain, Germany, Netherlands and the Scandinavian Countries) and the major United Nations multilateral institutions notably the UN Population Fund (UNFPA) and UNICEF. Over the last decades however, North American and European donors have become increasingly reluctant to commit sufficient funds for sexual and reproductive health. Needs are being met financially and in kind by Japan, development banks (such as the World Bank and African and Asian development banks) and other quasi-private or private sources such as the Gates Foundation. In addition, notably in response to the AIDS crisis, pharmaceutical companies are offering support through donation of drugs. However, banks and private companies also participate by giving loans. Other agencies involved in AIDS funding include UNESCO, UNDCP, UNDP and UNAIDS.

Family planning, safe motherhood and HIV/AIDS continue to be the three major areas of donor funding. Accurate figures on donor financing remain extremely difficult to find, despite repeated calls for the establishment of an international tracking record system. UNFPA estimates suggest a total global budget of $ 10 billion, while little information is available on funding for HIV/AIDS services, although funding by the World Bank and other development banks is reported to have almost tripled since 1990. Funding for AIDS now appears to come predominantly from this non donor source and increasingly from the private sector.

3.2 **HIV/ AIDS Financing in Developing Countries**

Several previous studies and reports have estimated the amount spent on HIV/AIDS related activities. Some focused only on expenditure incurred by the public sector, whereas others provided more information on the sources and uses of funds for HIV/AIDS. In the early 1990s, two studies sought to estimate expenditures on HIV/AIDS in Asia, one in Thailand for 1991-92 and the other in Sri Lanka for 1993. The Thailand study highlighted HIV/AIDS expenditures by various sources of funds - the government, the donor community and the private sector. In most cases, records of expenditures on HIV/AIDS are not complete when they are available as there are often no records of pocket expenditures incurred by households, a key indicator of the economics burden of

AIDS on families and also expenditures linked to the management of HIV/AIDS related activities and research.

3.3 Agencies in Support of HIV/AIDS

Some agencies have been assisting in financing HIV/AIDS programmes. Many of the agencies are international and also multi-national and in the fore- front is the United Nations(UN) through UNAIDS – The United Nations responds to AIDS.

From 1986, the World Health Organisation (WHO) had the lead responsibility on AIDS in the UN, helping countries to set up much –needed national AIDS programmes. But by mid-1990s, it became clear that the relentless spread of HIV, and the epidemic's devastating impact on all aspects of human lives and on social and economic development, were creating an emergency that would require a greatly expanded UN effort. It also became clear that no single united Nations organisation could provide the coordinated level of assistance needed to address the many factors driving the HIV epidemic, or help countries deal with the impact of HIV/AIDS on households, communities and local economics. Greater coordination would be needed to maximise the impact of the UN efforts.

Addressing these challenges head, the UN took an innovative approach in 1996, drawing six organisations together in a joint and co-sponsored programme - the joint UN programme on HIV/AIDS (UNAIDS). The six original co- sponsors of UNAIDS- UNICEF, UNDP, UNFPA, UNESCO, WHO and the World Bank - were joined in April 1999 by UNDCP.

The goal of UNAIDS is to catalyse, strengthen, and orchestrate the unique expertise, resources and networks of influences that each of these organisations offers. Working together through UNAIDS, the co- sponsors expand their outreach through strategic alliances with other UN agencies, national governments, corporations, the media, religious organisations, community- based groups, living with HIV/ AIDS and other non- governmental organisations.

3.4 The United Nations AIDS Co- Sponsors

In developing countries, UNAIDS operates mainly through country-based staff of seven co- sponsors. Meetings are at the host country's UN theme group on HIV/AIDS. Representatives of the co-sponsoring organisations share information, plan and monitor coordinated action among themselves and with other partners and decide on joint financing of major AIDS activities in support of the

country's government and other national partners. The principal objectives of the theme group is to support the host country's efforts to mount an effective and comprehensive response to HIV/AIDS. Working singly, jointly and with the UNAIDS offer countries a broad range of expensive efforts and resources of relevance to the fight against the epidemics

3.4.1 The United Nations Children's Fund (UNICEF)

UNICEF mobilises the moral and material support of governments, organisations and individuals worldwide in a partnership committed to giving children a first call on society's resources in both good times and bad times. A decentralised operational agency, UNICEF works with government and NGOs to improve the lives of children, youth and women. UNICEF's priority programme areas in HIV/AIDS include youth, health, school AIDS education, communications, assistance to children and families affected by AIDS and the prevention of mother-to-child HIV transmission.

3.4.2 The United Nations Development Programme (UNDP)

The United Nations Development Programme supports countries in strengthening and expanding their capacity to respond to the HIV/ AIDS epidemic. UNDP emphasises support to initiatives which catalyse community and national mobilisation, create a supportive ethical legal and human rights frame work, are gender - sensitive, empowering people to take charge of their own well being drawing on local resources and building on local knowledge and values and foster an enabling political, economic and social environment . UNDP is responsible for assisting the Secretary –General in strengthening the resident co-coordinator system through which the UN theme groups on HIV/AIDS operate.

3.4.3 The United Nations Population Fund (UNFPA)

The United Nations Population Fund (UNFPA) has a mandate to build the knowledge and capacity to respond to needs in population and family planning. Reproductive health is a major focus of UNFPA support and it includes family planning and sexual health, of which HIV prevention is an integral component. In it's reproductive health activities, UNFPA gives special attention to adolescents, to information, education and communication, and to the training of service providers. Among other things UNFPA brings in UNAIDS, a network of country-level offices which support national reproductive health programmes, it's expertise in reproductive

health promotion and service delivery with a special focus on the needs of women and it's experience in logistics management of contraceptives, including the use of condoms.

3.4.4 The United Nations Drug Control Programme (UNDCP)

The United Nations Drug Control Programme (UNDCP) which became a UNAIDS co- sponsor in April 1999, is responsible for coordinating and providing effective leadership for all United Nations drug control activities. Because HIV spreads through drug use, both via shared injection equipment and as a result of the inhibiting effects of drugs on sexual behaviour, international prevention is needed. In this context UNDCP is active in supporting HIV/AIDS prevention programmes and including prevention in its own programme to reduce the demand for illicit drugs. High-risk groups are of particular concern

3.4.5 The United Nations Educational, Scientific and Cultural Organisation (UNESCO)

The United Nations Educational, Scientific and Cultural organisation (UNESCO) is to foster international cooperation in intellectual activities designed to promote human rights to help establish a just and lasting peace, and to further the general welfare of mankind. Thus, the ethical imperative is central to UNESCO's mandate. In its quest for competence – education, science, culture and communication – UNESCO can bring the vast network of institutions to collaborate into the fight against AIDS.

3.4.6 World Health Organisation

The World Health Organisation (WHO) is the directing and coordinating authority on international health work. In 1986, WHO established the special programme on AIDS later renamed Global Programme on AIDS which was chi mantled in 1996 with the creation of UNAIDS. Through WHO's new initiative on HIV/AIDS and sexually transmitted infections (STIs), the organisation contributes by providing countries with expertise in areas relevant to the health sector. These areas include straightening HIV and STI prevention (particularly for those vulnerable and/or at increased risk); ensuring safe blood supplies; surveillance of HIV/AIDS and STIs; developing health

policies and standards; planning of integrated services; caring for people with STIS, HIV or AIDS and evaluating STI/HIV policies and programmes.

3.4.7 World Bank

The mandate of the World Bank is to alleviate poverty and improve quality of life. HIV/AIDS entails an enormous loss of human and economic resources and poses a substantial threat to the economic and social growth of many nations in the developing world. Between 1986 and 1999, the bank disbursed over US $ 750 million for more than 75 HIV/AIDS projects worldwide. Most of these resources were provided on highly concessional terms through the International Development Association. Of recent, other non-governmental organisations have joined in providing support for the treatment of people affected with HIV/AIDS. Among them is The Leprosy Mission of Nigeria.

SELF ASSESSMENT EXERCISE

List four roles of UNDP and UNICEF in the fight against AIDS.

i. _____
ii. _____
iii. _____
iv. _____

4.0 CONCLUSION

A lot has been done by these agencies including non-governmental organisations and individuals but it seems we are still far away from gaining complete results. There is there for need effective collaboration and proper coordination to avoid duplication and repetition of some and similar efforts so as to quicken both the race and the pace toward total control of the disease

5.0 SUMMARY

This unit has considered the different public health organisations involved in the control and treatment of HIV/AIDS. It also examined the funding policies with a conclusion on the need for more financial and social support to curb this devastating health problem.

6.0 TUTOR MARKED ASSIGNMENT

1. Since the emergence of AIDS funds and materials have been committed to the various activities by non-governmental bodies

in the fight against the disease. Clearly justify the roles of UNDP, WHO and UNFPA in this regard.

Answer to Self Assessment Exercise

UNDP

- Supports countries in strengthening and expanding their capacity to respond to the HIV/AIDS epidemic.
- Emphasises support to initiatives which catalyse community and national mobilisation.
- Creates a supportive ethical legal and human rights frame work.
- Fosters an enabling political, economic and social environment.

UNICEF

- Works with government and NGOs to improve the lives of children, youth and women.

7.0 REFERENCES/FURTHER READINGS

Adeyi, O; Kanki, P.J; Odutolo; O and Idoko, J.A (2006).*AIDS in Nigeria: A Nation on the Threshold.* USA:Harvard University Press.

FAO and UNAIDS (1999). *Sustainable Agricultural Rural Development and Vulnerability to the AIDS Epidemic*. UNAIDS Best practice collection. December 1999.

Population Report (1983).Sources of Population and Family Planning Assistance-*Family Planning Programs Population Reports Series 1* Number 26, January to February.

MODULE 5 DEALING WITH the HIV/AIDS STIGMA

UNIT 1 SEXUALITY AND GENDER ISSUES

CONTENTS

1.0 INTRODUCTION

Sexuality is the process of becoming and being a man or woman with all its attending manifestations. Sex as a topic or an issue has long been considered a “taboo” for proper adult conversation. People hardly want to talk about it openly, however, in the last two decades, knowledge about sex and discussions of sexuality have come to be recognised as important and necessary for human development.

Sexuality health has also been recognised as being relevant in the overall component of well being. In the face of this recognition, there is still lack of knowledge regarding human sexuality among many adults including health care providers. Clients are often reluctant to raise questions related to sexuality, the health worker in her bid to provide holistic care must assume the responsibility of initiating discussions of relevant sexual topics within clients’ current developmental and health status.

This unit will consider sexuality and gender issues in relation to personal attitudes and beliefs, sexuality counselling and disorders with

the peculiar health process which enables health care provider to be non-judgmental and more effective in working with clients.

2.0 OBJECTIVES

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

- State the concept of sexuality and gender identity.
- Identify various attitudes towards sexuality.
- Discuss the nursing intervention in relation to sexuality and gender issues.

3.0 MAIN CONTENT

3.1 The Concept of Sexuality

Sexuality is described as the sense of being a female or male. It has biological, psychological, social and ethical components. It influences and is influenced by life experiences. The biological aspect of sexuality is the act of sexual activity. Sex may be used for pleasure and reproduction. The activity can be controlled or curtailed due to life's change or a choice for brief or prolonged periods. Being born with female or male genitalia social roles is the main ingredient to the emergence of sexuality.

The adult sexuality has four major divisions:

- Biological sex
- Sexual behaviour
- Core gender identity
- Sex role imagery

Biological Sex

This is determined at conception and refers to individual's physical attributes. This is based on the inherent genotype X and Y chromosomes. Female foetus receives two x chromosomes from the mother and a Y chromosome from the father. Initially, the genitalia of the foetus are undifferentiated, when the sex hormones begin to cue fatal tissues, the genitalia assumes male or female characteristics with corresponding underlying hormonal, neutral, vascular and physical components.

Core Gender Identity

This refers to one's sense of being a man or a woman and is established early in life, usually by 3years of age. Apart from the sex determination in uterus with the aid of C. T. Scan, at this age, the child is known whether he is a boy or a girl. As children begin to explore and understand their own bodies, they combine this information with the way that society treats them to create images of themselves as girls or boys. It is the core gender identity that corresponds to the physical attribute of the individual and self-concept development.

Sex Role Imagery

It refers to the learned behaviour that the particular society subscribes to their men and women. Sex imagery is complex because it includes the myriad beliefs about what is labeled feminine or masculine in a society. It also conveys the appropriate image of sexual conduct for particular social groups. It is important as it represents much of the learned behaviour which influences human choice and life-style.

SELF ASSESSMENT EXERCISE 1

i. Mention 3 examples of sex role imagery beliefs for male and female alike.

Male	Female

When does sex role imagery learning begin and end?

_____

_____

Sexual Behaviour

This is the acting out of sexual expressions, feelings and beliefs. It is a combination of human behaviour and varies from how one walks to how and with whom one relays with sexually. These behaviours include promiscuity, masturbation, sexual preference (oral or genital) and the like.

3.2 Sexual Anatomy and Physiology

The Female Sex Organs

The female genitalia comprise the external and internal organs. The external sex organs, collectively called the vulva include the mons veneris, labia majora, labia minora, the clitoris and the vagina opening. The internal sex organs include the vagina, uterus, fallopian tubes and ovaries. Menstruation and menopause are the main physiological features of female sex organs.

The Male Sex Organ

The male sex organ is made up of the penis, testicles, epididymis and ductus deference, the prostrate gland, seminal vesicles and cowpers glands whose secretions become part oaf the ejaculated semen.

3.3 Attitudes towards Sexuality

Attitudes towards sexual feelings and behaviours change as people grow older. These changes become traditional or liberal because of societal changes, feedback from others, and involvement in religious or community groups. Individuals reveal themselves as females or males by their gestures, mannerisms, clothing, vocabulary and patterns of sexual activity.

Factors Influencing Attitudes

Two main factors that help shape sexual attitudes and behaviors are biological factors and personality. Other powerful factors that are involved include religious beliefs, society and traditions.

- Clients' sexual attitudes

Everyone has sexual value systems which are acquired throughout life. These make it easy for a client to deal with sexual concerns in a health care setting or it becomes an obstacle to expressing it.

- Health workers' attitudes towards sexuality

Health workers should deal with personal attitudes by accepting their existence, exploring their sources and finding ways to work with them. Health workers are part of the society and their professional behaviour must guarantee that clients receive the best health care possible without diminishing their self worth. The promotion of sex education and honest examination of sexual values and beliefs can help in reducing sexual

biases that can interfere with care. They should give clients information about sexuality and this does not imply advocacy. Clients require accurate honest information about the effects of illness on sexuality and the ways that it can contribute to wellness.

3.4 Sexuality Counselling

Sexuality complains are determined during history taking. An acceptance to open up makes sexuality an acceptable topic to discuss. Once the nature of the problem has been identified, treatment commences on the hinges of sexuality counselling. Sexuality counselling operates at four levels:

- Permission: This involves letting the client realise or be reassured that he/she is normal and may continue doing what he/she has been doing.
- Limited information: This involves only providing information specific to the patients concerns or problem. A closed monitoring by the nurse is made possible by the assumed change in behaviour or action.
- Specific suggestions: These may be a suggested course of action through more in-depth education and sexual exercise.
- Intensive therapy: This should be highly individualised and provided by professionals who have advanced experience and knowledge in the sex therapy field.

SELF ASSESSMENT EXERCISE 2

Using levels 2 and 3 what will be your guiding principle in the sexuality counselling of an Acquired Immune Deficiency Syndrome (AIDS) patient / client.

3.5 Disorders of Sexuality

Disorders of sexuality can occur in each of the four areas of sexuality (see 3.1), but most disorders are psychosexual in origin. These disorders include the under stated.

1. Variation in sexual expressions classified by objective choice and sexual aim.
    - Trans- sexuality in which an individual appears to have a gender identity at odds with his or her physical self.
    - Ambiguous genitalia which presents a genitalia different from the physical gender identity on the child.

- Sexual concerns over performance are also prevalent in which an individual doubts his or her necessary physical attribute to attract, satisfy and keep a sexual partner.
- Sexual dysfunction in the form of impotence, premature ejaculation, frigidity, dyspareunia and vaginism. It can be as a result of psychological or physical factors.

3.6 Sexuality and the Caring Process

Sex is a natural, spontaneous act that passes easily through a number of recognisable physiological stages and culminates in satisfaction for both partners. Health practitioners should expect to encounter clients who have problems with one or more of the stages of sexual behaviour excitement, plateau, orgasm and resolution.

Many health workers are uncomfortable talking about sexuality with clients, but they can reduce their discomfort by using a caring process which includes assessment, diagnosis, planning, implementation and evaluation.

The assessment level considers the factors affecting sexuality: physical relationship, lifestyle and self esteem factors. These assist in eliciting the exact cause of sexual concerns or problems of the client/patient. As a follow up to the assessment, altered sexuality patterns and sexual dysfunction are recognised as approved health diagnosis. The difference is in whether the client perceives problems in achieving sexual satisfaction or expresses concern regarding sexuality.

The planning of health care is dependent on clients needs, and should include referrals to resources to promote achievement of goals after contact with the health care provider is discontinued.

Interventions (implementation) should address client alterations in sexual patterns or sexual dysfunction generally to raise awareness, assist clarification of issues or concerns, and provide information. An acquisition of specialised education in sexual functioning and counselling may provide more intensive sex therapy.

Evaluation of the impact of the caring process on sexuality is determined by client or spouse's verbalisations as to whether goals and outcomes have been achieved. Sexuality is felt more than observed and sexual expression requires an intimacy not amenable to observation. Clients are expected to verbalise concerns, share activities and satisfaction as well as relate risk factors. Outcomes are evaluated, the client, spouse and the health care provider may need to modify

expectations or establish more appropriate time frames to achieve the target goals.

4.0 CONCLUSION

Sexuality is an integral component of personhood and therefore may have an impact on or be affected by health status. The health care provider therefore needs to be clear about his or her own sexuality and moral beliefs about sex and reproduction before addressing the needs of the patient. Sex will always remain a controversial issue because of ethical value systems. Facts of conception, development conception and sexual disease transmission may be taught but cannot be totally separated from ethical issues.

You have many opportunities to be a promoter of good health in the fields of sex and reproduction. You should utilise these opportunities when they are available . No one should be left out (male or female) as the responsibility for sexual health transcends all boarders. With sensitivity and insight, we all can assist clients in assuming responsibility for decisions about sexuality, thus enhancing their total health**.**

5.0 SUMMARY

This unit on sexuality and gender issues reflects on the concept of sexuality stressing the four major divisions of adult sexuality.Also,it gives a brief description of the anatomy and physiology of the sexual organs, and people's attitudes towards sexuality and counselling in the face of sexuality disorders. The levels of care and intervention were also identified in order to appropriate the client's expectation of health care from the service provider.

6.0 TUTOR MARKED ASSIGNMENT

Highlight the various gender issues that are often associated with the incidence of HIV/AIDS.

Answers to Self Assessment Exercises

Exercise 1

i. Male: Leadership, Benefactor, and Dominance.
   Female: Service, Caretaker and Role model.
ii. From 3years to death.

Exercise 2

Close monitoring, provide privacy in management, provide education to overcome the stigma and offer suitable treatment.

7.0 REFERENCES/FURTHER READINGS

Bartscher, PWB (1983). Human Sexuality and Implication for Nursing Intervention: A Teaching Format *Journal of Nursing Education* 22 (3): 123 – 127.

Glover, J (1984). *Human Sexuality in Nursing Care* London:Croom Helm.

Joan, A.R. & Mike, W (1992). *Watson's Medical-Surgical Nursing and Related Physiology* ELBS (4th ed) London.

Katchadourian, H.A & Lunde, D.T. (1987). *Fundamentals of Human Sexuality* (3rd ed) New York: Holt Rinehart & Winston.

UNIT 2 STIGMA AND HIV /AIDS

CONTENTS

1.0 INTRODUCTION

Following the identification of HIV and AIDS by scientists, social responses of fear, denial, stigma and discrimination have accompanied the epidemic. Discrimination has spread rapidly, fuelling anxiety and prejudice against the groups most affected, as well as those living with HIV or AIDS. It goes without saying that HIV and AIDS are as much about social phenomena as they are about biological and medical concerns. Across the world the global epidemic of HIV/AIDS has shown itself capable of triggering responses of compassion, solidarity and support, bringing out the best in people, their families and communities. But the disease is also associated with stigma, repression and discrimination, as individuals affected (or believed to be affected) by HIV have been rejected by their families, their loved ones and their communities. This rejection holds as true in the rich countries of the North as it does in the poorer countries of the South.

Stigma is a powerful tool of social control. Stigma can be used to marginalise, exclude and exercise power over individuals who show certain characteristics. While the societal rejection of certain social groups (e.g. homosexuals, injecting drug users and sex workers) may predate HIV/AIDS, the disease has, in many cases, reinforced this stigma. By blaming certain individuals or groups, society can excuse itself from the responsibility of caring for and looking after such populations. This is seen not only in the manner in which “outsider” groups are often blamed for bringing HIV into a country, but also in

how such groups are denied access to the services and treatment they need.

In this unit, we shall examine the place of stigma in relation to HIV and AIDS and how to resolve it with a view to assisting those affected with it.

2.0 OBJECTIVES

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

- Describe stigma in relation to HIV and AIDS
- Identify the factors which contribute to HIV/AIDS-related stigma:
- Discuss the forms of HIV/AIDS-related stigma and discrimination
- Explain the impact of stigma on the sufferers and society.

3.0 MAIN CONTENT

3.1 The Relationship of Stigma to HIV and AIDS

In many societies people living with HIV and AIDS are often seen as shameful. In some societies the infection is associated with minority groups or behaviours, for example, homosexuality. In some cases HIV/ AIDS may be linked to "perversion" and those infected will be punished. Also, in some societies HIV/AIDS is seen as the result of personal irresponsibility while it sometimes brings shame upon the family or community. And whilst negative responses to HIV/AIDS unfortunately widely exist, they often feed upon and reinforce dominant ideas of good and bad with respect to sex and illness, and proper and improper behaviours.

3.2 Factors which Contribute to HIV/AIDS-Related Stigma

There are factors which have been adduced as contributing to the stigma attached to HIV/AIDS. These include the following:

- The feeling of HIV/AIDS as a life-threatening disease
- People are scared of contracting HIV
- The disease is associated with behaviours (such as sex between men and injecting drug-use) that are already stigmatised in many societies
- People living with HIV/AIDS are often thought of as being responsible for becoming infected
- Religious or moral beliefs lead some people to believe that having HIV/AIDS is the result of a moral fault (such as promiscuity or "deviant sex") that deserves to be punished.

Sexually transmitted diseases are well known for triggering strong responses and reactions. In the past, in some epidemics, for example TB, the real or supposed contagiousness of the disease has resulted in the isolation and exclusion of infected people. From time immemorial, the epidemic of AIDS has a series of powerful images used that reinforced and legitimised stigmatisation. The disease was seen as a punishment (e.g. for immoral behaviour), a crime (e.g. in relation to innocent and guilty victims), a war (e.g. in relation to a virus which needed to be fought), a horror (e.g. in which infected people were demonised and feared) and as otherness (in which the disease was an affliction of those set apart).

Together with the widespread belief that HIV/AIDS is shameful, these images represent "ready-made" but inaccurate explanations that provide a powerful basis for both stigma and discrimination. These stereotypes also enable some people to deny that they personally are likely to be infected or affected.

3.3 Different Forms of HIV/AIDS-Related Stigma and Discrimination

In some societies, laws, rules and policies can increase the stigmatisation of people living with HIV/AIDS. Such legislation may include compulsory screening and testing, as well as limitations on international travel and migration. In most cases, discriminatory practices such as the compulsory screening of "risk groups", furthers the stigmatisation of such groups and creates a false sense of security among individuals who are not considered at high-risk. Laws that insist on the compulsory notification of HIV/AIDS cases, and the restriction of a person's right to anonymity and confidentiality, as well as the right to movement of those infected, have been justified on the grounds that the disease forms a public health risk.

Perhaps as a response, numerous countries have now enacted legislation to protect the rights and freedoms of people living with HIV and AIDS and to safeguard them from discrimination. Much of this legislation has sought to ensure their rights to employment, education, privacy and confidentiality, as well as the right to access information, treatment and support.

Governments and national authorities sometimes cover up and hide cases, or fail to maintain reliable reporting systems. Ignoring the existence of HIV and AIDS, neglecting to respond to the needs of those living with HIV infection, and failing to recognise growing epidemics in the belief that HIV/AIDS "can never happen to us" are some of the most

common forms of denial. These denial fuels AIDS stigmas by making those individuals who are infected appear abnormal and exceptional.

Stigma and discrimination can arise from community-level responses to HIV and AIDS. The harassing of individuals suspected of being infected or of belonging to a particular group has been widely reported. It is often motivated by the need to blame and punish and in extreme circumstances can extend to acts of violence and murder. Attacks on men who are assumed gay have increased in many parts of the world, and HIV and AIDS related murders have been reported in countries as diverse as Brazil, Colombia, Ethiopia, India, South Africa and Thailand. In December 1998, Gugu Dhlamini was stoned and beaten to death by neighbours in her township near Durban, South Africa, after speaking out openly on World AIDS Day about her HIV status.

3.4 The Prevalence and Manifestation of the HIV/AIDS Stigma

HIV/AIDS-related stigma and discrimination occur everywhere: in families, among friends, in workplaces, religious communities etc. HIV/ AIDS stigma is very widespread. It is insidious and very hard to measure because it manifests in so many different ways. One reason is that stigma is born of human behaviour. AIDS has such a complex mix of sexual behaviour, and potential drug use, and also the psycho-social dynamics of men and women, gender, age, and poverty. Because some people think of HIV-infected individuals as having done something (behaviour) to get infected, you have the recipe for stigma.

Stigma often takes the form of discrimination—acts that separate people living with the virus from those who are HIV-negative. However**,** it is changing but not fast enough. People have lost their jobs, got kicked out of their homes, and generally ostracised by loved ones, colleagues, and society. In many parts of the world, you find very high awareness about AIDS, HIV transmission, and risk factors. However, we find that in these settings, people still stigmatise those living with HIV/AIDS. There is a fear factor around AIDS that is very rational.

In developed and developing countries, individuals are still wary of disclosing their HIV status for fear of being ostracised by their families or loved ones. This creates a situation in which individuals may not get tested and do not access life-saving treatments which fuels morbidity, mortality, and further HIV transmission.

3.5 The Impact of the HIV/AIDS Stigma

On Women

There is great impact of HIV/AIDS on everybody. However, the impact on women is particularly acute. In many developing countries, women are often economically, culturally and socially disadvantaged and lack equal access to treatment, financial support and education. In a number of societies, women are mistakenly perceived as the main transmitters of sexually transmitted diseases (STDs). Together with traditional beliefs about sex, blood and the transmission of other diseases, these beliefs provide a basis for the further stigmatisation of women within the context of HIV and AIDS

HIV-positive women are treated very differently from men in many developing countries. Men are likely to be "excused" for their behaviour that resulted in their infection, whereas women are not. In some African countries, women, whose husbands have died from AIDS-related infections, have been blamed for their deaths.

On Families

In the majority of developing countries, families are the primary caregivers to sick members. There is clear evidence of the importance of the role that the family plays in providing support and care for people living with HIV/AIDS. However, not all family response is positive. Infected members of the family can find themselves stigmatised and discriminated against within the home. There is also mounting evidence that women and non-heterosexual family members are more likely to be badly treated than children and men.

On Employment

While HIV is not transmitted in the majority of workplace settings, the supposed risk of transmission has been used by numerous employers to terminate or refuse employment. There is also evidence that if people living with HIV/AIDS are open about their infection status at work, they may well experience stigmatisation and discrimination by others.

Pre-employment screening takes place in many industries, particularly in countries where the means for testing are easily available and affordable.
In poorer countries screening has also been reported as taking place, especially in industries where health benefits are available to employees. Employer-sponsored insurance schemes providing medical care and pensions for their workers have come under increasing pressure in countries that have been seriously affected by HIV and AIDS. Some

employers have used this pressure to deny employment to people with HIV or AIDS.

On Health Care

Many reports reveal the extent to which people are stigmatised and discriminated against by health care systems. Many studies reveal the reality of withheld treatment, non-attendance of hospital staff to patients, HIV testing without consent, lack of confidentiality and denial of hospital facilities and medicines. Also fuelling such responses are ignorance and lack of knowledge about HIV transmission.

One factor fuelling stigma among doctors and nurses is the fear of exposure to HIV as a result of lack of protective equipment. Also at play, it appears was the frustration at not having medicines for treating HIV/AIDS patients, who therefore were seen as "doomed" to die.

Lack of confidentiality has been repeatedly mentioned as a particular problem in health care settings. Many people living with HIV/AIDS do not get to choose how, when and to whom to disclose their HIV status. In some hospitals, signs have been placed near people living with HIV/ AIDS with words such as "HIV-positive" and "AIDS" written on them.

4.0 CONCLUSION

HIV-related stigma and discrimination remains an enormous barrier to effectively fighting the HIV and AIDS epidemic. Fear of discrimination often prevents people from seeking treatment for AIDS or from admitting their HIV status publicly. People with (or suspected of having) HIV may be turned away from health care services, employment or refused entry to foreign countries. In some cases, they may be evicted from home by their families and rejected by their friends and colleagues. The stigma attached to HIV/AIDS can extend into the next generation, placing an emotional burden on those left behind.

Denial goes hand in hand with discrimination, with many people continuing to deny that HIV exists in their communities. Today, HIV/AIDS threatens the welfare and well being of people throughout the world. At the end of the year 2005, 40.3 million people were living with HIV or AIDS and during the year 3.1 million died from AIDS-related illness. Combating the stigma and discrimination against people who are affected by HIV/AIDS is as important as developing the medical cures in the process of preventing and controlling the global epidemic.

So how can progress be made in overcoming this stigma and discrimination? How can we change people's attitudes to AIDS? A certain amount can be achieved through the legal process. In some countries people who are living with HIV or AIDS lack knowledge of their rights in society. They need to be educated, so they are able to challenge the discrimination, stigma and denial that they meet in society. Institutional and other monitoring mechanisms can enforce the rights of people living with HIV or AIDS and provide powerful means of mitigating the worst effects of discrimination and stigma.

However, no policy or law can alone combat HIV/AIDS-related discrimination. The fear and prejudice that lie at the core of the HIV/AIDS discrimination need to be tackled at the community and national levels. A more enabling environment needs to be created to increase the visibility of people with HIV/AIDS as a "normal" part of any society. In the future, the task is to confront the fear based messages and biased social attitudes, in order to reduce the discrimination and stigma of people who are living with HIV or AIDS.

5.0 SUMMARY

In this unit, we have done on the following:

- Described stigma in relation to HIV and AIDS
- Identified the factors which contribute to HIV/AIDS-related stigma
- Discussed the forms of HIV/AIDS-related stigma and discrimination and
- Eexplained the impact of stigma on the sufferers and society.

6.0 TUTOR MARKED ASSIGNMENT

HIV/AIDS is always associated with stigma, repression and discrimination. Discuss these in line with your experience in the life of a 35 year old business executive.

7.0 REFERENCES/FURTHER READINGS

Bartscher, PWB (1983). Human Sexuality and Implication for Nursing Intervention: A Teaching Format *Journal of Nursing Education* 22 (3): 123 – 127.

Glover, J (1984.. *Human Sexuality in Nursing Care*. London: Croom Helm.

Joan, A.R. & Mike, W (1992). *Watson's Medical-Surgical Nursing and Related Physiology*; ELBS (4th ed). London.

Katchadourian, H.A & Lunde, D.T. (1987). *Fundamentals of Human Sexuality* (3rd ed). New York: Holt Rinehart & Winston.

UNIT 3 HEALTH EDUCATION

CONTENTS

1.0 INTRODUCTION

You will recall that we explored the concept and components of primary health care in the earlier units of this course. Health education was one of such cmponents. These components are processes by which individuals or groups of persons learn to prevent diseases, promote and maintain or restore health through voluntary adaptation of healthy behaviour**.**

The importance of health education was strongly highlighted by the Alma Ata Conference. It was pointed out that community participation is crucial to ensure optimum utilisation of health resources. It was also stressed that health is an individual responsibility and every individual needs to be health conscious so that he/she may observe healthy living practices.

You know already that preservation of good health is dependent on following good health practices. Health education and communication about healthy practices bring about a change in health behaviour so that harmful health practices can be given up and good health practices can be reinforced.

This unit presents you with the definition, growth, principles, practices, and levels of health education.

2.0 OBJECTIVES

After going through this unit, you should be able to:

- Explain the concept of health education.
- List the objectives of health education.
- Describe how health education can be planned and explain its methods of delivery.

3.0 MAIN CONTENT

3.1 Definitions

Health is a state of complete physical, mental, social and spiritual well being and not merely the absence of diseases or infirmity (World Health Organisation, 1948).

Education is the process by which there is a behavioural change resulting from an experience undergone.

Health education is a process that informs, motivates and helps people to adopt and maintain health practices for a healthy lifestyle; it advocates environmental changes as needed to facilitate this goal and conducts professional training and research towards the same end (National Conference on Preventive Medicine, U.S.A).

Health education is also a process of known information which has the purpose of promoting health (Pearce, 1980).

Health education is also described as a process by which habits, attitudes and knowledge are changed to choose the path leading to better health. Success in health education depends a great deal on the skills of communicating with the community (WHO, Health Panel).

It is also seen by many as a process of positively changing or influencing people's health knowledge, attitudes and behaviour through their own actions (Ewles and Simnelt, 1985 and Tones, 1990).

It is an all-round process which involves the whole life thereby helping people to help themselves live a healthy life.

SELF ASSESSMENT EXERCISE 1

What is your concept (idea) of health education?

3.2 The Growth of Health Education

Health education has begun with people being systematically interested in general sanitary progress, social and material causes which can impede their health.

In 1875, Maryland State of Health emphasised that the health of the pubic is dependent on the public conviction about health. Health education initially was the responsibility of public health personnel until the 2nd quarter of the century when it became formally recognised as a speciality and a major function of public health. The development of newer interpretation of public health bought about the need to do things with people and to get people to accept an increasing responsibility for their own health.

Clair Turner at the Massachusetts Institute of Technology later recognised health education academically with the development of a specialised graduate curriculum in 1922. Its global acceptance for knowledge acquisition and practice has brought its operation beyond the hospital setting to communities, schools, churches, mosques and the public at large.

3.3 Purposes of Health Education

Health education is a process that informs, motivates and helps people to adapt and maintain healthy practises and lifestyles. The three main purposes of health education will be discussed below:

Informing People

Information is the right of an individual. It is prerequisite to proper awareness and assessment of one's duties and rights. Health is a basic right of all human beings, so is health information. Only an informed community will aspire, work, demand and fight for its right, that is, health. Health information helps people to be aware of their health problems and guides them to appropriate solutions for same.

Motivating People

Only information is not enough. Information that alcohol or tobacco is harmful to health does not ensure that people will leave them. Besides providing information, it is also necessary to motivate people to adopt certain behaviours. Health education must provide learning experiences,

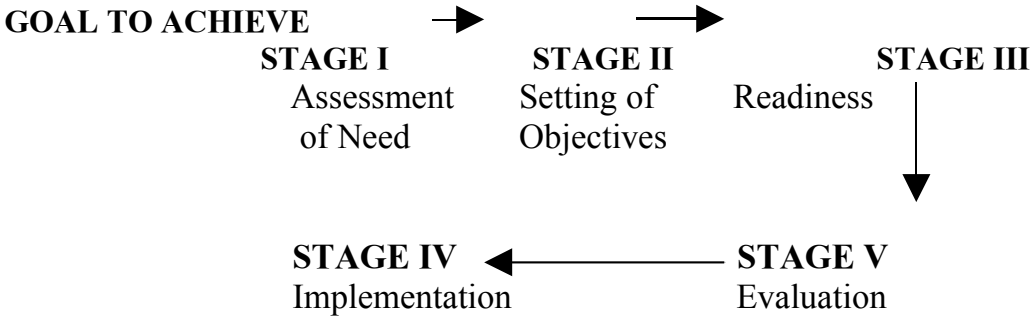
which favourably influence habits, knowledge and attitudes. Consumers should make choices and decisions about health matters.

Guiding People into Action

Motivation must be accompanied by guidance to achieve the expected behaviour. People need to adopt and maintain healthy practices and lifestyle.

3.4 The Process of Health Education

The process involved in health education as identified by Books (1980) includes: assessment, objectives setting, readiness, implementation and evaluation.



3.5 Principles of Health Education

Health education brings together the art and science of medicine and the principle and practice of general education. It involves teaching, learning and inculcation of habits concerned with healthy living. The guiding principles are these:

- Issues to be discussed must be interesting (or made interesting) to the people.
- Encourage personal involvement in form of group discussions, panel discussions and workshops.
- Start health education from what the people know before going to the unknown.
- Study the people's level of understanding, literacy and education to ensure prompt comprehension.
- Reinforcement and repetition at intervals is useful.
- Motivation: incentives must be incorporated for good and bad habits.
- The education should present a role model for any issue being taught. Consider this Chinese proverb. "If I hear it, I forget it. If I see it, I remember it. If I do it, I know it."

- Make the whole exercise attractive, palatable and acceptable with necessary methods.

SELF ASSESSMENT EXERCISE 2

Health education involves the following:

3.6 Health Education in Patient Care

Health education is a continuous professional activity in health care at all levels. It places on the health practitioners a sense of responsibility to:

- Supply relevant, accurate information about general and specific health matters to patients and their relatives.
- Teach patients and their relatives about self-care, avoidance of complications and reduction of consequences of ill health.
- Teach patients and their relatives how to cope effectively with disability both in hospital and after discharge.
- Communicate effectively, appropriately and sensitively with patients and their relatives.

SELF ASSESSMENT EXERCISE 3

Mention 4 problems in health education**.**

4.0 CONCLUSION

We have limitless opportunities to practise health education regardless of the varying speciality. Health education can occur at both formal and informal settings whenever and wherever. The only limitation is when we fail to appreciate or recognise those occasions and opportunities which are favourable.

A health educator desirous to affect the people for good must be sympathetic and friendly. He has to be knowledgeable and be one who practises what he teaches (a role model), speaks the language of the people and uses different methods of health education (as identified by you in Exercise 4).Also he has to use audio-visual technology and various means of communication in order to be an effective communicator and in order to achieve the desired result (a change of life style for healthy living).

5.0 SUMMARY

In this unit, we have examined health education in relation to the definition, growth principles, purposes and processes. We considered its relationship with our varying areas of specialty. We have also done some exercises to check your progress on the unit.

6.0 TUTOR MARKED ASSIGNMENT

Using the process of health education, prepare a presentation for the control of HIV/AIDS spread among secondary school students.

Answers to Self Assessment Exercises

Exercise 1

The answer is to incorporate an all round process/procedure which contributes to healthy living.

Exercise 2

Teaching, learning and inculcating habits that are concerned with healthy living.

Exercise 3

No clarity of purpose, inappropriate methods, the wrong audience and wrong evaluation

7.0 REFERENCES/FURTHER READINGS

Brooks Health Education in A General Textbook of Nursing, EBLS (13th ed), London.

Ewles and Simnett (1985). Health Education and Patient Teaching in Watson's *Medical-Surgical Nursing and Related Physiology* p. 23

Lucas, A. O and Guiles, H. M (1984). *Preventive Medicine for the Tropics.* Kent: Hodder and Stoughton Ltd.

Otun Kalu (1994). Workshop paper on "The Role of the Media in Information Dissemination on Family Planning and Population Issue"

Pearce, E (1980). *A General Textbook of Nursing*, (12th ed). EBLS, London.

Santhosh, M. (2000). *Primary Health Nursing (PHN)*. Indria Gandhi National Open University, New Deli: Berny Art Press.

UNICEF (1999) Publications on Health Communications.